NHS
North East and North Cumbria

Longer and healthier lives for all...

Annual report and accounts

1 April 2023 – 31 March 2024

Contents

Chair's Foreword

Professor Sir Liam Donaldson

Reflections of the year

After a very hard year, my deepest gratitude goes to all our teams in the Integrated Care Board (ICB) and across health and care for their unwavering commitment and pursuit of the highest standards of service for all three million people whom we serve.

In my role as chair of the ICB and interim chair of our Integrated Care Partnership, I have seen the many benefits that collaborative working can bring both at regional and local community level.

Despite it only being two years since we were formed, our strategic discussions, partnerships and programmes are fully engaged as we collectively work to address the wider determinants of health such as poverty, housing, and economic development, as well as some of biggest killers such as smoking and alcohol.

We have not had as much time as we would have liked to focus on aspects of population health and prevention. We are still a new organisation. We also have the challenge of balancing our long-term ambitions against more immediate actions to improve the speed of access to services for patients, addressing the rising tide of urgent and acute illnesses, as well our recovery from the pandemic.

I believe we have still made inroads in these areas in the last year with many examples in this report. However, we have to make space to get to grips with prevention and hit at the root causes of poor health and inequalities. This will benefit people living in the North East and North Cumbria, but it is also of crucial significance in improving the health and wellbeing of future generations.

Patient safety and high-quality care

There can be no area that people receiving health services, and those providing them, should care about more deeply about than being protected from avoidable harm.

It's something that I am passionate about and where we have a real opportunity to do even more to make care safer.

This year saw the development of a regional quality strategy. Individual health organisations have actions in place but there will be added value in having common standards that are applied consistently across our region.

I am excited that we will be establishing a new patient safety centre. We are the largest ICB in the country and can work at scale to tackle some of the common causes and risks of unsafe care.

With a population of three million people, we have access to a huge amount of data to identify risks and collectively problem solve. Drawing on the best international evidence through my role as a World Health Organisation Special Envoy for Patient Safety, will

put us in a strong position to innovate in this area and make the care of our patients as safe as it can possibly be.

Preventing ill-health

A national consultation by the Department of Health and Social Care (DHSC) is underway to expand water fluoridation schemes across the North East.

Fluoridation of water is a naturally occurring phenomenon and topping it up to a healthy level of fluoridation brings huge benefits with evidence of this going back to the 1940s.

Indeed, some areas of the North East already have tap water which contains fluoride, and this has proven to be effective at reducing dental decay for people living in these areas.

So, we are right behind it. If it goes ahead, we would be making history by introducing what has been called 'one of the top 10 public health achievements of the 20th century,' along with tobacco control, vaccination, and safer healthier foods.

As a child, I went through a lot of pain and anxiety because of my own tooth decay. Today's children don't need to have that.

This year saw the Tobacco and Vapes Bill introduced to the House of Commons which would raise the age of sale for all tobacco products one year, every year from 2027 onwards. If approved, this Bill would be a significant milestone in our steps as a country for a smoke-free generation.

Despite the reductions we have made in the number of people smoking in our region, tobacco smoking remains our biggest cause of ill health, cancer, disability, and death – with more than 120,000 deaths in the North East since the year 2000. No other product kills up to two thirds of its users, most of whom (83%) start as teenagers. Which is why bold action continuing to be needed and we were one of 50 organisations in the North East who submitted responses in a consultation about this Bill in 2023.

Equally, bold action is needed to tackle the harm caused by alcohol.

Latest figures show the North East has the highest rate of deaths from alcohol for any English region in 2022 and of great concern is a new report from the World Health Organisation which puts the UK at the top of 44 countries when it comes to child alcohol use among 11- and 13-year-olds. Not only that but research shows that alcohol harm is costing the North East nearly £1.5 billion a year in terms of ill health, crime and disorder, social care, and the economy.

We have a comprehensive plan in the region to help us reach our goal of a reduction of 20 percent in alcohol related hospital admissions by 2030. But this must also be combined with action to tackle things like pricing, access and the appeal of alcohol and is why our partnership approaches to this are so important.

Collaborations

Collaborations within the NHS are also crucial to improving outcomes and attracting and retaining the specialist clinicians we need – especially with advances in technology and the development of more highly specialised services.

With colleagues at North Tees and Hartlepool NHS Foundation Trust and South Tees NHS Foundation Trust, we signed a new partnership agreement marking an important milestone for the formation of their new hospital group which will allow them to work together closely to deliver better outcomes for patients and communities right across the Tees Valley and surrounding areas.

The year ahead

This year has seen political elections in our region. We look forward to continuing to work closely with our combined authorities in the North East and Tees Valley.

There is so much more we can do to pool our expertise and look at how we share our resources to improve the health and prospects for people living and working in our region.

It has been a challenging time for all our staff in the ICB this year with uncertainty while we completed our programme to reduce running costs by 30 per cent and at an early stage of forming our new organisation. I would like to thank them for their continued professionalism during this time and as we have move forward to deliver our ambitions for longer and healthier lives for all our communities.

My hopes for this year are that we make significant inroads to improve access to care for patients, as well as create more time to focus our collective efforts on preventing ill-health and reducing health inequalities.

Finally, I would like to thank the many people who have shared their experiences as patients, carers and of working in our region with us.

As I said at our children and young people's summit earlier this year - these personal experiences are the power that drives us forward.

Statement from the Chief Executive

Samantha Allen

Reflections of the year

When we publish our review of 2023 to 2024, we will be marking our second year as an Integrated Care Board (ICB).

Reflecting on this busy year, I want to thank all our teams in the ICB, everyone working in health and care in our region, and all the unpaid carers and volunteers who have supported their communities. It has been a privilege to work alongside you and to have met some of you this year.

Together we have achieved a great deal and have much to be proud of. This is despite the significant and sustained pressures we continue to experience across health and care services, as well as the added challenges we have had as result of industrial action throughout the year.

Even with the improvements we have made, I wanted to recognise the inevitable impact these pressures have had on the experiences of our patients and on the wellbeing of our workforce too.

Some of this has borne out in recent surveys with the public, which show a decline in overall satisfaction in the NHS as well as a clear message that they want to see better access to primary care, more staff and shorter waiting times. While we recognise this is not where we want to be, we are making progress on these areas and more, with many examples highlighted in this report.

But there is much more still to do.

The NENC Way

We are still a young organisation. Our first year was one of transition as we moved from eight clinical commissioning groups to create the one organisation and started to set out our ambitions for 'longer and healthier lives for all'.

Our focus this year has been on starting to deliver these ambitions which has been alongside a tough ask to reduce the ICB's running costs by 30 percent. We have now completed our plans to achieve this national requirement, which equates to around £17.6m less to spend on running our organisation.

Our transition to new ways of working is now well underway and we are now turning 100 percent of our focus to delivering our Integrated Care Strategy called Better health and wellbeing for all – very much guided by the values and approaches we have agreed in 'our North East and North Cumbria' way.

Since its publication, we have also launched our Joint Forward Plan, in September 2023, which sets out how the NHS, with our partners, will deliver and support these goals.

It has been a challenging time for all ICB staff, and I understand the anxiety that change can bring.

Our first participation in the national NHS staff survey reflected this, with staff indicating they feel safe to voice concerns and trust these will be addressed. This shows our commitment to a culture where staff feel heard and valued. However, we need to do more to ensure more staff would recommend the ICB as a workplace. Supporting and valuing our staff to be 'the best place to work' is a key focus for us moving forward.

Delivering our ambitions

Longer and healthier lives

We have set demanding goals which include tackling the key causes of early death in our region – such as smoking, alcohol, obesity, heart disease, substance misuse and suicide.

Our comprehensive plan to tackle alcohol harm in the region has included the roll out of alcohol care teams (ACT) in all our NHS trusts so patients can access specialist support during their hospital stay. These teams will continue to be supported with an investment of £2m this financial year. We are also putting training and support in place so that all staff can give key messages to our patients about the risks around alcohol.

We are working collaboratively with our partners across the region (such as NHS providers, councils, universities, and the voluntary sector) to raise awareness of the harm caused by alcohol so that people get support when they need it, and to use data and intelligence to understand how we can make the biggest difference.

Supporting our communities to quit smoking continues and it's great to see that in all our hospitals we now have Tobacco Dependency Treatment Services (TDTS) which means patients are screened for smoking on admission and have access to specialist trained advisors. Together with Fresh, our tobacco programme, and other partners we are committed to working towards a 'smoke free generation' – so our future generations have a life free of addiction and harm caused by smoking.

Fairer outcomes for all

This year we have started to see some green shoots from our collaborative programmes with partners aimed at tackling broader issues such as poverty, housing, and employment, as well as rural disparity. There are no easy fixes to these issues but by working together I strongly believe we will make a difference.

Our Housing, Health and Care Programme is building on work already underway across our region to deliver more integrated housing, care, and support so that people can be healthy, live well and stay independent in their own home. The programme has been co-created with the North East branch of the Association of Directors of Adult Social Services (ADASS), the Northern Housing Consortium and the Technology Enabled Care Services Association (TSA).

Working with organisations such as Children North East, we have been looking at how we can 'poverty proof' services to ensure that people living in poverty aren't further disadvantaged when accessing healthcare.

Our 'deep end' general practices in some of our more deprived communities have been working together to drive up childhood vaccination rates and reduce opioid usage.

Our Waiting Well programme has offered support to more than 9,000 people so far from clinically and socially vulnerable groups to improve their health and wellbeing while they wait for surgery.

Better health for the 51 percent

It's with great pride that I can say we've started to build a movement to raise the profile and awareness of women's health issues in our region and launched new services, working closely with our colleagues across primary care, specialist women's services and public health.

While women live longer than men, they spend more of their lives in sickness or disability and the reality is that services have often been designed by men, for men. As a result, women often have to move from service to service, their needs are not always well understood.

We hosted our first ever women's health conference in partnership with the Office for Health Improvement and Disparities (OHID) with keynote speaker Dame Lesley Regan, Women’s Health Ambassador for England. With our second event planned for July this year. As part of this we are developing a women's health implementation plan for the region.

We're investing £595,000 in women's health hubs in Sunderland, Gateshead and North Cumbria which bring together healthcare professionals and means easier access to care that is tailored to women's needs from gynaecology, sexual health to pelvic pain, menopause care and more.

We were also the first region with all NHS trusts signed-up to the national sexual safety charter.

Better health and care services

Dentistry and primary care access

On 1 April 2023, we took on commissioning responsibilities for NHS dentistry along with pharmacy and optometry. Since the pandemic, dental services have faced massive challenges in meeting the increasing and more complex needs of our patients.

Recognising this we agreed, early on, a recovery plan to protect, retain and stabilise local NHS dentistry, backed by an initial investment of £3 million in 2023-2024. Since then, we have seen a steady but slow improvement in the number of people accessing dental treatment but recognise there is still more to do. We are investing more in 2024-25 with £1.3million to provide additional urgent dental capacity in Darlington and North Cumbria while we work to secure 11 general dental service contracts offering

thousands of extra appointments covering Darlington, North Cumbria, Durham, Sunderland, and Northumberland.

General practice

Demands on general practice continue to grow and we have been focusing on a number of important issues to support our colleagues in primary care, as part of the national recovery access plan.

This includes supporting practices to help tackle the '8am rush' through improved access routes such as the NHS App and investment in telephony, making it easier and more efficient for patients to get help. As well as improving referral routes for community services so patients don't need to see a GP first and increasing workforce capacity with additional clinical roles.

Expansion of pharmacy services

Across our pharmacies we are seeing more services being developed that people would have traditionally gone to their GP surgery for. Our pilot scheme to enable women to get treatment for urinary tract infection (UTIs) by a community pharmacist has treated more than 30,000 women and was adopted nationally as part of NHS England's primary care recovery plan and Pharmacy First scheme. We have also delivered the largest number of 'Pharmacy First' consultations nationally since the new scheme was launched in January 2024. This is a tribute to the hard work of all our teams in the ICB and across primary care including our local pharmaceutical committees, community pharmacists and general practice.

Collaborations

This year has seen the establishment of the North East and North Cumbria Primary Care Collaborative (PCC), creating a combined voice for primary care, and ensuring that their expertise and experience is fully utilised as a key part of our health and care system.

We have continued to work with our Provider Collaborative which includes our 11 NHS foundation trusts. Working together the Collaborative has tackled waiting times, increased diagnostic capacity, and attracted major capital funding investment with three new community diagnostic centres planned for our region in North Cumbria, Gateshead (Metro Centre) and Stockton and the creation of a new Medicines Manufacturing Hub.

The Collaborative is also leading the delivery of a three-year programme of investment in digital diagnostics across the region which will see around £17.8 million of national funding invested by 2025.

Over the last couple of months our region has had the best referral to treatment times in the whole country with 67.6 percent of patients receiving their treatment within 18 weeks. This compares to 58.8 percent nationally for March 2024.

The North East Ambulance Service NHS Foundation Trust (NEAS) remains the best performing ambulance service in the country for responses to 'category one' calls, which are the most serious or life threatening.

Managing winter and beyond

Sharing best practice and collaborative working across the health and care system supported our planning for winter this year, with much of this work now being part of our year-round approach to managing demand and improving and joining-up care.

Working collectively across the region we have focussed on reducing delays for patients, so they get to the right place first time, speeding up ambulance handovers at hospitals and avoiding delays in the transfer of care of patients from hospital. As well as supporting frail patients in communities, targeting those most at risk of falls or emergency admissions and providing enhanced support.

During winter, we invested £1m in extra experienced navigators for emergency departments and £1.5m to roll out 42 acute respiratory infection hubs – providing hundreds of extra and dedicated appointments for people with respiratory illnesses. We also set up a system co-ordination centre where we use real-time data and intelligence to help us manage the anticipated high number of patients needing help.

This year also saw the opening of a £9 million new Urgent Treatment Centre for Middlesbrough at The James Cook University Hospital reflecting work underway to improve urgent and emergency care and develop consistent models for urgent treatment centres including co-location with emergency departments.

Improving mental health

We have embarked on a range of initiatives as part of our unwavering commitment to improve mental health, learning disability and autism care and support so that more people receive the right care, in the right place, at the right time.

We know that too many people are waiting too long for support and that the number of people needing support is increasing.

A key priority has been to invest in access to services for children and young people, recognising that we have specific challenges in our region with higher levels of poverty which we know are linked to poorer mental health. This has included investment in services provided by our Voluntary, Community and Social Enterprise (VCSE) organisations to provide early help and support.

I was incredibly moved by the stories we heard from young people, parents, and carers, as well as our teams across health and care and the voluntary, community, and social enterprise sector at our children and young people's mental health summit, 'Always the right door'.

The event has helped to inform our planning going forward including the need for integrated teams and the involvement of young people in the design of services.

Strengthening the voice and engagement of people with lived experience is vital and we have created a lived experience advisory group to embed these insights into our work.

People in our region can now also access crisis mental health support via NHS 111, simplifying access and eventually replacing multiple freephone lines.

Working with partners including our mental health trusts we are re-designing inpatient facilities so that people can be cared for in more modern facilities and a key priority is to support people to live well in their own communities when they don't need to be in hospital.

Quality and learning

Quality is essential to everything we do – from how we commission and plan services to the way we deliver care and learn from each other.

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

This year we started to develop our region-wide quality strategy to support and build a positive culture of safety, openness, and learning.

I have been delighted at the early feedback from partners that this is something they want to adopt and believe we have a real opportunity to set the highest ambition for quality and safety standards in our region. As part of this, we are seeking the views of our partners, staff, and the public on what high-quality care looks like and means to them.

What will be key is ensuring that quality is reflected throughout all of our objectives, so this isn't just something that sits on a shelf gathering dust and becomes the way in which we work across our organisations.

As ever there is learning for us all from national inquiries, notably the Ockenden Review, Cass Review, and introduction of Martha's Rule; as well as cases and issues which are closer to home, such as recent Care Quality Commission (CQC) reports into leadership and culture and quality of maternity services.

We want our region to be the safest place to be pregnant, give birth and transition into parenthood. Working with the Local Maternity Neonatal Service (LMNS) and a range of partners we have established a Maternity and Neonatal Alliance which aims to build a more co-ordinated and effective system of care that supports improved outcomes for all.

This year, we have conducted assurance peer support visits to all eight of our providers trusts to ensure we are meeting the immediate and essential actions from the Ockenden Review and used this an opportunity to share good practice.

Being the best at getting better

Early on we set a clear ambition that we wanted to be the best at getting better and for learning and improvement to be at the heart of everything we do.

We've made great progress and our learning and improvement community, Boost, has grown from strength-to-strength over the past year and boasts more than 7,000 members.

As well as delivering a range of fantastic training and events focusing on leadership and improvement, we launched a discharge and safe transfer of care collaborative to improve the safety, experience, and outcomes of patients. We will soon be launching the Boost Learning Academy which will see an expanded offer of learning opportunities for teams across health and care, including topics in prevention and health inequalities linked with our healthier and fairer programme.

Innovations, data, digital and technology

Understanding data and using digital technology in new ways is vital to unlocking new innovations as well as further understanding the needs of our communities.

We are leading on the development of a Secure Data Environment programme for the region which will radically change how health and care data is accessed for research and development. Once implemented, we will be able to carry out more research and derive new insights from the rich data sources we hold which will benefit the people we care for.

Our revised Digital, Data and Technology Strategy builds on the great work we have already done in the region and focuses on five key themes from getting the basics right to building insights and enabling more personalised care closer to home.

We are a region of innovators and can be proud of the many experts we have here in the North East and North Cumbria. None of this could happen without our many partners such as our universities, Health Innovation North East and North Cumbria, Newcastle Health Innovation Partners, National Institute for Health and Care Research, Applied Research Collaborations (NIHR ARC's), and many more.

Our year ahead

Managing our resources wisely

As ever, we will need to manage our resources wisely and this will be a key challenge for us not only in the year ahead but the ones that follow. We will need to make the most of opportunities we have to work at scale across the region and for greater collaboration between our NHS providers and partners; as well as engaging our wider partners and communities to support more effective and efficient use of health services.

For 2024/25, we have worked with our NHS partners to agree a financial plan with NHS England which will see our system with a deficit plan of £50m.

Working together across all NHS organisations, our priority now is to develop a realistic medium term financial recovery plan over the next three to four years.

We have established a System Financial Recovery Board which will oversee a programme of work across key areas and be responsible for keeping our plan on track to deliver the agreed savings and benefits, and value for money for services across the system.

As I have mentioned before, we have some unique challenges in our region, and I have been open about what we call the 'quadruple whammy' for the North East and North Cumbria.

We have greater health and care needs which have been made worse as a result of the pandemic alongside a complex geography which makes it more expensive to provide services. In addition, as a result of how growth funding is allocated, we have seen a reduction in this too, despite these complexities.

This is difficult and there are some longstanding issues that we need to address if we are going to be able to deliver our plans for longer and healthier lives for all our communities.

Turning ambitions into reality

The year ahead will also see the publication of some key plans from ambitious standards around quality and safety, embedded in all that we do, to our new clinical strategic delivery plan.

This has been developed using population health management approaches, data, and intelligence to enable us to determine which conditions to focus our collective NHS efforts on, and where we can make the biggest impact.

It sets out 12 clinical conditions which for adults are: anxiety and depression, lung cancers, respiratory diseases, cardiovascular health and strike and lower back pain. For children these are: asthma, diabetes, epilepsy, oral health, mental health, learning disabilities, autism, and obesity.

Every one of us – as patients or colleagues – has seen the incredible commitment and expertise of our health and care staff first-hand at some point in our lives.

With health and care changing, work patterns changing and older colleagues retiring, we need to look to the future. Our recently published People and Culture Plan aims to address these urgent challenges: to support our staff, ensure we have the skilled workforce we need for the future, and equip us for the changing demands on our services in the future.

Developed by a wide partnership including the NHS, local government, education, and the voluntary sector, as well as patients, staff and trade unions, our strategy has a clear ambition – to make the North East and North Cumbria the best place to work in health and care.

Hopes for the year ahead

The public commitment to the underlying principles of the NHS are as strong as they have ever been – with 91 percent supporting the NHS being funded through taxation and 82 percent supporting the service being available to all.

So, I start our next year with much hope and optimism.

I know from my everyday conversations with people that there are always things we can improve, but I also hear all the really good work too – with compassionate and high-quality care being delivered every day by our dedicated teams.

With the support of our communities and our hardworking teams across health and care, and all our partners, I know we can re-build confidence and deliver our ambitions for better health and wellbeing for all our communities here in the North East and North Cumbria.

Performance report

Samantha Allen

Chief Executive of North East and North Cumbria Integrated Care Board

26 June 2024

Performance overview

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

The performance overview summarises the purpose of the ICB including its business model and structure as well as its objectives and strategy. The section gives an overview of how the ICB has performed against its key objectives in 2023/24 to date and highlights its main risks to achievement and how it mitigates against these risks.

About our Integrated Care Board

The ICB is part of a system of statutory NHS organisations which formed on 1 July 2022 and is responsible for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services. NHS England (NHSE) continues to be responsible for specialised commissioning. The ICB also works locally with health and wellbeing boards in each of the 14 local authority areas. The ICB`s place-based teams work alongside our 64 primary care networks (PCNS) which are groups of local GP practices, social care teams and other community-based care providers.

NENC ICB has the general statutory function of arranging health services for its population and is responsible for the performance and oversight of NHS services within its ICS. The NENC ICB Oversight Framework is integrated into the wider ICB cycle of business, and this ensures that it is a powerful tool for the achievement of the ICB`s strategic and operational aims as articulated in its strategy and operational plan. Following extensive engagement and co-production with a wide range of partners, the Better Health and Wellbeing for All strategy has been created to improve the health and care for people who live in the North East and North Cumbria. The ICB, working with partner organisations as part of the Integrated Care Partnership (ICP) has developed its Integrated Care Strategy, in line with national guidance. The ICB has operated its oversight arrangements with regard to its statutory duties, its agreed priorities and the requirements set out in its 2023/24 Operating Plan which addresses the NHS England Operating Plan Guidance for this year.

The ICB, along with 14 local authorities, forms the statutory committee of the ICP. The ICP is responsible for setting and developing our strategy for health and care in the region. It is an equal partnership between local government and the NHS with a key purpose to align the ambition and strategies of partners across the area to improve the health of our communities.

Our vision, goals, and ambition

Within the ICB, our vision is better, fairer, health and wellbeing for everyone. This is intended to be an inclusive vision, capturing the need to improve health and broader wellbeing for everyone across the North East and North Cumbria (NENC). The North East and North Cumbria ICP is a statutory committee of fourteen local authorities and the Integrated Care Board (ICB).

The ICP published the North East and North Cumbria integrated care strategy, Better Health and Wellbeing for All, in December 2022. It is an ambitious strategy organised around four key goals:

- Longer, healthier lives: reducing the gap between how long people live in the North East and North Cumbria compared to the rest of England.
- Fairer outcomes: we know that everyone does not have the same opportunities for good health, because of where they live, their income, education, and employment.
- Better health and care services: high quality services no matter where you live and who you are.
- Giving our children the best start in life: enabling them to thrive, have great futures and improve lives for generations to come.

Our joint forward plan is a delivery plan for the parts of the strategy related to NHS delivered or commissioned services. Our joint forward plan is aligned to the Better Health and Wellbeing for All strategy. Each of these sections of the plan are interdependent. A key challenge is to ensure links between the different elements of the plan, summarised in the graphic below.

Figure 1 Better health and wellbeing for all – a strategy for the North East and North Cumbria Framework

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

We recognise that this is a challenging time for the NHS and social care. As services continue to recover from the long-lasting impact of the Covid pandemic, we have also been impacted by industrial action and rising energy costs, along with the cost-of-living crisis which has impacted significantly on the quality of life for our citizens. Most measures of health and wellbeing, population health, health inequalities and performance measures for health and care services have worsened since the pandemic and continue to be impacted by industrial action. Work continued in 2023/24 on a shared ambition to deliver a programme of health and care improvement for the people of the NENC that reverses these negative trends and delivers the healthier and fairer lives they deserve. The pandemic has further reduced life expectancy at birth of our population and there is need for focused work to ensure we recover from this position through supporting our providers to recover.

Key issues and risks that could affect delivery of objectives and future performance and plans relate to capacity and workforce challenges, and services which have been adversely impacted by Industrial Action. The ICB continues to support its providers in managing these pressures and some improvements have been seen during 2023/24, in particular we have minimised the number of patients who have been waiting over 104 weeks by the end of March 2024, and a there has been a significant reduction in patients waiting 65+ weeks. We have also seen the long-standing upward trend in waiting list size reversed.

In addition, we continue to see a reduction in the number of patients waiting over 62 days for cancer treatment, although work continues, as well as an improvement in the cancer faster diagnosis standard so that by March 2024, 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.

Specific pressures are noted below which could impact delivery of our objectives and future performance:

- Access to Primary Care, across General Practice and community Dentistry, Pharmacy and Optometry
- Urgent and Emergency Care (UEC) capacity
- Ambulance Handover delays
- High level of hospital attendances leading to high bed occupancy
- Pressures within social care together with health service capacity resulting in patients who no longer meet the criteria to reside have had their discharge delayed
- The size of the elective waiting list and pressures in certain specialties
- Increase in need for mental health, learning disability and neurodiversity pathways and very long waits in some pathways
- Increased waiting times have a negative impact on mental health conditions of patients whilst they are waiting

- Workforce and industrial action
- Workforce pressures have placed additional pressure on existing staff

Performance analysis

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

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

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

The ICB measures performance utilising a range of performance metrics which are aligned to NHS England's operational planning metrics and encompass a wide range of recovery objectives as well as some NHS Long Term Plan (LTP), NHS People Plan commitments, quality and safety, and health inequality measures. This is underpinned using a statistical process control (SPC) approach which is considered best practice to enable boards and systems to understand where there is significant variation and most risk and therefore focus attention on those areas that require improvement support.

The ICB routine performance assessment encompasses key elements of the 2023/24 operational planning priorities, NHS Oversight framework (NHS OF) metrics, and the targets as set out in the NHS Constitution, noting nationally the impact of the pandemic. The Finance, Performance and Investment Committee, Executive Committee and Quality and Safety Committees consider the element of risk to achievement of the operational planning priorities within the organisational risk register so that the impact on the quality of care to our patients is minimised.

Performance management is a key element of oversight meetings with our trusts involving the Executive teams from the ICB and the trust. The frequency of these will be dependent on the NHS OF segmentation of each trust. A segmentation decision indicates the scale and general nature of support needs (ranging from no specific support needs in segment one to a requirement for mandated intensive support in segment four) and influences the oversight arrangements that are established. NHS England holds the responsibility to review and change segmentation. Oversight of trusts in segment one and two is led by the ICB, and oversight of trusts in segments three and four is undertaken in partnership with NHS England.

During 2023/24 four of our trusts moved into segment 3 due to increased support needs, this has significantly changed the balance across the system with 7 of 11 trusts requiring support.

During 2023/24, NHS England continued a process introduced in 2022/23 by which trusts were allocated to tiers in relation to their elective and cancer backlog and also considered Cancer Faster Diagnosis Standard (FDS) positions throughout 2023/24. Trusts placed in Tier One have regular escalation meetings chaired by the NHSE North East and Yorkshire regional team, and trusts placed in Tier Two have similar meetings chaired by the ICB with NHSE in attendance. During 2023/24, the ICB has had two trusts placed under the tier escalation process for cancer and three trusts in escalation for elective backlogs. All trusts continue to see improvements through this process, and two trusts remain under escalation for elective care and one for cancer. NHSE will review Tiering and Segmentation in early Quarter 1 of 2024/25.

In 2023/24 NHSE introduced a tiering system for UEC similar to the existing system for elective care. However, for UEC, ICBs were allocated to tiers, rather than trusts. Like elective, Tier 1 involves national support and Tier 2 regional support from NHSE. NENC ICB was not assessed as needing Tier 1 or Tier 2 support.

Table: NHS Trust's Oversight Framework Segmentation and Tiering

Provider	NHS OF segment	Tiering	CQC
Cumbria, Northumberland, Tyne and Wear NHSFT (CNTW)	1	N/A	Outstanding (2022)
Northumbria Healthcare NHSFT (NHCFT)	1		Outstanding (2019)
North Tees and Hartlepool NHSFT (NTHFT)	2		Requires Improvement (2022)
South Tyneside and Sunderland NHSFT (STSFT)	2		Requires Improvement (2023)
County Durham and Darlington NHSFT (CDDFT)	3		Good (2019)
Newcastle Upon Tyne Hospital NHSFT (NUTH)	3	Tier 1 elective and cancer	Requires Improvement (2024)
Gateshead Health NHSFT	3		Good (2019)
North Cumbria Integrated Care NHSFT (NCIC)	3		Requires improvement (2020)
North East Ambulance Service NHSFT (NEAS)	3	N/A	Requires improvement (2023)
South Tees NHSFT (STHFT)	3	Tier 1 elective	Good overall (May 2023)
Tees, Esk and Wear Valleys NHSFT (TEWV)	3	N/A	Requires Improvement (2021)

Performance summary 2023/24

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.

Dashboard Key: The tables which follow include the following items:

Actual

This number represents the actual performance in the most recent reported month. 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

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.

Urgent and Emergency Care (UEC)

The ICB continues to focus UEC resources to improve responsiveness and build additional capacity in the community. A key aim for 2023/24 and beyond is to ensure greater resilience in the system resulting in improved ambulance response times, ensuring patients are seen in the right place at the right time by the right person, improved hospital flow and discharge processes by reducing bed occupancy and effectively managing system flow.

The specific measurable objectives for March 2024 are shown in the table below.

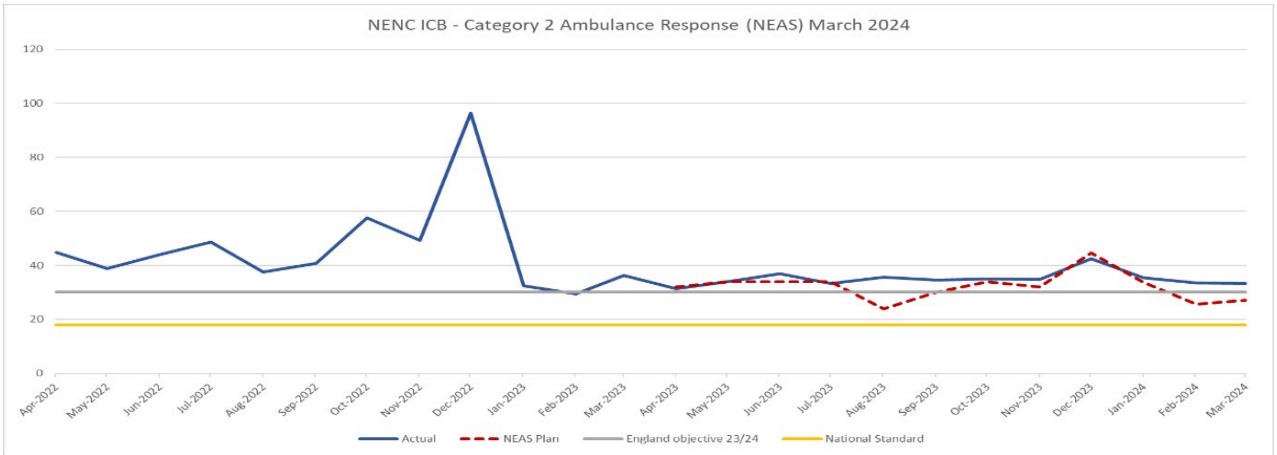
2023/24 Performance summary and mitigations

Urgent and Emergency Care - March 24 (except *data)

Objective	Plan (March 24)	Plan (month)	Actual	Trend	Benchmark
Accident and Emergency (A&E) waiting times < 4hrs (76% by March 2024)	79.2%	79.2%	76.0%		74.2% 16/42
Category 2 (Cat2) ambulance response (NEAS)	30 min av	27:05	33:20		6/11
Adult General and Acute (G&A) bed occupancy	92.1%	92.2%	91.5%		95.5%
Patients not meeting the criteria to reside (CtR)		8.2%	8.3%		
Ambulance handovers >59mins:59s*w/e 01/04/24	0	0	229		
111 Call Abandonment (NEAS plan)	3%	12%	8.6%	Improving	
Mean 999 call answering time (NEAS)	<10s	9s	3.3s	Improving	4.5s

- A&E performance has improved in 2023/24 even though there were increased attendances at A&E departments.
- There has been a large reduction in the number of patients waiting 12 or more hours from the decision to admit to admission in 2023/24
- There has been an increased number of Adult G&A beds available in 2023/24, with improved bed occupancy over the winter months
- NEAS Cat 2 average response times have improved in 2023/24
- Ambulance Handover delays over 60 mins have decreased in 2023/24

Category 2 mean ambulance response calls are those that are classed as an emergency or a potentially serious condition that may require rapid assessment, urgent on-scene intervention and/or urgent transport. Performance for the North East Ambulance Service (NEAS) has improved in March 24 to 33 minutes and 20 seconds compared to its peak in December 2023 and NEAS is ranked 6/11 of ambulance providers nationally. The end of year plan for March 2024 of 27 minutes and 5 seconds however has not been met. Performance has been relatively stable over the year as a whole compared with the previous year with notably better performance in November and December compared with the previous winter as shown in the chart above.



Accident and Emergency 4-hour response time measures the percentage of patients arriving at an A&E department who are admitted to hospital, transferred to a more appropriate care setting, or discharged home within 4 hours**.** There has been a specific focus nationally on the delivery of the 76% standard for 4 hour waiting time in A&E in March 2024, which was met across the ICB. Our performance at 76%, although above the national average of 74.2% in March, was short of the NENC 2023/24 operational planning commitment in relation to A&E and we continue to work collaboratively with each trust to proactively address pressures with patient flow.

Ambulance handover delays: the focus on reducing ambulance delays and getting vehicles back on the road has been sustained during the year. This has included the development and agreement of an immediate release policy for use across the ICB. Throughout 2023/24 there has been an increase in ambulance arrivals to Emergency Departments for NEAS compared to 2022/23 and with an increase in both conveyed and non-conveyed cases for NEAS.

Variation – the main work area for the UEC transformation programme is to understand and then reduce inappropriate variation through a learning and improvement approach. An escalation process for ambulance handover delays including a whole system focus on managing undifferentiated risk and trigger is now in place and a front door navigation and MDT working in A&E evaluation is now underway.

Delivery and risk into 2024/25

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

Primary and Community Care

Although more GP appointments per working day are being provided in General Practice across the ICB in March 2024 compared to March 2023, challenges remain for some patients in getting access to the appointments that they need.

A key objective for 2023/24 has been to develop and implement the Primary Care Access Recovery Plan (PCARP) to support primary care providers to increase capacity and the number of appointments that are provided and to get the most out of the capacity and resources that are available.

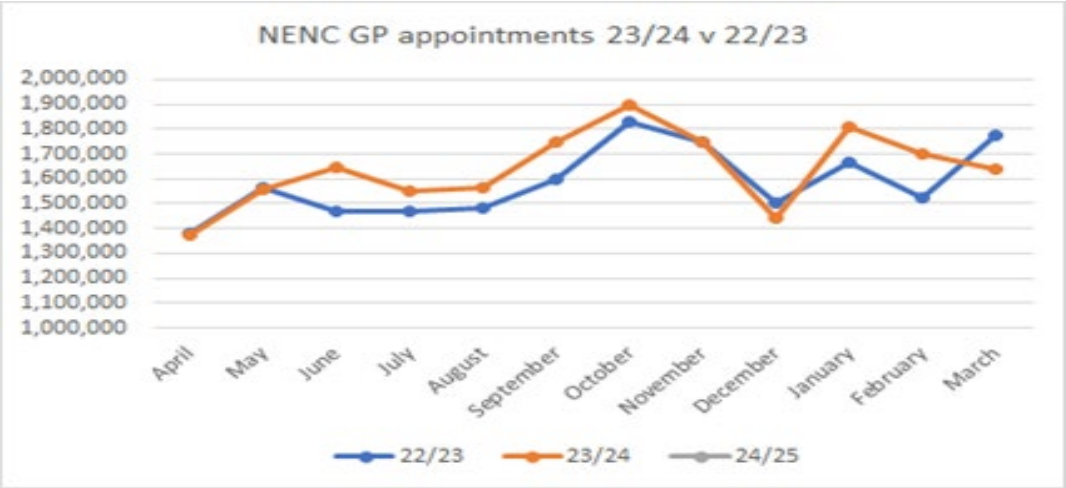
NENC is committed to deliver community health crisis response services as well as reablement care within 2 days of referral to patients who need it. Urgent community response (UCR) services provide urgent care to people in their homes which helps to safely avoid hospital admissions and enable people to live independently longer.

2023/24 Performance summary and mitigations

Primary and Community Care – February 24 (except *data)					
Objective	**Plan (March 24)**	**Plan (month)**	**Actual**	**Trend**	**Benchmark**
2-hour urgent community response (UCR) *January 2024	70%	70%	83.0%	Improving	83.2%
Reduce unnecessary GP appts: direct referral community optometrists/self-referral					
Proportion of GP practice appointments within two weeks (where appt been requested within 2 weeks)			80.7%		80.8%
More appointments in general practice by March 24*	1.6m	1.6m	1.64m		
Additional Roles Reimbursement Scheme (ARRS)	1526		1,717	Improving	
Improving units of contracted dental activity (UDA) Quarter 3	5.315m	5.315m	3.59m		
Proportion of appointments the same or next day			64.8%		64.8%
2-hour UCR first care contacts attended*February 2024			4895		

Urgent Community Response (UCR) teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. **UCR** referrals seen within 2 hours has consistently exceeded the 70% threshold during the year across the ICB – all trusts are now publishing data via the National UCR Dashboard following work to increase data quality.

General Practice appointments: March 2024 saw a decrease in the number of GP appointments in NENC ICB (1,640,880), although this was above the plan of 1,600,314. Although total GP appointments are below the March 2023 levels, when the number of working days are taken into account for March the March 2024 levels were above those of March 2023.



A Primary Care Access Recovery Plan was received by the ICB board in November 2023. There are significant delivery gains to this plan including:

a) practices are now underway with the general practice improvement programme
b) the first cohort of practices on analogue systems are converting to digital
c) the launch of the Pharmacy First scheme
d) the development of the primary to secondary care interface groups to look at reducing bureaucracy

Dental access recovery is underway across NENC and is being addressed in three streams:

- 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.

NENC Commissioned Dental activity

Units of dental activity contracted against operational plan: Performance for February 2024 year to date is 3.59 million compared to a March 2024 plan of 5.31 million.

NENC has commissioned 15,000 additional dental appointment slots to date across the patch, **and** 48,200 appointments have been secured from existing practice capacity for patients in greatest clinical need. In addition:

- 908.5 hours of additional dental clinical triage call handling capacity is now available in 2023/24.
- 836 additional sessions have been commissioned from dental out of hours providers until the end of March 2024.

NENC has also commissioned additional treatment capacity:

- 39,080 additional Units of Dental Activity in 2023/24
- 53,537 additional Units of Dental Activity for 2024/25

(This will be made recurrent in 2025/26 if providers can demonstrate delivery).

Incentive scheme and flexible commissioning capacity as at 15 February 2024:

- Appointment slots commissioned (2023/24) = 77,311
- Appointment slots delivered = 44,120 (used for clinical treatment)
- Patients who Did not Attend (DNA) or Failed to Attend (FTA) = 9,542 appointment slots (i.e., slot booked but patient failed to attend or were late cancellations therefore slot could not be refilled)

Healthwatch is helping assess progress so far with patient satisfaction and mystery shopping assessments of services newly commissioned. Two urgent dental access services are being commissioned in North Cumbria and Darlington while longer term services are procured.

Delivery and risk into 2024/25

- Urgent Community Response (UCR) data quality work continues. Work is ongoing to improve data collection and increase activity.
- NENC ICB is working with General Practice on predictive modelling and by November 2024 will be able assess plans for routine and urgent appointments to prepare the Urgent Emergency Care (UEC) system accordingly.
- NENC ICB has led a programme of workshops supporting General Practice with workforce recruitment, reducing the predicted Additional Roles Reimbursement Scheme (ARRS) underspend outturn pro-rata for the year 2023/24.
- To increase access to Units of Dental Activity (UDA) the ICB is funding schemes in areas with access issues.

Elective Care

During 2023/24 a key aim has been to eliminate long waiting times for elective care, particularly in spinal services, reduce unwarranted variation, transform outpatients, and ensure specialty-based development work in high volume pressured specialties such as dermatology and ophthalmology across our system.

The ICB and Provider Collaborative has continued to support trusts in managing pressures and improvements have been made in 2023/24, in particular the reduction of patients who have been waiting over 104 weeks, 78+ weeks and 65+ weeks.

2023/24 Performance summary and mitigations

Waiting lists for non-urgent, consultant led treatments for physical health conditions continued to increase across the ICB through April – August 2023/24, although this trend has reversed with a gradual reduction from August 2023-February 2024, the first time a reduction has been evident since the pandemic.

At the end of February 2024 there were 196,059 people on the elective waiting list (NENC provider aggregate excluding the Independent Sector) compared with 357,059 at the end of March 2023.

NENC was the best performing ICS in February 2024 for Referral to Treatment (RTT) performance with 68.4% of patients on the waiting list for elective (non-urgent) treatment waiting less than 18 weeks.

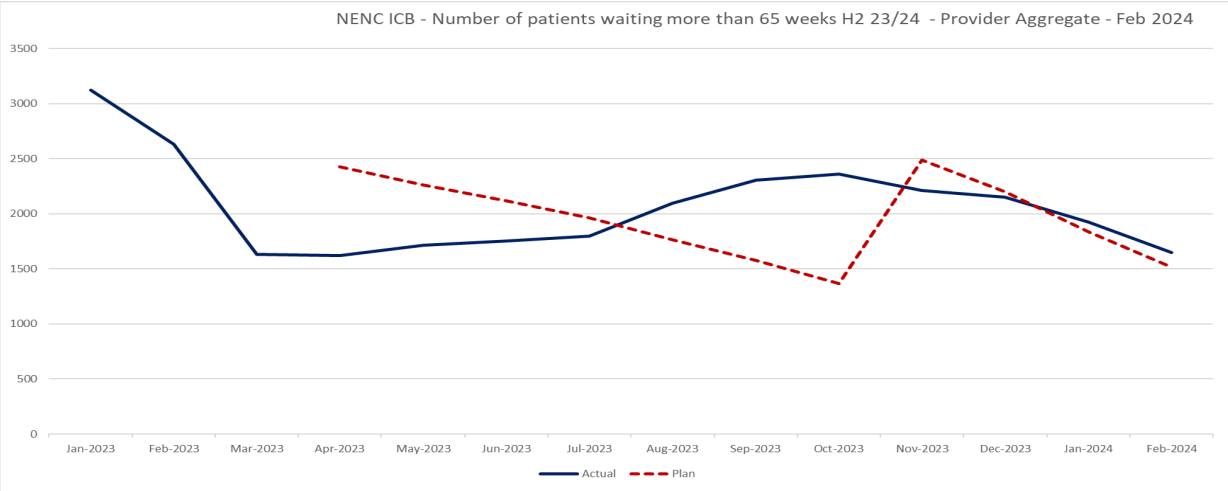
There was one 104+ week waiter at end of March 2024.

There were 198 78+ week waiters compared to a 191 plan at the end of February 2024 (provider aggregate excluding the Independent Sector (IS)). Although the plan was not met for February 2024, more recent unvalidated data has demonstrated a further decrease to 10 and subsequent achievement of the year end plan of 167 for March 2023/24.

There were 1647 65+ week waiters as at the end of February 2024 (provider aggregate excluding IS) compared to a plan of 1516. Although the plan has not been met for February 2024, more recent unvalidated data indicates that the year-end plan for March 2023/24 of 1145 was met across NENC with 920 patients waiting 65+ weeks.

Elective care – February 24 Actual data displayed at provider aggregate level.

Objective	Plan March 2024	Plan (Month)	Actual	Trend	Benchmark
52 week waits (eliminate by March 2025) (No H2)	5,135	5,467	7452	Improving	
65 week waits (0 by end of March 2024) *	1,145	1,516	1,647		
Value weighted Activity levels (105%) *17/04/24	105%		102%		
78 week waits (0 by end March 2023) *	167	191	198		
104 week waits (0 by end of March 2022)	0	0	1		
Reduce outpatient follow ups by 25%					
FFT – outpatients (trust range)			94.7%-100%		
FFT – inpatient care (trust range)			89.8%-99%		



There were 7451 52+ week waiters as at the end of February 2024 compared to a plan of 5467. More recent unvalidated data demonstrates this to have reduced further to 7252 as at the end of March 2024, although this remains above the March 2023/24 plan of 5135.

Waiting times – Individual trust pressures are variable, with specific pressure in spinal, orthopaedics, dermatology, and ophthalmology. Small numbers of spinal patients

A Provider Collaborative led mutual support group was established in November 2023 and has supported collective oversight of pressures and potential support resulting in the transfer of long waiting patients to access earlier treatment at alternative providers. This is a significant achievement and has supported the reduction of 78+ and 65+ waits.

Delivery and risk into 2024/25

Recovery in 2023/24 has been impacted by several periods of industrial action. Work to continues through the Tier 1 and 2 elective meetings with NHSE to monitor trajectories to clear 78+ and 65+ week waiters and maintain zero 104+ waiters throughout 24/25.

Cancer and Diagnostics

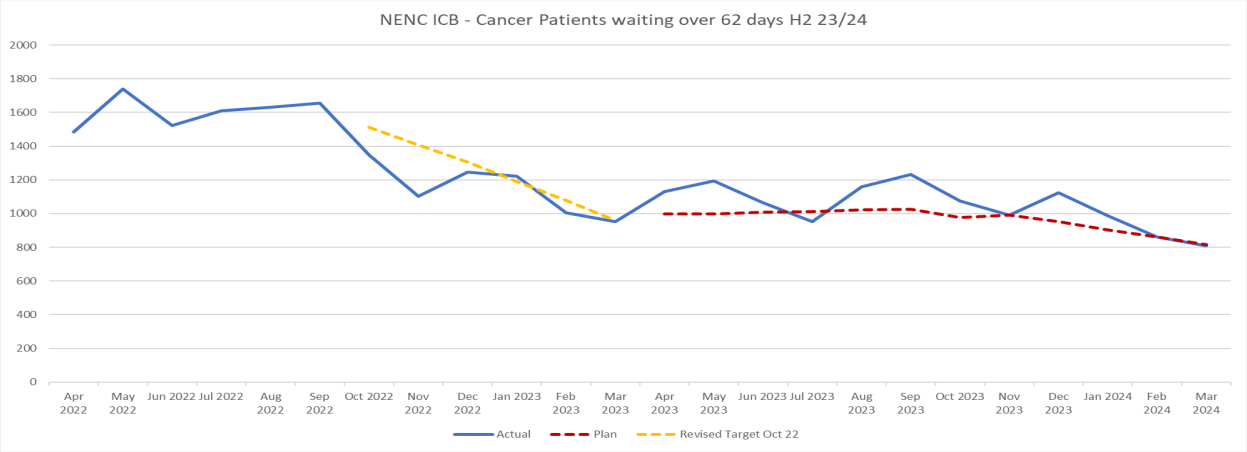
NENC ICB and the Northern Cancer Alliance (NCA) aims to speed up cancer pathways, increase diagnostics capacity, reduce waiting times, and improve operational performance. Early diagnosis is key to increasing survival rates and reducing variation in treatment for our cancer patients. This in turn will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

2023/24 Performance summary and mitigations

Cancer and Diagnostics – February 24 (except *data)

Objective	Plan (March 24)	Plan (month)	Actual	Trend	Benchmark
Reducing 62 Day Backlog *March 2024	817	817	810	Improving	
Faster Diagnosis Standard (FDS)	77.2% (77.6%)	78.4%	83.0%		78.1%
Stage at diagnosis ambition 75% by 2028					
Monthly Cancer 62 Day Performance**			60.4%		63.9%
% Receiving diagnostic test < 6 weeks (by March 2025)	89.4%	89.5%	88.1%		79.2%
Diagnostic activity against plan *28/1/24	109%	108%	103%		

Cancer 62 backlog – NENC ICB has achieved the planned cancer 62-day backlog performance standard for March 2024, achieving 810 compared to a plan of 817. The greatest challenges remain in Urology, Skin, Upper and Lower Gastrointestinal tumour pathways. Skin referrals have dropped since October 2023. Urology remains a significant pressure and is a priority for the cancer work programme.



Faster Diagnosis Standard (FDS) – measures the percentage of patients that are diagnosed or have a cancer diagnosis ruled out within 28 days. The ICB has demonstrated success in this standard, above the national position in February 2024 at 78.1% compared to 71.1% nationally and continues to improve above 2022/23 levels.

Diagnostics – An improved position is noted in February 2024, with a reduction of 3021 patients waiting more than 6 weeks for a diagnostic test compared to January 2024.

The highest number of patients waiting more than 6 weeks are in Magnetic Resonance Imaging (MRI) and Audiology across the ICB. There is a continued improvement in Colonoscopy performance and reduction in 13 week waits. Performance in 2023/24 has improved to the highest level since the pandemic across NENC. MRI and Audiology remain a focus for the ICS.

Delivery and risk into 2024/25

- Work on specific pathways via NENC pathway boards and with our Trusts with biggest backlogs ongoing to reach the best possible starting position for 2024/25
- FDS strong performance is expected to continue
- Recovery is expected by March 2025 for the diagnostics standard
- Implementation of diagnostic workforce strategies continue, and the ICB is working to identify expansion in training

Mental Health and people with Learning Disability and Neurodiversity

As a region we are committed to reducing health inequalities of people with mental health problems and for people with a Learning Disability and Autistic people. Improving waiting times for adults and young people for mental health services is key in addition to ensuring there is more support to meet emotional and mental health and wellbeing needs through improved access to psychological therapies. Reducing the reliance on inpatient settings and beds for Adults and Children and Young People with a Learning Disability is a key aim.

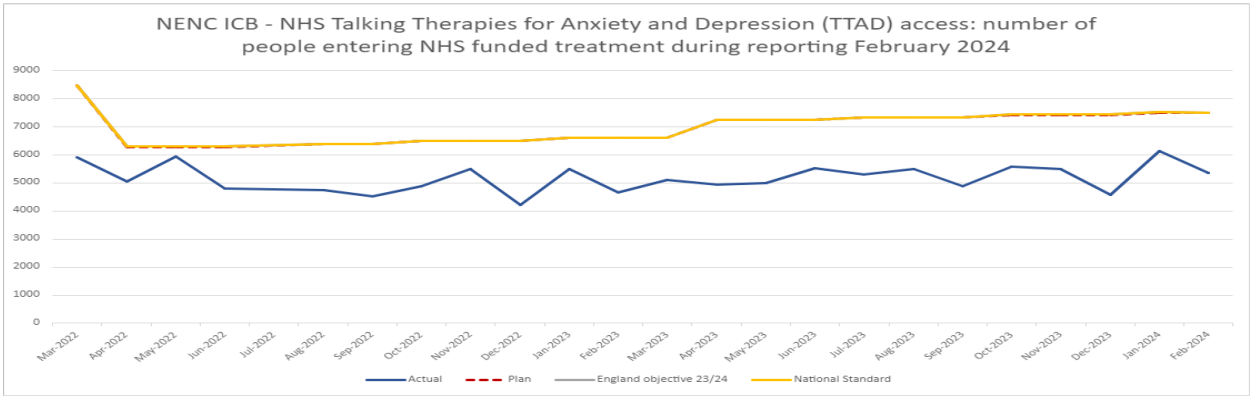
2023/24 Performance summary and mitigations

Mental Health: Adults – February 24 (*except)

Objective	Plan March 2024	Plan (month)	Actual	Trend	Benchmark
Talking Therapies for Anxiety and Depression access	22,540	7,513	5,345		
Community mental health (CMH) 2+ contacts 5% increase	34,855	34,030	38,280	Improving	
No. inappropriate out of area (OOA) bed days *January 2024	162		995		
Dementia diagnosis rate	66.7%	67%	68.1%	Improving	
People with SMI receiving physical health check *December 2023		20,406	16,002	Improving	
MH Adults waiting >104 weeks for 1st Direct appt** January 2024			6,591	Worsening	
MH Adults waiting >52 weeks for 1st Direct appt** January 2024			15,218	Worsening	

***MHSDS data subject to variable data quality between providers. All providers submitting to MHSDS included. Definition **Adult** "People with an accepted referral waiting for a 1st direct or indirect contact" open to difference in interpretation. Reporting to move to new national standard once supported by MHSDS.*

NHS Talking Therapies for Anxiety and Depression (TTAD) – access remains below plan and target, which reflects the national position. Challenges relate to workforce, increased acuity, inappropriate referrals continue. Recovery targets are consistently met across NENC ICB, and most providers are meeting 6- and 18-weeks waiting times from referral, and their recovery targets, however no providers are meeting the waiting time standard from 1st to 2nd appointment, signifying waiting pressures routinely manifest downstream.



Community mental health services play a crucial role in delivering mental health care for adults and older adults with severe mental health needs as close to home as possible. Systems have set out to develop and achieve a year-on-year increase in the number of adults and older adults supported by community mental health services since April 2023 and performance is assessed against the planned number of patients having 2+ community mental health contacts. This standard continues to show gradual improvement.

Out of Area (OOA) placements (bed days) – The number of Out of Area Placements (OAP) bed days reduced significantly across NENC from July 2023 following a peak in June 2023. This reduction has been maintained until January 2024 where there has been an increase in the 3-month rolling total (995 November 2023-January 2024) which is a significant risk to achievement of the year end 2023/24 plan of 162 bed days for January-March 2024.

NENC ICB continue to explore the pressures with all partners. Actions include robust case management, embedding clinically ready for discharge reporting and discharge facilitation.

Dementia diagnosis rate – remains in excess of the national standard and the NENC target, this is a continuing positive trend since May 2023.

SMI Physical Health checks: Improvement against target continues across NENC.

Adult and older adult (AMD) MH waiting times: As of January 2024, across NENC, 36,353 adults have been waiting for a 1st MH Direct contact, 31.4% have been waiting <18 weeks; 18.1% 104+ weeks.

Mental Health (MH): Children & Young People (CYP) – January 24 (*except)

Objective	Plan March 24	Plan (month)	Actual	Trend	Benchmark
Improve access to mental health support for CYP – * February 24	53,245	52,786	57,580	Improving	
CYP Eating disorders (ED) - urgent within 1 week	95%	95%	82%		
CYP Eating disorders (ED) – routine within 4 weeks	95%	95%	81%		
MH CYP waiting time (WT) for 2nd contact >104 weeks**			2,721	Worsening	
MH CYP waiting time (WT) for 2nd contact >52 weeks**			8,751	Worsening	
MH CYP WT Autism & Neurodevelopmental >104 weeks **			1,303	Worsening	
MH CYP WT Autism & Neurodevelopmental >52 weeks**			6,416	Worsening	

***MHSDS data subject to variable data quality between providers. All providers submitting to MHSDS included. Definition "Children and Young People (0-17) with an accepted referral waiting for 1st or 2nd direct or indirect appointment" open to differences in interpretation. Reporting to move to new national standard.*

The NHS has set out to 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).

Access to mental health support for Children and Young People (CYP) across the ICB remains above the operational plan trajectory showing significant improvement, however, remains below the Long-Term Plan (LTP) target. Demand has increased, and combined with an inability to recruit and retain staff this has created significant pressures since the pandemic. A recovery plan is underway. Challenges in reporting accurate data have been addressed, together with transformation work developing to improve this position.

People with a learning disability and autistic people – Data period stated below

Objective	Plan (March 24)	Plan (month)	Actual	Trend	Benchmark
Annual health check and plan for people on GP LD registers (Cumulative 75% March 2024) - February 2024	75%	67.9%	67.5%		
Reduce reliance on inpatient care adults (ICB) - March 2024	52	52 (Q4)	95		
Reduce reliance on inpatient care -adults (Secure) -March 2024	61	61 (Q4)	79		
Reduce reliance on inpatient care <18s - March 2024	8	8	10		

Eating disorder services – pressure remains in CYP eating disorder services not meeting the 95% standard (12 month rolling), exacerbation that developed in the pandemic and continues. New ways of working and successful recruitment are showing some improvement which is expected to continue.

Children and Young People (CYP) MH waiting times: At the end of January 2024 across NENC, 25,707 CYP (15,837 CYP autism and neurodevelopment patients) had been waiting for a 2nd contact, 35.5% CYP waiting <18 weeks, 10.6% CYP (8.2% CYP autism, neurodevelopmental) 104+ weeks. The waiting time position continues to worsen.

Reducing reliance on inpatient care (IP) – The end of Quarter 4 trajectory of 113 (ICB 52; Secure 61) was not achieved. Actual position at end of Quarter 4: 174 (ICB 95; Secure 79), this is 61 over target (ICB 43; Secure 18).

Delivery and risk into 2024/25

Challenges have remained in the delivery of key ambitions in 2023/24 for mental health and for people with Learning Disabilities and Autism. The ICB is working hard to improve mental health pathways for our patients, as well as investing in extra support to meet emotional, mental health and wellbeing needs. The ICB is making progress in improving services with further work underway to address any variation within the region.

Workforce

The NENC People and Culture Plan has three of the six priorities being supply, retention and health and wellbeing. Higher levels of sickness affect patient safety & quality as there are less staff available for duty. Staff turnover will impact on quality due to: 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. Both sickness and turnover continue to be trust priorities for action. Plans have been set for 2023/24 for trusts to aim from March 2023 to March 2024 to:

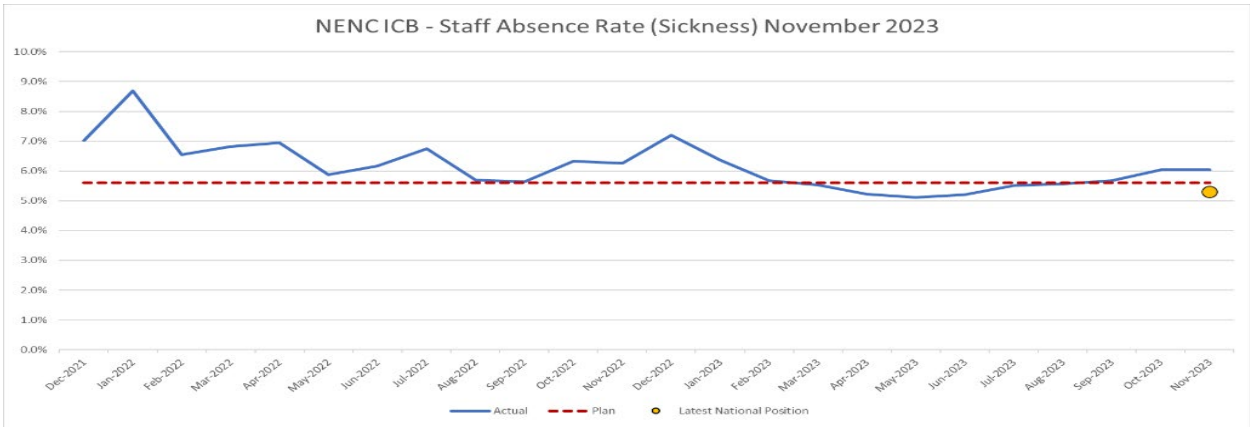
- reduce sickness absence by 0.33%
- reduce turnover by 0.38%

2023/24 Performance summary and mitigations

Workforce – Staff Sickness November 2023/ Turnover December 2023

Objective	Plan March 24	Plan (Month)	Actual	Trend	Benchmark
Improve staff retention (turnover systemwide NENC Providers)	12.1%		9.2%	Improving	11.0%
Improve staff attendance (sickness systemwide NENC Providers)	5.6%		6.0%	Worsening	5.3%

Staff attendance – The nationally reported in-month Electronic Staff Record (ESR) recorded the sickness rate for November 2023 has deteriorated and is higher than target.



Turnover – NENC continues to improve showing a 9.2% turnover rate against a plan of 12.1%.

Delivery and risk into 2024/25

Risk linked to pressure on remaining staff due to sickness and turnover having a detrimental impact on their health and wellbeing. This will be mitigated as staff health and wellbeing has been identified as a key priority within the ICB People & Culture Plan. The NENC People and Culture Plan is now in the final stages of development and will be key to delivery in 2024/25.

Safety

The NHS Patient Safety Strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems. NENC will continue to support staff and providers to share safety insight to improve safety including patient safety culture, patient safety systems and the strategic aims of insight, involvement, and improvement. Oversight continues across NENC through the Healthcare Acquired Infection (HCAI) Subcommittee where learning and good practice is shared at place and through local Quality Review Groups. The Quality & Safety Committee monitors data relating to mortality, and the regional mortality network supports quality improvements.

2023/24 Performance summary and mitigations

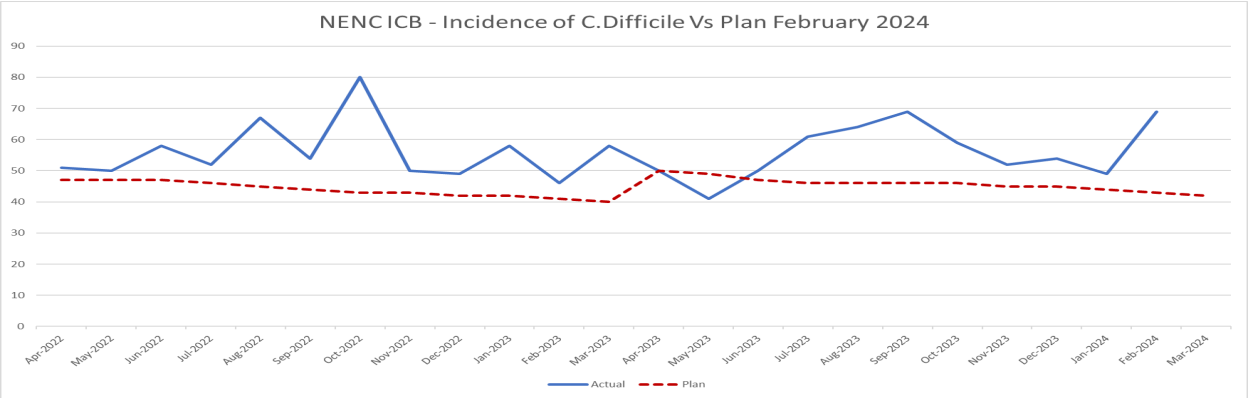
Safety – February/March 2024

Objective	Plan March 24	Plan YTD	Actual (month)	Actual YTD	Trend	Benchmark
Never events	0	0	0	18		
(Methicillin-resistant Staphylococcus aureus) MRSA February 2024	0	0	3	25		
Clostridioides difficile (C-Diff) February 2024		507	69	618		
Escherichia coli (E-Coli) February 2024		787	69	944		
Mortality	**Two Trusts (CDDFT & STSFT) are showing higher than the expected range for SHMI**					

Never Events – themes are closely monitored to gain appropriate assurances to ensure learning has been identified and shared. Eighteen never events were reported during 2023/24. Themes for Never Events are monitored to gain appropriate assurances to ensure learning has been identified and shared.

The Infection Prevention and Control (IPC) Patient Safety Incident response framework (PSIRF) matrix and framework has been developed. Regular updates are taken to the Quality and Safety Committee.

Pressures continue with key Healthcare Acquired Infections (HCAI) across NENC ICB, and the key infections remain over target year to date. An ICB wide plan has been developed and agreed for Clostridium Difficile (C diff) and Gram-Negative Bacterial Infections.



Delivery and risk into 2024/25

The ICB is looking to establish a learning platform to support learning across the region. Sound risk assessments have been developed by our Trusts for management of HCAI. IPC PSIRF matrix and framework developed. Regular updates are provided to the Quality and Safety Committee.

NENC Oversight

During 2023/24, the ICB has continued to implement an oversight framework which provides a comprehensive set of arrangements for effective oversight of NHS services within the ICB and the management of risk.

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

The oversight framework is a comprehensive framework and includes arrangements for the oversight of delivery of all elements of the ICB`s statutory duties and strategic and operational priorities, incorporating all the measures of success included within the NHS Oversight Framework and monitoring the delivery of the strategic plan. Oversight within the ICB is examined through the lens of the overall ICB, provider trusts, 14 places, primary care providers and programme and clinical networks. Place and programme oversight as well as provider oversight has been implemented across NENC in 2023/24.

The ICB works in partnership with NHS England regional team in relation to oversight of trusts including the tiering introduced for elective and cancer. These meetings are focussed on identifying and deploying high-quality support to aid rapid performance improvement.

In addition, the ICB works with trusts within the key strategic programmes to drive performance improvement via service improvement and the deployment of programme investment, for example via the Urgent and Emergency Care Programme, the Cancer Alliance, and the Strategic Elective Board.

Statement of activities

The statement of activities section outlines the ICB's main areas of work and highlights of our workstream priorities and key achievements 1 April 2023 – 31 March 2024.

During 2023/24 the ICB developed and delivered a programme of change to restructure the organisation, in response to the NHS England requirement for all ICB to reduce their running costs by 30% by 2025/26.

The Programme: ICB 2:0, took the opportunity to reset the operating arrangement of the organisation. This was seen as essential to set conditions for success in delivering our Integrated Care Strategy 'Better health and wellbeing for all'.

Ten success measures were set for the programme, and they included measures relating to strategy and statutory responsibility delivery, population health and business intelligence, partnership and collaboration, and an effective and efficient operating model, delivered by a healthy, diverse, and skilled workforce, all within the running cost envelope. There were also commitments to aligned clinical and managerial leadership, hybrid working and a fair and compassionate change process.

The proposed new staffing structure was developing following extensive engagement with staff across the organisation as well and with wider partners. A formal consultation with the staff side took place during the Autumn of 2023 and the outcome of the consultation was published in January 2024.

The ICB sought and received approval for a voluntary redundancy (VR) programme and VR was approved for 42 members of staff. Throughout this period a tight vacancy control process was maintained, which allowed the number of staff in post to reduced significantly through turnover, thereby minimising the risk of compulsory redundancies. As a result, despite the effect of the running cost allowance reduction being a requirement to reduce our like for like staffing establishment by over 100 whole time equivalent posts, we are forecasting a worse case of fewer than 20 and a best case of no compulsory redundancies.

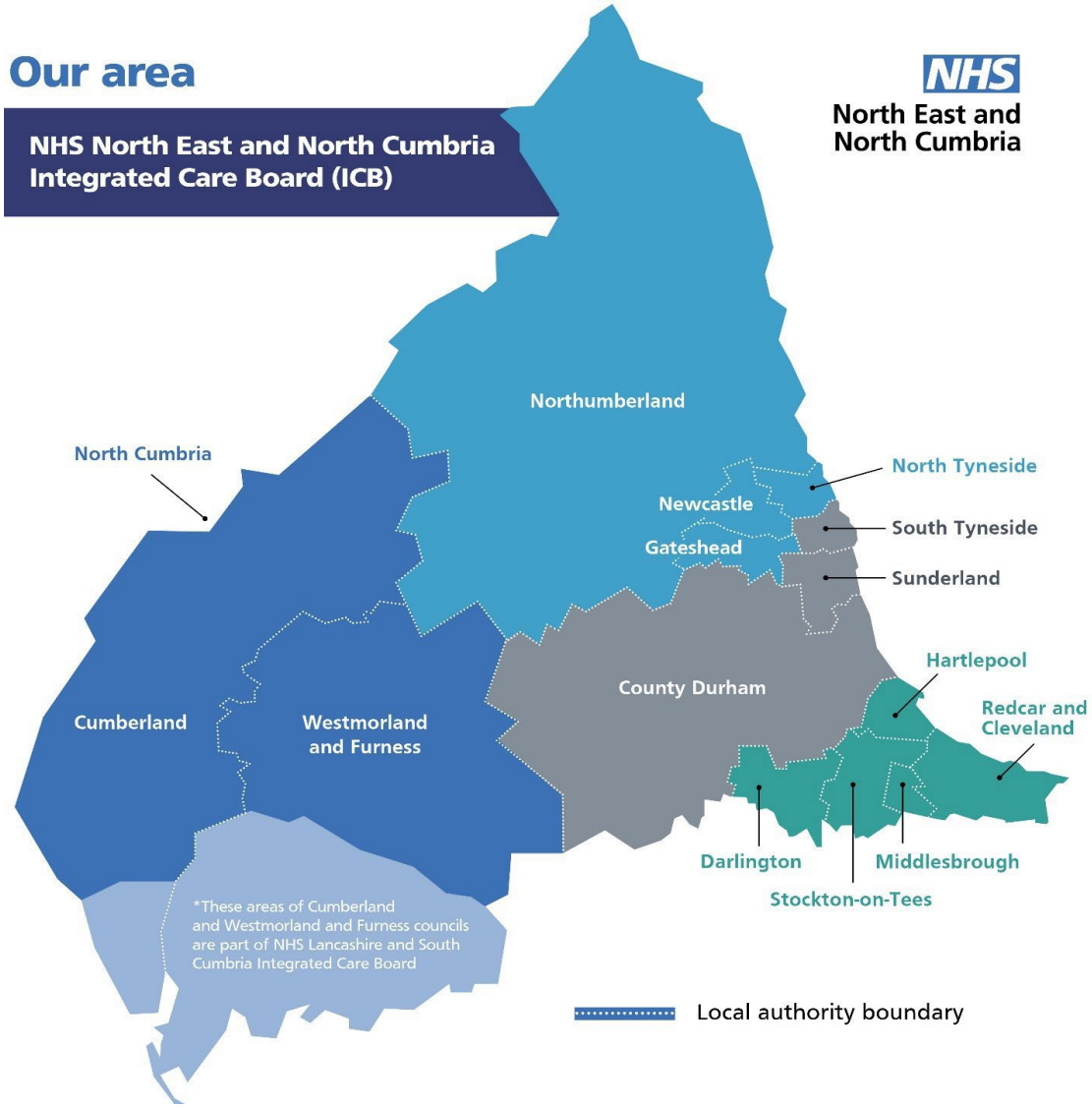
A filling of posts process took place during February and March of 2024, with most staff being placed into post after a pooling and preferencing exercise, which resulted in over 480 staff being offered new posts. The remain staff (under 75) were required to undertake a competitive interview for posts within a ringfence. At time of writing, all but a small number of staff who are delayed due to prolonged absence will be in post by the end of March 2024

The new structure will have taken effect on 1 April 2024. A smooth transition plan was developed and implemented to manage the risk of delay or disruption. An assessment against the success measures was undertaken in March 2024. Many were judged achieved, with a small number requiring further work. These are being handed over to Executive Leads within the new structure for completion as part of business as usual.

Partnership working

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

The detail of our governance and partnership arrangements was initially developed through a Joint Management Executive Group (JMEG) of senior leaders from across the NHS, local authorities, and wider partners. The feedback from JMEG helped us to develop our ICB constitution and board membership, our unique Integrated Care Partnership model, and our arrangements for delegating ICB functions and resources to each of the fourteen local authority 'places' within the North East and North Cumbria. The implementation of our 'place committee' model throughout 2024, supported by six ICB locality teams, will be a key milestone in the development of our place-based working arrangements.



Back in 2022 the members of our Integrated Care Partnership (which is a statutory joint committee of the ICB and the fourteen local authorities in our region) decided that we should operate our partnership based on one Strategic ICP that meets twice a year, supported by four Area ICPs that meet on a bi-monthly basis.

Alongside their role in developing the Integrated Care Strategy for the North East and North Cumbria, the Area ICPs provide key forums for the sharing of intelligence and learning, and as an important means to strengthen relationships between political, clinical, and professional leaders from the health and care sector.

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

The formation of the North East Mayoral Combined Authority (NEMCA) is planned for May 2024 and has presented an opportunity to realign some of our Area ICPs to match the boundaries of the two Combined Authorities in the North East and North Cumbria, i.e., the Local Authority 7 Area (County Durham, Gateshead, Newcastle upon Tyne, North Tyneside, Northumberland, South Tyneside, and Sunderland), as well as the existing Tees Valley Combined Authority (TVCA). Having discussed this with the elected member chairs of our Area ICPs, and at our Strategic ICP in December 2023, ICP members agreed that this change can be made by combining the North and Central Area ICPs into a single Area ICP that matches the boundaries of NEMCA. The other existing Area ICPs in Tees Valley and North Cumbria would remain as they are now.

Better health and wellbeing for all

The North East and North Cumbria ICP is a statutory committee of fourteen local authorities and the ICB. Each ICP in England is required to publish a long-term integrated care strategy.

The North East and North Cumbria ICP published its strategy, Better Health, and Wellbeing for All, in December 2022. The strategy is heavily informed by the views of a wide group of stakeholders, and was finalised following extensive engagement including a 'call for evidence' process during 2022. The engagement and call for evidence process has strongly informed the strategy, alongside the population health data.

It is an ambitious, long term, population health focussed strategy, organised around four key goals:

- Longer, healthier lives: reducing the gap between how long people live in the North East and North Cumbria compared to the rest of England.
- Fairer outcomes: everyone does not have the same opportunities for good health, because of where they live, their income, education, and employment.
- Best start in life: enabling children and young people to thrive, have great futures and improve lives for generations to come.
- Better health and care services: high quality services no matter where you live and who you are.

The delivery of the four goals is supported by five key enabling programmes:

2023/24 became year one of the implementation of the strategy. Delivery is supported by the ICB and wider NHS, and our equal partners in local authorities, other public sector organisations, the voluntary, community and social enterprise sector and the independent sector delivering NHS commissioned free at the point of delivery services.

Joint Forward Plan

In 2023/24 NHS England introduced a new duty for ICBs and their partner NHS Trusts to publish a joint forward plan, covering a five-year period. The North East and North Cumbria joint forward plan was approved by the ICB Board in September 2023. A draft of the plan had been published in early July for stakeholder feedback as part of ongoing engagement.

ICBs and partner NHS Trusts are required to publish an updated joint forward plan every March. The plan is required to describe how the ICB and its partner NHS Trusts:

- Intend to arrange and/or provide NHS services to meet their population's physical and mental health needs.
- Will deliver the NHS long term plan and universal NHS commitments.
- Will address the ICS four core purposes and meet the ICB legal requirements.

The North East and North Cumbria plan is intended to act as the medium-term delivery plan for our ICP strategy Better Health and Wellbeing for All. As part of our Joint Forward Plan, we have developed action plans including:

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

As the first joint forward plan was only agreed in September 2023, we chose to refresh and recommit to the existing plan, rather than re-write the plan. The refreshed plan included updates to most sections, many of which were minor. The refreshed plan also included some new sections in response to stakeholder feedback as outlined in the September 2023 version, including:

- Working with the voluntary, community and social enterprise sector.
- Long term condition management.
- Dementia and organic mental health.
- Gender dysphoria services.
- Individual care packages and neurorehabilitation

The plan will be updated again for March 2025, and will be informed by the views of stakeholders. We are committed to developing a much clearer set of impact/outcome metrics to measure the success of our plan implementation. This will be incorporated into the ICB Strategy Deployment Framework, to be published twice annually from Autumn 2024.

Emergency preparedness, resilience, and response

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

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

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

As a Category 1 responder, the ICB must:

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

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

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

The ICB is committed to developing and maintaining planned and resilient services by taking a proactive approach to EPRR.

Since inception of the ICB in July 2022 the ICB EPRR Team have worked to ensure that the ICB is able to deliver its core statutory functions as a Category 1 responder.

The ICB EPRR Team have developed ways of working to ensure an integrated resilience function able to respond to any emergency across the NENC Integrated Care System.

The ICB work collaboratively across the system with all NHS Accountable Emergency Officers (AEOs) their EPRR leads and with a range of multi-agency partners including representing the NHS at the Northumbria, Cumbria, Cleveland and County Durham and Darlington multi-agency Local Resilience Forums (LRFs).

The ICB EPRR Team continue to work with NHSE and system providers to ensure appropriate training and exercising is in place as a critical component of delivering the ICB's statutory responsibilities, ensuring that all staff who would support any escalation or incident are trained, competent and qualified to effectively undertake that role.

The ICB have participated in numerous "Live" and "Table-top" multi-agency training events with partners and hosted a successful regional ICB exercise in December 2023 to further enhance understanding between internal and external stakeholders. The ICB continue to participate in a variety of exercises to determine the effectiveness of specified functions, to support individuals and test roles within a safe environment, acting on feedback via a robust debriefing process to maximise organisational learning.

During 2023/24 the ICB EPRR Team have been pivotal in managing the frequent periods of Industrial action and continue to provide system co-ordination, oversight and leadership to significant operational pressures including outbreaks of infectious disease, business continuity and critical incidents.

The ICB EPRR function continues to ensure the ICB develop and maintain planned and resilient services for residents and patients that meet the statutory and mandatory duties as set out in the Civil Contingencies Act 2004 and the NHS England Framework 2015.

Our workstream priorities and key achievements

Mental health, learning disabilities and autism partnership

The ICB and its partners spent this year further developing and consolidating our broad and inclusive Mental Health, Learning Disability and Autism (MHLDA) Partnership. Building on our long-established relationships and strong record of working together, the formation of the North East and North Cumbria (NENC) MHLDA Sub-committee aims to further strengthen this partnership working.

Our partnership is a vehicle for:

- Delivering integrated planning and service provision on behalf of the ICS and ICB
- Integrating the planning and commissioning of specialised and local services to reduce fragmentation across pathways
- Delivering transformation at scale on behalf of the ICS and ICB in partnership with place-based delivery teams
- Delivering the long-term plan for mental health
- Driving up quality, outcomes and improving experience

Achievements during 2023/2024

Key accomplishments during the report period include:

- Working with our delivery partners CNTW, TEWV, NEAS and North West Ambulance Service NHS Foundation Trust, a service model has been developed for the implementation of NHS 111 Select Mental Health which will go live in April 2024
- A full review of NENC NHS Talking Therapy services for anxiety and depression has been completed, throughout 24/25 the focus will be collaborating with partners and stakeholders to agree the next steps
- Community Mental Health Transformation (CMHT), there has been an increase in the number of transformed Primary Care Networks (PCNs) across NENC in 2023/24, this work will continue throughout 2024/25
- A full mapping exercise of alternative to crisis services was conducted across NENC resulting in an increase in the number of services available, this work will continue throughout 2024/25
- Creation of a new Data and Digital workstream has made significant progress in system interoperability and has enabled the VCSE organisations to report into the national mental health services data set (MHSDS)
- An ICB wide service review of Children and Young People community eating disorder services was concluded, this identified a range of service improvements and recommendations to ensure continued compliance with access and waiting time standards as well as national quality and outcome standards. These recommendations will form an implementation plan for 2024/25

- Strengthening the voice of and engagement of people with lived experience across the mental health programme has been led by the appointment of a Lived Experience Associate Director. This has resulted in the creation of a lived experience advisory group to the MHLDA sub-committee, ensuring a lived experience representation on that committee and across transformation workstreams

Priorities for 2024/2025

A series of system wide reviews will be conducted with the aim of developing proposals to be shared and considered for subsequent implementation. These will include:

- Adult Mental Health Urgent Care Pathway
- Adult Mental Health Rehabilitation
- Mental Health Services for Older People
- Expanding coverage of Perinatal and Maternal Mental Health services

Supporting place-based deliver teams and seeking assurance on progress for the following:

- Adult and older people as well as CYP community transformation, including integration of Talking Therapies services
- Child Eating Disorder access to services which reduce admission to inpatient units (jointly with Specialist Provider Collaborative)
- Roll out of Individual Placement and Support services (which help people with a serious mental illness into work as part of their recovery journey)
- Reductions in the use of inpatient care for autistic people and people with a learning disability through the provision of alternative housing and care tailored to need.

Mental health spending

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

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

The ICB has reported achievement of the MHIS for the 12 months to 31 March 2024, with total growth in mental health spend of 9% during the year.

The table on the following page summarises mental health spend as a proportion of recurrent programme allocations for 2022/23 and 2023/24:

Financial years	2022/23 £'000	2023/24 £'000
Mental health spend	632,047	688,966
CCG / ICB programme allocation	5,989,569	6,035,724
Mental health spend as a proportion of CCG / ICB programme allocation	10.55%	11.41%

Notes: Mental health spend reflects expenditure falling within the scope of MHIS

Learning disability and autism workstream

Recognising the importance of addressing inequalities within learning disability and autism, the Integrated Care Board (ICB) established a dedicated programme team. There are a number of key areas of work that contribute towards improving the standard and quality of care, which also help to reduce inequalities. These include learning disability annual health checks, learning disability mortality reviews (LeDeR) and initiatives focussed on transforming care. Throughout the reporting period of 2023/24, significant strides were made, with a focus on addressing key challenges and fostering collaboration with stakeholders across the region.

Main deliverables for the workstream

In alignment with national priorities and the overarching goals of the ICS, the programme team's main deliverables for the upcoming year, 2024/25, include:

- Continued implementation of the 'Building the Right Support' national plan, aimed at bolstering community services and reducing reliance on Improving the quality of care and support on inpatient care
- Continuous efforts to improve the quality of care and support, thereby enhancing health outcomes for individuals with autism or a learning disability
- Emphasis on co-production and fostering collaborative partnerships
- Workforce development to ensure a skilled and compassionate workforce capable of meeting the diverse needs of individuals with autism or a learning disability.

Achievements during 2023/2024

Key accomplishments during the report period include:

- Progress in facilitating discharges across the North East and North Cumbria (NENC) region, with a continued focus through 2024/25 on supporting place-based delivery teams facing the greatest challenges
- Establishment of an ICS Housing, Health and Care Strategy poised to drive innovation and transforming in the upcoming year
- Senior Intervenor programme steered by Sir David Pearson resulted in a report highlighting common systemic barriers to discharge and recommendations to address has been completed. The focus over the next year will be aimed at addressing those barriers to discharge identified and fostering partnership-based solutions
- Implementation of intensive support meetings across main provider trusts, resulting in the removal of barriers at a senior level and supporting discharge planning
- Establishment of Learning disability and Autism Lived Experience groups in collaboration with Inclusion North, the year ahead will be focused on further enhancing engagement and co-production efforts

Priorities for 2024/2025

Looking ahead to the next reporting period, priorities for the Learning Disability and Autism Workstream include:

- Holistic approaches to housing, health, and care, ensuring integrated support for individuals with learning disabilities and autism
- Reshaping the provider market to better meet the evolving needs of the community and enhance service provision
- Preventing avoidable admissions through proactive interventions and community-based support
- Implementation of the Senior intervener programme and oversight of performance and delivery plans
- Addressing challenges in meeting 'Building the Right Support' trajectories through collaborative efforts and innovative solutions
- Development of a model for delivering NENC Community (Education)Treatment Reviews (C(e)TRs) and Dynamic Support Registers (DSR) to enhance care co-ordination and support planning.

Mental health, learning disability and neurodevelopmental

In light of the ICB consultation and subsequent changes to our operating model and structure, adjustments will be made to the mental health, learning disability, and autism programme team. This team will now reside within the Strategy and Transformation Directorate, serving as the transformation hub for mental health, learning disabilities, and neurodevelopmental conditions. This strategic move aims to foster closer collaboration across workstream areas, breaking down silos and optimising our collective resources for greater impact.

Combined highlights of Mental Health, Learning Disabilities, and Autism achievements during 2023/24:

- Through collaborative efforts with system partners there has been a significant and sustained reduction in inappropriate Out of Area Placements
- Commitment to transforming inpatient care has gained momentum by establishment of our inpatient quality transformation programme. This will support cultural change and a new bold, reimagined model of care for the future across all NHS-funded mental health, learning disability and autism inpatient settings. Central to this will be the acceleration of new models of care that enable systems to harness the potential of people and communities, within a citizenship model that promotes inclusion and respects their human rights. This programme will complement and further support our existing commitments to improve the quality of community care, and the Mental Health Act reform agenda
- The Housing, Health, and Care Programme is NENCs sector led improvement initiative that is dedicated to delivering better, more integrated housing, care, and support service. We aim to empower individuals to maintain health, well-being, and independence within their own homes

Combined priorities for 2024/25 in Mental Health, Learning Disabilities and Autism

We are embarking on a series of comprehensive system-wide reviews aimed at crafting proposals that will be collaboratively shared and considered by our partnership for subsequent implementation. Key areas of focus include:

- Neuro Diagnostic Pathway
- Inpatient Quality Transformation Programme
- Housing, Health, and Care Programme

These initiatives underscore our unwavering commitment to advancing mental health, learning disability and autism care and support, ensuring individuals receive the right care, in the right place, at the right time.

Local maternity and neonatal system

In March 2023 the Three Year Delivery Plan for Maternity and Neonatal Services was released which outlines the strategic plan for making maternity and neonatal care safer, more personalised and more equitable for women, babies and families.

The plan is based on the following four themes:

- Theme 1: Listening to and working with women and families with compassion
- Theme 2: Growing, retaining, and supporting out workforce
- Theme 3: Developing and sustaining a culture of safety, learning and support
- Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care.

The Local Maternity Neonatal System (LMNS) has developed a response to the plan to ensure each of the requirements under the above 4 themes are delivered through each of their programmes of work.

The three-year delivery plan for maternity and neonatal services sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families, services are asked to concentrate on four themes:

- Listening to and working with women and families, with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support
- Standards and structures that underpin safer, more personalised, and more equitable care.

Delivering this plan will continue to require the dedication of everyone working in NHS maternity and neonatal services in England who are working tirelessly to support women and families and improve care.

The following has been achieved by the LMNS in the last 12 months

Staff Appointments

The LMNS has appointed into the following clinical lead roles: Deputy Obstetric Lead, an additional Midwifery Lead, Neonatal Medical Lead and Neonatal Nurse Lead. These appointments are critical to the delivery of LMNS programmes of work and ensure that the LMNS is clinically led.

The ICB has appointed a Director of Nursing and Midwifery which provides senior leadership to the LMNS, alongside David Purdue, ICB Executive Chief Nurse and People Officer and LMNS Senior Responsible Officer.

The LMNS Programme Management Team capacity has been increased through the appointment of key roles to support programme delivery.

Service User Engagement

The LMNS continues to remunerate the Maternity and Neonatal Voice Partnership representatives to ensure meaningful engagement with service users. The LMNS have also successfully appointed additional service user representatives across several workstreams.

Establishment of the Maternity and Neonatal Alliance

In August 2023 the Maternity and Neonatal Alliance was formed which brings together a range of strategic stakeholders from across the NENC to work together towards a common ambition to be the safest place to be pregnant, give birth and transition into parenthood.

By collaborating and sharing ideas, resources and expertise, the Alliance aims to build a more co-ordinated and effective system of care that supports improved outcomes for all. Improving maternal and neonatal health requires a multi-disciplinary approach that addresses a wide range of factors from access to high quality safe and personalised care to social determinants of health and beyond. By pooling resources and expertise, the members of the Alliance will work together to create positive systemic change and improve outcomes and experiences for women, babies, and families across the continuum of care.

Three Year Delivery Plan for Maternity and Neonatal Care – NENC LMNS Event

On 10 May 2023, the LMNS held a multi-stakeholder, co-production workshop to shape the future of services across our system geography.

The key output was the development of a shared vision of future services and ways of working together, that are fundamentally better than now, bringing benefit: to our people, women, babies, and families; to our current and future staff; and to our organisations and wider system. We need to continue to develop that shared vision, to reach out across all our communities and stakeholders, and to hear every voice so that everyone can contribute to the better future we all wish to create.

Ockenden Peer Support Assurance Visits

The LMNS have facilitated the Ockenden Peer Support Assurance Visits to all eight Provider Trusts between September and December 2023.

The aim of the visits was first and foremost to obtain assurance that providers are compliant in all areas of the Ockenden Immediate and Essential actions. Specifically demonstrating:

- Evidence of how areas of compliance are embedded into practice.
- An action plan of all areas of non – compliance with a clear timeline of when compliance will be achieved.

Secondly, the visits provided an opportunity to seek assurance around other national and local areas of work within maternity and neonatal.

In addition to seeking of assurance, the visits were planned to be supportive in nature with an aim of sharing areas of good practice which could be disseminated across the eight Trusts and highlight areas of concern that the LMNS could support with. To embed the peer review element of the visits, the visiting teams consisted of senior leaders from another Trust within NENC which was very well received by each of the eight provider Trusts.

The LMNS held an Ockenden Learning and Improvement Event on the 2 February 2024 which was attended by 115 people from across the LMNS, the aim of the event was to:

- Share themes and learning from the visits
- Enable each Trust to showcase areas of outstanding practice to support collaborative learning and improvement across the NENC
- Chance for reflection and to identify solutions to the challenges we face; and
- To celebrate, listen and learn as a NENC maternity and neonatal community

Establishment of New Workstreams

The Equity and Equality steering group has been set up to support and enable the implementation of the NENC LMNS Equity and Equality Action Plan.

The Personalised Care and Supporting Planning steering group has been set up, the purpose of the group is to enable and support the eight Provider Trusts and ICB in fulfilling the Personalised Care Workstream requirements of the Three-Year Delivery plan and the NHS Long Term Plan for maternity and neonatal services.

The LMNS have commenced work on the commissioning arrangements for Perinatal Pelvic Health Services, despite significant delay in release of the national service specification and technical guidance progress has been made during quarter 3 and 4 to commence implementation of equitable service provision across the NENC.

Maternity and Neonatal Independent Senior Advocate (MNISA)

One of the Ockenden Immediate and Essential Actions is to create a Maternity and Neonatal Independent Senior Advocate role:

- Work alongside women, birthing people, and their families to make sure their voices are heard
- To help them understand their options and navigate system and signpost to other relevant services.

The LMNS have successfully commissioned People First, and independent advocacy service to deliver this service on a 12-month pilot basis across the NENC.

Establishment of the NENC Training Faculty

In September 2023 the NENC training faculty was launched with a purpose to:

- To address the variation in training and competency assessment across maternity services in the NENC
- To meet the Ockenden immediate and essential actions in relation to workforce planning, sharing of resources, sustainability, and multidisciplinary training
- To develop a NENC local training plan to ensure all six core modules of the core competency framework version 2 are included in the programme
- To support NENC transferrable training between Trusts to reduce duplication and maximise clinical time
- To proactively plan training needs in accordance with national guidance
- To develop an annual TNA for maternity staff; and
- To succession plan to ensure a skilled teaching workforce

Badgernet Implementation

All eight NENC Provider Trusts have now implemented Badgernet, which is the full Maternity Electronic Patient Record. This means that the patient record can be shared across the Provider Trusts in NENC which enables safer more personalised care. Patients will also be able to access their own patient record via the Badgernet app.

Maternity and Neonatal Services Escalation Policy

In November 2023 the LMNS went live with the newly develop Maternity and Neonatal Services Escalation Policy, the policy has been developed to enable maternity and neonatal services to align their escalation protocols to a standardised NENC process and escalate when required.

Since implantation, the LMNS has seen evidence of effective management of surge and escalation to avoid unnecessary unit closures and improved outcomes for patients.

All age safeguarding, cared for and care experienced children and young people

Statutory Responsibilities

NHS North East and North Cumbria ICB has continued to discharge its statutory safeguarding duties throughout 2023/24 in relation to its all-age safeguarding responsibilities and for cared for and care experienced children and young people. The ICB was able to maintain assurance and oversight of its duties as outlined in the NHSE Safeguarding and Accountability and Assurance Framework 2022.

The Executive Chief Nurse and People Officer who holds the statutory accountability for safeguarding was supported by the Directors of Nursing who held delegated statutory safeguarding responsibilities in each of the four ICB areas as well as for the delivery of the statutory functions undertaken by the place Designated Teams.

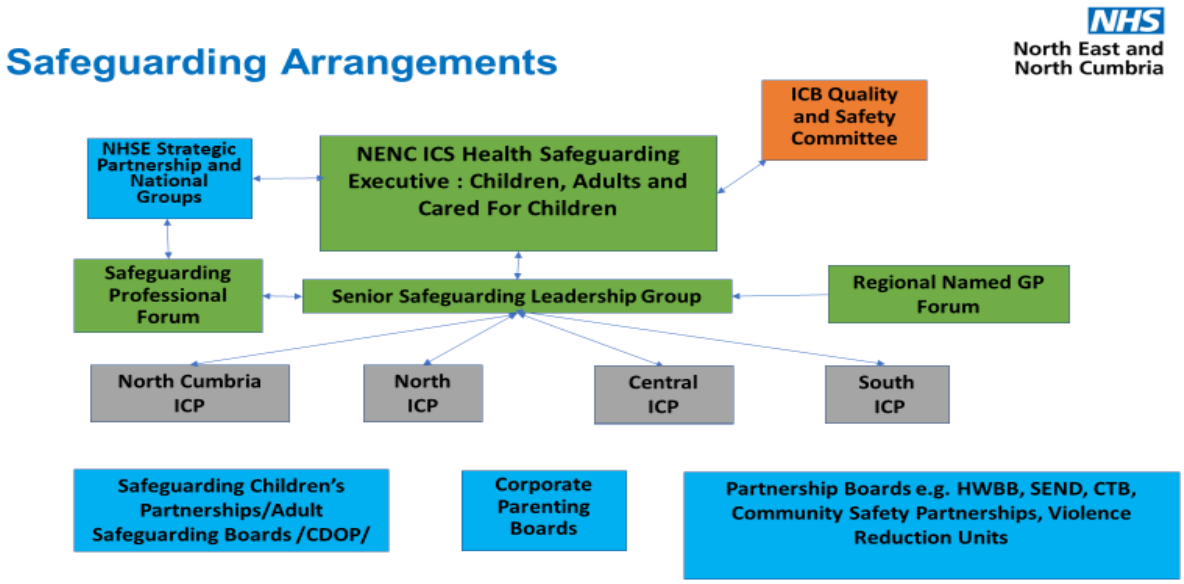
Clear processes were in place to monitor the safeguarding arrangements of our commissioned health services and to provide assurance that children and adults at risk of abuse were safeguarded in all NHS settings as well as individual homes, independent hospitals, and care sector provision. The Designated Teams took account of national and local guidance, directives and learning from reviews in order to continuously improve and develop our services.

The ICB has worked closely with regulators such as NHSE in providing assurance that the ICB was fulfilling its safeguarding statutory functions, duties, roles, and responsibilities. NHSE regional leads attended the NENC ICS Health Safeguarding Executive and provided feedback to the ICB and, where required, further information and clarification on specified areas of monitoring in order to provide the required assurance or data requested.

The ICB was able to demonstrate that appropriate safeguarding governance systems (see diagram below) were in place for discharging their statutory safeguarding duties and functions in line with the following key legislation:

- Care Act 2014
- Children Act 1989 and 2004,
- Children and Social Work Act 2017
- Working together to Safeguard Children 2018 (updated December 2023)
- Child Deaths - The Child Death Review Statutory Guidance (2018)
- Looked After Children - Promoting the health and wellbeing of Looked after Children (DfE 2015)
- Prevent - Counter Terrorism and Security Act, 2015 (Prevent Duty)
- Mental Capacity - Mental Capacity Act (MCA, 2005)

The ICB continued its leadership and/or membership of the Child Death Overview panels (CDOP) which meet regularly to review child death cases. Modifiable factors identified during these reviews mirror the national picture including parental smoking, maternal obesity, and unsafe sleeping arrangements. In support of this the ICB has led a number of safe sleeping campaigns. CDOP chairs are formal members of the NENC ICS Health Safeguarding Executive.

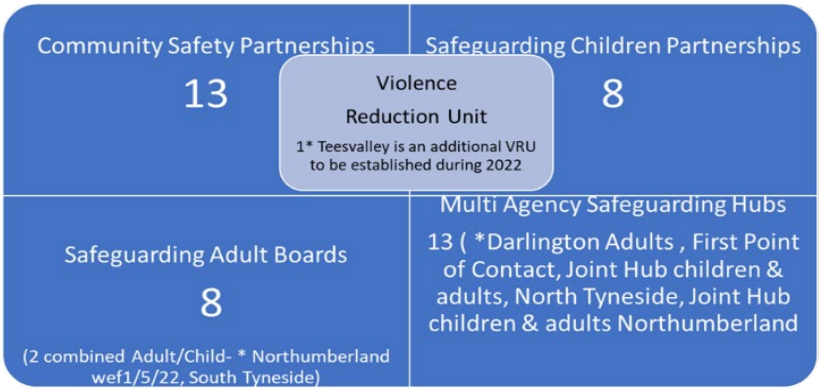


Safeguarding Partnerships and Boards Annual Reports

	Safeguarding Children's Partnership Annual Reports	Safeguarding Adults Board Annual Report
North	• Cumbria CSCP Annual Report 2022-2023 • North Tyneside NTSCP Annual Report 2021-2022 • Newcastle NSCP Annual Report 2022-2023 • Gateshead GSCP Annual Report 2021/22-23	• Cumbria Safeguarding Adults Board Annual Report 2022-2023 • North Tyneside NTSAB Annual Report 2022-2023 • Newcastle NSAB Annual Report 2022-2023 • Gateshead GSAP Annual Report 2022-2023
South	• Durham DSCP Annual Report 2022-2023 • South Tyneside STCAP annual report 2021-2022 • Sunderland SSCP Annual Report 2021-2022 • Darlington DSP Annual Report 2022-2023 • South Tees STSCP Annual Report 2022-2023	• Tees Wide TSAB Annual Report 2022-2023 • Darlington DSP Annual Report 2022-2023 • Durham DSAP Annual Report 2022-2023 • South Tyneside STCAP annual report 2021-2022 • Sunderland SSAB Annual Report 2022-2023

Partnership Working

The ICB worked seamlessly across the Integrated Care System (ICS) to safeguard children, young people, and adults at risk, working with statutory and responsible partners and agencies to effectively safeguard our population. This included meeting all the statutory ICB duties relating to domestic abuse, sexual violence, and serious violence, with each relevant area undertaking a strategic needs' assessment and co-producing a plan to tackle serious violence. In relation to serious violence the ICB as members of the Community Safety Partnerships (CSP) and Violence Reduction Units (VRU) have contributed to and agreed a Strategic Needs Assessment (SNA) as per its duty (Police, Crime, Sentencing and Courts Act 2022) and the resulting strategies. Working with partners to prevent and reduce serious violence is highlighted as one of our strategic priorities.



ICB Strategic Priorities

The ICBs strategic safeguarding priorities were highlighted in the ICS Integrated Care Strategy and the complementary Joint Forward Plan as: -

- Collaborating with local authorities to improve health outcomes and service access for cared-for children and those transitioning from child to adult mental health services
- Implementing a trauma-informed approach in all health services
- Following the Domestic Abuse Act 2021 for multi-agency support to victims
- Supporting people with self-neglect and those needing treatment
- Working with partners to prevent and reduce serious violence

Cared for and Care Experienced

For cared for and care experienced the Designated teams maintained oversight of the commissioned services compliance with Looked after Children requirements via the provider safeguarding contractual standards to ensure system oversight and assurance. Designated Nurses Looked After Children represent and contribute to place Corporate Parent Boards to ensure statutory requirements are fulfilled. A key relationship has been established with the North East Care Leavers Board comprising 12 of the 14 regulatory Local Authorities. The ICB was also selected as one of the national pathfinders for the Care Leaver Covenant, the national inclusion programme that supports care leavers aged 16-25 to live independently.

Mental Capacity Act

Mental Capacity Act remained a key element of the ICB Safeguarding Governance arrangements.

- Designated teams maintained oversight of the commissioned services compliance with MCA requirements via the provider safeguarding contractual standards to ensure system oversight and assurance
- The designated team provide MCA support on complex safeguarding cases

Implementation of national and local safeguarding reviews

Learning and emerging themes from reviews and incidents are shared from each place through the Designated Professional Forum whose membership is made up of the designated, deputies and lead professionals for adults, children, children looked after, primary care and the Mental Capacity Act. Joint and collaborative work continues with partners and cross references and takes account of high profile local and national reviews such as Whorlton Hall to ensure local safeguarding arrangements are safe and effective.

Cancer alliance workstream

Cancer alliances are structures that bring together our local senior clinical and managerial leaders who represent the entirety of the pathway from pre-diagnosis to post treatment. Collaboratively the Alliance works together to improve cancer outcomes.

Breast pain pathway

In 2023 the NENC Breast Managed Clinical Network in collaboration with primary care clinicians, secondary care imaging and breast clinicians, the public and Alliance team introduced a Breast Pain Pathway (BPP) for the diagnosis and treatment of patients with breast pain only.

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

Having initially tested out this pathway it is now in place across four of our six providers, with plans to roll out to the two remaining organisations in 2024/25

Teledermatology pathway for skin cancer

Teledermatology direct from GPs has been embedded into standard referral practice across NENC at 3 out of 4 skin cancer providers delivering urgent suspected cancer. The 4th service also delivers an urgent skin cancer pathway through a dermatology service; however, the pathway utilises a hybrid model of Teledermatology, giving us whole population coverage. Skin cancer teledermatology pathways allow for triage of suspected cancer referrals by a dermatologist and ensuring timely upgrade of routine referrals to the cancer pathway.

This can reduce the need for hospital appointments. Embedding the pathway across the Cancer Alliance was based on learning from CDDFT who were one of the first to implement this new technology which is now a national recommendation for all skin cancer services.

During 2024/25 we will learn from the 2 different models we now have in place across the NENC bringing together partners and other stakeholders to further develop pathways to increase where appropriate the use of Teledermatology as an effective component of the urgent skin cancer pathways.

Non-specific symptoms pathway

The Non-specific symptoms (NSS) pathway is an urgent suspected cancer pathway for people who do not meet the criteria for traditional site-specific cancer pathways, but who have a set of symptoms that put them at risk of being diagnosed with cancer.

In 2023/24 we have continued with 100% of our population having access to this rapid access pathway, providing GPs with a service that will hold a patient until a diagnosis is determined. Referrals to this pathway have increased over the past year as they have become more embedded in practice and patient feedback has been positive.

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

The focus for 2024/25 is maintain the current pathways and evaluate of the various models and provide a recommendation to the ICB on mainstreaming of the services.

Lynch Syndrome

Lynch syndrome is an inherited condition which can cause some cancers. During the past year the NCA has made good progress with the implementation of testing for lynch syndrome across colorectal and endometrial pathways. Recent national audits show that the pathway is well established across our region with above average implementation.

The NCA will continue work with NENC ICB, our Genomics Medicine Service Alliance and our partner Alliances across Yorkshire to ensure that Lynch testing remains a fundamental part of local pathways and that a sustainable approach to commissioning for genomics in general is developed as local resources allow**.**

Head and Neck behavioural science approach (Nudge Theory)

Data suggests that there are potentially, a group of people not presenting early with signs and symptoms of Head and Neck Cancer. NCA has used a “nudge theory” which aims to increase the rate of early diagnosis for people who have a Head or Neck (H&N) cancer to improve their long-term prognosis.

The project has had two forms of nudge;

(i) Raise awareness of the signs and symptoms for those at greatest risk of H&N cancer, encouraging them to seek medical advice if symptoms appear.

(ii) Ensure healthcare practitioners consider Head and Neck cancer given they see so few instances

This work has been co-produced and is currently in testing with some GP practices and with awareness raising posters in targeted populations (men 50+ years smokers and/or regular drinkers). The campaign work is enhanced by the cancer community awareness workers who use their local knowledge to ensure the posters and other materials are available in the most appropriate places for this population.

Achievement of the 28-day cancer waiting times standard (Faster Diagnosis Standard)

NENC has consistently been in the three highest performing cancer alliances in the country for the Faster Diagnosis Standard (FDS) throughout 2023/24.

Our achievement is due to significant improvement work within our Trusts, implementing the national best practice timed pathways and putting non-specific symptoms pathways in place.

Whilst as a system there are some site-specific pathways and some Trusts that need further improvement work, this provides a good foundation for 2024/25 as we work on the priority pathways for skin, gynae, breast and urology. Our focus will be on improving the number of people receiving a cancer diagnosis by day 28.

Cancer workforce

Building on the NCA Cancer Workforce Strategy we have continued with our plans to grow and upskill the cancer workforce in 2023/24, to try to address the forecasted Clinical Nurse Specialist (CNS) workforce gap over the next three years.

Our approaches to improving the supply of CNSs included:

- The continuation of a two-year collaborative workforce development programme between NCA, Macmillan Cancer Support, Health Education England, Yorkshire Cancer Alliances, and provider trusts across Northeast and Yorkshire. This programme supports aspirant band 5 nurses to meet the capabilities and competencies of a band 6 cancer CNS, with participants being supernumerary for the first six months while focusing on academic and observational learning.
- A HSJ nominated Cancer Nurse Internship Programme, originally developed by STSFT, with South Tees and other Trusts subsequently participating in this approach. This model gives nurses (bands 5 and 6) the opportunity to leave their ward environment for one day per week for 12 months to work as part of a specialist cancer multi-disciplinary team, through the provision of clinical placements across a variety of cancer specialties.

In 2023/24 funding was secured for our 8 Provider Trusts to appoint a cancer clinical educator. Whilst each clinical educator has specific objectives within their own organisation, all of them are engaged in supporting the implementation of the Cancer ACCEND framework. The ACCEND Framework provides guidance on the knowledge, skills and capabilities required by all cancer support workers, nurses and allied health professionals who care for people living with cancer. The Lead cancer nurses from all 8 Trusts came together in 2023/24 to develop a set of competencies and capabilities for cancer nursing and cancer care coordinators which aligns with the ACCEND framework. These competencies are currently being piloted in all Trusts and will be reviewed/evaluated during 2024/25.

Faecal immunochemical testing (FIT)

The NCA FIT pathway is well embedded in our combined Gastro- intestinal symptoms pathway and continues to lead performance nationally on its utilisation. Thanks to the work of the colorectal pathway group, GPs, and the cancer PCN facilitators this clinically led initiative is impacting on patient experience.

Personalised care key achievements

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

Project	Key Achievements
NENC-wide	
Training for staff in **Primary Care Networks (PCN) - personalised care roles**	Worked in partnership with voluntary, community and social enterprise providers to fund and commission training for social prescribing link workers and health and wellbeing coaches, to ensure they meet the requirements of new national competency frameworks. Additional Health Education England funding for a supervision and support offer for health and wellbeing coaches was secured and delivered in 2023/24.
Personal Wheelchair Budgets (PWB)	Established PWB Task and Finish Group, with engagement from all wheelchair services across NENC. Focus on improving consistent PWB offer and accurate data collection.
Personal Health Budgets (PHB)	Engaged with NECS to deliver a project to address issues relating to data collection and processes linked to PHB offer, with an aim of improving the offer and ensuring groups with a legal right to a personal health budget receive an assessment and option of a PHB. Learning from this project has been transferred into the ICB for continued development. Transformation programme in place, led by the Nursing, AHP and People Directorate, to ensure that PHBs continue to be offered consistently to those eligible, working in partnership with people with lived experience, local government, local areas, clinicians, professionals, providers, the voluntary and community sector. The NENC ICB PHB Strategy was developed from the input of stakeholders across the NENC ICB region and incorporates the vital inclusion of lived experience input from people and families who have used a PHB in the region. It uses the analysed national and local data available to highlight success and areas for improvement and development.
Personalised care in trust contract	Personalised care means people have choice and control over the way their care is planned and delivered, based on ‘what matters’ to them and their individual strengths, needs and preferences. This happens within a system that

	supports people to stay well for longer and makes the most of the expertise, capacity and potential of people, families, and communities in delivering better health and wellbeing outcomes and experiences. Recognising that personalised care is central to how the NHS delivers services, including working through acute trusts and primary care networks, people have more options, better support, and properly joined-up care at the right time in the optimal care setting. Specific wording relating to the delivery of personalised care and support planning and shared decision making were included in Schedule 2 of the trust contract for 2023/24.
Expansion of personalised care workforce development project manager role	North Cumbria used previous personalised care programme funding to establish a dedicated Personalised Care Workforce Development Project Manager, which was expanded to cover the whole of NENC in 2023/24. The post holder successfully trained over 700 staff in personalised care approaches across NENC. This supports the workforce development trajectory of the NHS Long Term Plan. Data from training events shows that delegates increased their skills and confidence in having personalised care conversations. This also resulted in NENC contributing the highest figure nationally of people completing Personalised Care Institute-accredited training.
Project	**Key Achievements**
Place-based examples	
North Cumbria	Personalised Anticipatory Care pilot completed, working in collaboration with Ageing Well network, Year of Care partnerships and two PCNs. A Draft report and toolkit were developed with an intention to share with other PCNs. Feasibility study being led by Northumbria University.
Northumberland	Targeted PHB offer for people with mental health issues and in receipt of s117 aftercare.
Newcastle	Year of Care and support planning approach in all GP practices. Piloting social prescribing link worker role in additional areas e.g., hospital discharge/Emergency Department; development of a pilot for peer leaders in weight management services
Gateshead	Development of link worker and peer support roles to enhance the service offer for people living with mental health issues.

North Tyneside	Funding used to expand Admiral Nurse service to provide a more personalised service to people with dementia and their families / carers.
South Tyneside	Anticipatory care and prevention models being tested to target services at most vulnerable cohorts.
Sunderland	Well-established PWB offer across Sunderland
County Durham	Targeted programme focused on supported self-management for people with learning disabilities and diabetes.
Tees Valley	Personalised Care Project Manager role recruited for North Tees FT, leading on embedding personalised care across the Trust. Personalised care principles embedded in palliative and end of life care service design. Piloted NHS@home with volunteer practices, embedding personalised care approaches and supported self-management.

Physical health and long-term conditions network

During 2023/24 we continued to have a well-established series of networks with a focus on transformation of key clinical conditions, including:

- CVD prevention
- Lipids management
- Diabetes
- Vascular
- Stroke
- Cardiac
- Respiratory and post COVID

The networks, which have strong clinical leadership across our system, have been pivotal in the development and implementation of specific transformation projects. Here is a snapshot of some of those areas of work.

Diabetes

- Increased new referrals into the National Diabetes Prevention Programme across the North East and North Cumbria
- Expansion of the Low-calorie Diets programme across the ICB geography
- Implementation of the Type 2 diabetes in the young programme within general practice

Stroke

- The two tertiary centres within the region have worked collaboratively to develop a model for a 24/7 mechanical thrombectomy service. Work will continue in 2024/25
- The North East and North Cumbria Integrated Stroke Delivery Network has secured national catalyst funding for 8 workstreams and will continue to roll these projects out into 2024/25
- This includes the establishment of health and wellbeing groups, stroke rehabilitation in care homes, enhancing access to therapy within existing rehabilitation services, roll out of Psychological Adjustment After Stroke Training to key staff within existing services
- Work has continued to focus on delivering against the national Integrated Community Stroke Service model and needs based community rehabilitation

Respiratory

- In collaboration with the Learning Disabilities Network, the Respiratory Network have designed a tool kit to consider reasonable adjustments for people with Learning Disabilities
- A review of diagnostics for respiratory patients has been undertaken and recommendations for future commissioning will be considered for implementation
- Work has been ongoing with providers to develop a model for future delivery of post COVID services into 2024/25

Diagnostic programme workstream

We continue to strive towards earlier diagnosis for patients through easier, faster, and more direct access to the full range of diagnostic tests so we can understand and treat patients' symptoms, reduce hospital visits, streamline diagnostic pathways, and improve our contribution to the NHS' net zero ambitions by providing multiple tests at one visit. Across 2023/24 we continue to see a reduction in the number of patients in NENC ICS waiting more than 6 weeks for their diagnostic test.

Community Diagnostic Centres (CDC)

- All four approved hubs are well into build phase with expected go live dates in Quarter 2 2024/25, Quarter 3 2024/25, and Quarter 2 2025/26
- In excess of 170,000 additional diagnostic tests have been delivered through our CDC programme in 2023/24

Endoscopy

- North Cumbria secured £15m to build a new endoscopy unit
- North Tees, South Tees and STSFT are consistently meeting the 28-day cancer diagnosis target in conjunction with using the combined GI referral pathway
- North East Endoscopy Training Academy – Funding has been confirmed for 22 clinical endoscopist training places across North East and Yorkshire and we are seeking to appoint a clinical endoscopist training lead to oversee the programme. Plans are in place to recruit a senior practice educator and nurse to the JAG

Endoscopy Training System (JETS) workforce modules. An administrative and clerical training programme is in development

Imaging Network

- Funding secured for Gateshead second MRI scanner (£2.3m) and North Cumbria second CT scanner at West Cumberland (£1.6m)
- Imaging Network governance models have been formalised and signed off by the Imaging Network Board and Diagnostic Programme Board
- The Imaging Network Quality plan and Capital plan developed and signed off by Network Board
- A refresh of the 2022-2024 imaging workforce strategy review is in progress
- Introduction of new leadership roles to provide expert advice and guidance to the network – Lead Radiographer and Digital Lead
- Development of the Imaging Academy (funded by Health Education England) has progressed significantly with advertisement of key roles within areas of Interventional Radiology nursing, ultrasound, and research to develop the training and education landscape across Radiology. The academy also secured funding to implement a Navigator project, introducing new roles into the Radiology workforce to free up clinical time and improve processes
- Progress has been made with the Interventional Radiology service model creating a sustainable service for the future across the network through increased staffing and service model redesign
- Updated development plan to guide the network through to mature status by March 2025
- Secured additional capital funding for imaging equipment (CT & MRI)
- Network digital plan (strategy for the next 3 years) in draft and progressing
- Success in securing approx. £2m through the NHSE Artificial Intelligence (AI) Diagnostic Fund to implement a Chest X-Ray AI tool across 7 Trusts. Procurement is complete with implementation beginning Quarter 1 24/25.
- Initiated a capacity and demand refresh to inform capital planning
- Launch of Specialist Interest Groups (SIG) for Paediatrics, Gynaecology, Ears Nose and Throat, Spinal and Musculoskeletal
- Launch of NENC Imaging Futures workspace

Pathology Network

- Formalised the NENC ICS Pathology Operating Model and Work Plan including the clinical governance arrangements and priority objectives
- The Cellular Pathology Specialty Reference Group (SRG) have established and are progressing the NENC histopathology transformation plan, in line with national guidance
- The Point of Care Testing (PoCT) SRG have undertaken a baseline exercise and have established links with relevant CDC leads to support and enable appropriate PoCT consideration
- We have commenced a review of cross-trust referrals and repatriation of specialist pathology testing
- Work is in progress to identify opportunities for network wide procurement to reduce pathology costs

Physiological Measurement

- Continued dialogue with clinical teams to develop the physiological science networks in line with national strategic direction
- We have undertaken a review of Paediatric Audiology services and are working with services to put improvements in place
- A NENC Audiology Network Group has been established and is providing a forum to share the beneficial outputs of audiology service reviews undertaken in a number of Trusts

Diagnostic workforce

- We have made progress against our diagnostic workforce priorities for 2023/24 and agreed our 2024/25 priorities
- Diagnostic Radiography Clinical Educators funded through the academy in post at every Trust
- Diagnostic Radiography project (aligned to the NHSE Diagnostic Radiographer report and recommendations) identified 13 whole time equivalent placement increase with further refinement to make
- Development against the Interventional Radiology project resulted in recruitment to Radiologist posts at South Tees creating a more sustainable workforce model
- Several surveys completed within Imaging to gather core data and requirements for the future to feed into recruitment and retention and training plans
- The £1 million NHSE funded Pathology Alliance Training Academy has progressed with recruitment of network wide training co-ordinator roles (the first of its kind in Pathology) to develop and deliver cross-network training to 20 additional trainee healthcare science practitioners, starting summer 2024
- Launched the first NENC network wide Pathology CPD programme, to start April 2024
- There continues to be significant development in ‘grow your own’ scientific workforce through apprenticeships in Healthcare Science: we now have 3 trusts who have their first cohort of Level 2 apprentices, there has been a steady increase in numbers of Level 4 and Level 6 apprentices, we have staff undertaking Level 3 pathology contextualised apprenticeship and we now have locally delivered courses for Level 2 and Level 4
- Secured ICS wide agreement to support additional medical trainees for Cellular Pathology with Trusts’ agreement to accept three in the NENC network in 2024
- Network clinical workforce data collected to enable identification of gaps in capacity and sustainability
- One additional pan-pathology training lead role in Trust, this means 5 of 7 Trusts now have this leadership role in place to support the training and education and support wider NENC workforce strategy objectives
- Supporting alternative pipelines T level placements have been piloted for healthcare scientist at one Trust, more Trusts planned to follow.
- International recruitment of medical staff event held signposting to guidelines and support available for Trusts to overcome barriers to successfully utilise international recruitment to support the medical staff pipeline
- Formal Healthcare Science representation for the first time on ICB People and Culture Board

Digital Diagnostics

- Procurement completed for the 2023/24 digital diagnostic programme with investment of more than £6.7m capital funding supporting an ICS-wide order comms solution, an ICS diagnostic capacity optimisation dashboard, a new high speed resilient diagnostic network, digital histopathology, and digital imaging reporting
- Progression of the Global Worklist image sharing functionality to allow radiology images to be viewed by clinicians anywhere irrespective of geography or organisation, this will speed up diagnosis and provision of specialist opinion. The system is in clinical use in two Trusts and four others are technically live; roll out is ongoing
- Installation of new Laboratory Information Management System (LIMS) at Northumbria Healthcare Trust is complete
- Path 5 LIMS project serving Newcastle, North Cumbria, Tees Valley and CDDFT is progressing with additional project support resources approved
- NENC ICS has achieved 100% Whole Slide Imaging (WSI) scanning capability for histopathology. A number or Trusts are successfully digitally reporting for more than 60% of cases
- Digital imaging of blood and bone marrow slides in haematology has progressed following the roll out of digital scanners last year with support of the digital haematology user group and haematology SRG

Ageing well workstream

Our ambition is to support people to live well in older age, enjoy life, and be able to contribute to their communities for as long as possible. Recognising people are individuals with different needs, we champion a personalised approach to care.

In 2023/24 we have maintained our focus on delivering national and local Ageing Well priorities:

Urgent Community Response

Urgent Community Response teams provide urgent care to people in their homes which helps to avoid unnecessary hospital admissions and enable people to live independently for longer. Through these teams, people who urgently need care can get fast access to a range of health and care professionals within two hours.

Over past year, there has been a sustained upward trend in the number of 2-hour urgent community response referrals across the NENC ICB and we have able to consistently evidence that we are exceeding the 70% 2-hour standard threshold, as all Foundation Trust providers are publishing data via the National UCR Dashboard and we continuing to work with smaller providers around their urgent community response offer, promoting cross organisational working.

In support of winter preparedness, we have worked collaboratively with the 111 and 999 services and providers to strengthen referrals pathways for a 2-hour community response, when clinically appropriate to do so, providing a real and safe alternative to taking people to hospital.

We have also strived to maximise referrals from care homes and strengthen the interface with other services, including Virtual Wards providing acute care at home.

Proactive Care

Over the past year, we have also continued our efforts to develop a proactive model of care providing care and support to those living at home with multiple long-term conditions, including frailty.

Part of this work has involved developing a case finding tool, to help integrated multi-disciplinary teams identify people who may benefit from proactive and personalised care, enhancing overall health and quality of life.

We have also joined forces with the Year of Care Partnership, to test out implementing proactive care using the 'Year of Care approach to personalised care and support planning', and work is underway to build a toolkit for frontline staff, to support local delivery based on a robust ‘feasibility study’ undertaken in North Cumbria.

With the VCSE sector being a key member of the Ageing Well Steering Group, we have been able to show case their valued contribution, in helping maintain people's wellbeing.

Enhanced Health in Care Homes

We recognised that people living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through collaborative working between health, social care, the voluntary and community sector, and care home partners.

We continue to act as an enabler and have developed insight and benchmarking tools to help local teams identify improvement opportunities, for example the Enhanced Health in Care Home Team in Darlington, who are revising their operating model, now have improved links with their local safeguarding team. We are also helping to join-up conversations across the system, to share learning and best practice.

Community Health Services Digital

We aim to support community health services to deliver better care for patients and service users by maximising the use of digital technology, including remote monitoring support.

Our community of practice now includes representation from Health Innovation, as well as Mental Health Learning Disability and Autism. This enhances our capability to share and receive learning across the Integrated Care System. We also feature and link in with the Virtual Wards workstream, now operating under Ageing Well programme, as this continues to work on digitisation.

We have also continued efforts to address interoperability of clinical systems, working with the Great North Care Record team, to identify and connect community providers to the shared care record, particularly around End-of-Life Care and Advance Care Plans.

Workforce support

Throughout 2023/24 we have increased uptake and utilisation of the Enhanced Care of Older People (EnCOP) competency-based framework as a workforce development programme across the ICB. We are aware that older people are the biggest consumers of care and workforce development specific to meeting their needs is a vital enabler.

To date, over 500 health and care professionals have enrolled on the EnCOP programme, and we are extremely proud that the programme has received recognition from the British Geriatric Society.

Celebrating at our Inaugural Graduation Event March 2023

Virtual Wards

Over the last year, the Ageing Well Network has supported roll out of the national Virtual Ward initiative, across North East and North Cumbria. A monthly programme group has shared best practice, tackled common challenges and offered supportive leadership for local places.

More recently, a North East and North Cumbria Virtual Ward dashboard has been developed and local places have come together to explore what our approach to Virtual Wards should look like and what outcomes should be captured to demonstrate impact both for the patient and the wider system.

We've started drafting our 'Acute Care @Home' model, an integrated community-based model, offering specialist acute care at home.

Virtual Wards support will continue into 2024/25 as we further explore commissioning options to allow delivery and implementation of fully integrated 'Acute Care @Home' model, interfacing with the Intermediate Care offer at place.

Metrics, Measurement and Outcomes

Throughout 2023/24, we have worked closely the NECS Business Information Team and North East Quality Observatory Service, to develop a suit of data information tools. These enable us to understand the impact of a range of service developments across the region, share areas of innovation and good practice and highlight opportunities to further improve, to ensure we deliver the best possible outcomes for our local populations.

Digital data and technology

As a function of the recent ICB organisational change programme, several Executive Director portfolios were realigned, this resulted the Digital and Information Directorate becoming the Digital and Infrastructure Directorate. Consequently, the ICB data and business intelligence functions transferred into the Strategy directorate, with; Estates, Sustainability and Health and Safety moving in to the digital and infrastructure directorate. This creates closer alignment of technology and estates under the Executive Digital and Infrastructure Officer (ECDIO).

Retaining an Executive Director role, with responsibility for Digital, signals the continuous and growing importance of the agenda to the ICB, and to the wider integrated care system.

Further changes in the structure were made to support the digital and infrastructure areas including changes to roles of senior team members including the Deputy Director of Technology and Deputy Director of Digital Programmes and Governance. These roles support both internal (ICB) and external (ICS) technology ambitions, business as usual and system transformation activities. Ensuring commissions are appropriate, governed correctly and assured responsibly.

To ensure there's a clear focus on clinically driven need, a Chief Clinical Information Officer (CCIO) will report directly into the ECDIO, in addition and to strengthen clinical leadership of the digital agenda, three geographically aligned Associate CCIO (ACCIO) roles have been created and will report into the CCIO. The ACCIOs will help create a common language when liaising with stakeholders, ensure strategic needs are clinically led and digitally enabled, in addition to supporting clinical safety oversight.

The new Estates responsibility for the directorate is led by the Strategic Head of Commissioning Estates and Premises. This brings a closer working relationship and alignment between digital and estates which will provide better oversight for new schemes which frequently require input from both areas.

The Digital and Infrastructure directorate, as an enabler for transformation activities, will be driven by strategic needs identified across care settings.

Examples of programmes of strategic importance include, but are not limited to:

- Primary Care Assess Recovery Plan (PCARP)
- Digitising Social Care (DiSC)
- Frontline Digitisation

- Shared Care Records - Great North Care Record
- NHS App
- Digital diagnostics (digital pathology, radiology, and laboratory information management systems)

The above are examples of driven and funded pieces of work to enhance digital maturity across the system and particularly across three key areas of primary care, social care, and our secondary care. Having oversight of these important programmes of work provides the opportunity to work at scale, look for opportunities for collaboration and identify early risks, issues, and interdependencies.

Furthermore, the Health Innovation North East North Cumbria (HI NENC), formerly the Academic Health Science Network (AHSN), support regional innovation and research activities and supported multiple digital transformation programmes projects during the period. Examples of this work comprise; digital inclusion, covering policy reviews and digital inclusion forum activities, and a digital skill working group along with a digital device repurposing initiative.

From a strategic perspective, the Digital Data and Technology (DDaT) Strategy for the region was approved by the ICB board in January 2024, the five key themes within the DDaT strategy:

Essentials - getting the basics right and working together.

Improving - an integrated health and care system needs digitally mature organisations and a digitally capable workforce.

Connecting - continuing to connect the region's health and care IT systems. Through secure sharing of information, we are improving quality and safety of care

Empowering - by using digital technologies where appropriate, we will empower people to be partners in their own health and care needs.

Learning - through use of reliable, up-to-date information, data, and research we can proactively respond to the needs of our population.

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

Example programmes include but are not limited to:

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

Eye care alliance

There is an ever-increasing demand for hospital eye services. Access to eye care is essential for people's health and quality of life.

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

In the short term, our priority is to reduce waiting lists for hospital eye care, this has been our focus in 2023/24. Looking further ahead, we are designing a more integrated patient pathway to make better use of community optometrists and offer more joined-up care to patients. It's important to make sure that patients are only referred for hospital eye care if their needs cannot be met by suitable community-based services.

The alliance's key objectives are:

- Review the current Glaucoma service and propose collective solution for standardised delivery of Glaucoma services within NENC
- Review of current ways of working of AMD pathways across NENC to meet current demand ensure timely treatment
- Refinement of pre-operative and post-operative care following cataract surgery
- Revisit the work undertaken in relation to Urgent Service delivery
- Review of gaps in Workforce and risks to fragile services
- Early intervention and prevention work
- Support the role out of further and faster program and completion of quarterly GIRFT metric.

Healthier and fairer programme

Healthier and fairer is a system-wide, multi-agency, ICS-wide approach to coordinate efforts to prevent ill health, tackle inequalities and support the NHS to play a greater role in economic regeneration and addressing the social determinants of health. The programme provides direction, oversight, and delivery to meet the ICB's statutory duty in reducing health inequalities and improving population health. This is based on a population health management approach, ensuring our actions maximise the impact in achieving better health outcomes and reduced health inequalities.

Our programme has three workstreams, prevention, healthcare inequalities (including CORE20Plus5) and broader social and economic determinants. Each workstream has a number of aligned projects which are clinically/expert led and managerially enabled.

Our approach to delivery is based on ensuring:

- partnership with place, building on the work of local health and well-being boards
- we achieve the biggest impact with the strongest evidence base
- by doing things once, we reap the benefit of at-scale working
- it is our NHS contribution to prevention, healthcare inequalities, and the broader socioeconomic determinants of health

During 2023/24 we have continued to develop the programme, working with stakeholders across our system to develop and implement projects which have an impact on our local communities.

Prevention

Within this workstream we have been delivering whole system approaches to prevention in reducing alcohol intake, reducing tobacco usage, promoting healthy weight, and treating obesity, CVD prevention, and prevention within maternity. The following section highlights some of the work which has been developed and implemented in 2023/24.

Tobacco

- The North East and North Cumbria system have an ambition to reduce smoking to 5% by 2030, as outlined in the Better Health and Wellbeing for All Strategy.
- This continues to drive the delivery of key services aimed at tacking tobacco dependency in our region
- In 2023/24 the Smokefree NHS/Treating Tobacco Dependency Taskforce, with representation from partners across the NHS and local authorities continued to meet and drive forward transformation
- The Taskforce works closely with the Fresh and Balance programme and Fresh is jointly funded by all 12 Local Authorities in the North East and the NENC ICB
- The Tobacco Dependency Treatment Services (TDTS) has been operational throughout 2024/25 in all hospitals across NENC providing systematic screening of smoking status on admission, opt out referral for all smokers to see an in-house specialist trained TD advisor, who will develop individualised treatment plans
- The regional approach to the NHS Staff Tobacco Dependency Offer (STDO) provided the opportunity for 1,972 NHS staff working in 11 Foundations Trusts (inc. NEAS) and the ICB to make a quit attempt

Alcohol

- Alcohol Care Teams (ACT) went live in 2023 and services are delivered within Foundation Trusts across NENC
- The teams are there to support our workforce in understanding and taking action on their own alcohol use
- The teams also seek to reduce alcohol harm by giving patients specialist support during their hospital stay

Healthier weight and treating obesity

- During 2023/24 a health needs assessment was developed to understand the impact of weight management on our health and care system
- As a result of this work has begun on the development of a whole system approach to ensuring healthy weight and preventing/treating obesity. This will be further developed in 2024/25
- During the year specialised weight management services continued to be delivered across four provider trusts within NENC, utilising Healthier and Fairer programme funding

- These services are provided by a multi-disciplinary team including bariatric physicians, dietitians, psychologist, physiotherapists, and healthcare wellbeing professionals

Healthcare Inequalities

Within the healthcare inequalities workstream, projects have continued to deliver in 2023/24. Here are some of the key achievements from this year:

- Delivery of the Deep End project within general practices who are based in deprived populations, this has included a focussed piece of work on driving up childhood vaccination rates, reducing opioid usage and providing training to practice staff
- The waiting well programme continued to identify, make contact, and provide intervention and sign posting for those waiting on surgical waiting lists at greatest need of support
- Al waiting well hubs were operational by March 2023 and as at December 2023, 7696 patients were contacted and offered support
- During 2023/24 the team worked on improving pathways in the areas identified through this framework to ensure a reduction in health inequalities across these clinical conditions for adults and children and young people

Broader Social and Economic Determinants

Within this workstream there are several projects which were delivered in 2023/24 and during the next year we will continue to evaluate and demonstrate improvement outcomes.

Some projects include:

- Poverty proofing
- Health literacy
- Anchor institutions
- Digital inclusion

Population health management

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

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

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

Workforce programme

In 2023/24 the ICB led the development of a shared people and culture strategy. This has been designed by a wide range of partners from across the health and care system. Below, we set out some of the partners who have come together through this initiative:

The NENC People and Culture strategy is owned by all partners. It aims to outline a shared vision that moves us closer to a ‘one workforce’ model for health and care in the region, focused on greater integration and building on the strong foundations already in place. Workforce remains a priority for the North East and North Cumbria and this strategy takes into consideration the national NHS Long Term Workforce Plan.

Image above sets out the six pillars of the People and Culture Strategy: supply, retention, health and wellbeing, health equity and inclusion, system leadership and talent and reform.

Pillar 1 - Supply

From school children to apprentices and qualified professionals across the country, we have a number of schemes helping to attract the workforce of the future. Our award-winning Find Your Place campaign, which promotes the region as a great place to live and work, has already helped increase the number of medical trainees choosing our region.

Pillar 2 – Retention

A key ambition of the NHS Long Term Workforce Plan (LTWP) is to increase the retention of current staff, in part by making the NHS a better place to work. Nationally, the leaver rate has improved faster in NHS trusts which have been participating in the People Promise Exemplar programme. North Cumbria Integrated Care NHS Foundation Trust was a trailblazer for our region employing a dedicated People Promise manager work with staff to bring to life the People Promise values every day. Following success alongside national colleagues, our region has successfully secured a further eight People Promise Managers to help make NHS organisations better places to work and encourage staff to stay with us.

Pillar 3 – Health and Wellbeing

Evidence shows that staff health and wellbeing impacts on the care our teams provide to patients and service users. That's why we have supported a special project designed to help managers across the region to have more effective and meaningful conversations about wellbeing with their staff. The project, which is supported by the Health Innovation Network, is the first step towards creating a regional standard, which will help managers have wellbeing conversations with their teams and follow them up with appropriate support.

Pillar 4 – Leadership and Talent

It can be challenging to focus on long-term change and improvement when working under daily pressures dealing with the here and now. We want everyone in our health and care system to be able to play their part in improving the services we provide to patients and service users. That's why we have launched a learning and improvement community, known as 'Boost'. This will support all of us to be 'the best at getting better' by sharing ideas, learning and good practice, helps us think about the future, try new things, and make a difference. Boost brings people together working for communities in the North East and North Cumbria in a spirit of innovation, idea-sharing, networking, supporting our vision for a leadership and culture based on learning and sharing.

Pillar 5 – Health equity and inclusion

The NHS is built on the values of everyone counts, dignity and respect, compassion, and improving lives. These values underpin how healthcare is provided but must also extend to our NHS workforce. A key part of our approach is a new regionwide equity, diversity, and inclusion (EDI) group. This brings together EDI leads from across the region to work together in embedding equality, diversity and inclusion into policies, networks, and staff communications. The group is developing a shared approach to areas like cultural awareness, events, staff networks, and equality impact assessments. This has included supporting events around Black History Month, Disability History Month and International Women's Day with staff sharing their personal stories in support of the #InspireInclusion theme.

Pillar 6 – Reform

Growing the NHS workforce is not enough on its own to ensure we can meet the changing needs of patients and service users. We need our staff to work in different ways, with each other and with patients and service users, and for clinicians to be able to spend more time with patients and service users providing high quality care. Plans this year to explore how we can work more effectively to make best use of staff time and deliver the best care for people using our services include a 'staff passport'.

All eleven NHS Foundation Trusts in the North East and North Cumbria are working collaboratively to identify ways in which staff can work across different organisations, taking things like training records with them so they do not have to repeat training when working for an organisation other than their main employer. This will enable staff with much needed expertise to work across a number of sites to delivering services to patients across the region and help ensure safe staffing levels.

Research engagement and network development

Research and Innovation Key Achievements

A Research and Innovation (R&I) Strategy has been developed with the input of key research and innovation players, aligned across the NENC ICB footprint. This was aligned to the ICB priorities for the NENC population and has 7 key principles: -

- Focus on research co-production and user centred health and care design to ensure we support real people and communities, with no one left behind
- Drive a strong culture of innovation, where we have 'licence to succeed and permission to fail.' Some projects will fly, and others fail, but all will support learning and improvement
- Nurture and grow, a confident and highly skilled workforce with the necessary capacity and tools required to deliver evidence-informed, place-based care
- Support the use of evidence, data, and analytics to understand if we are doing the right things in the right way, drawing on the lived experience of people using our services
- Collaborate across the regional ecosystem, capitalising on our unique assets, infrastructure, and relationships, to unlock new technologies, accelerate clinical trials and develop new methodologies to meet the health and care needs of our population
- Attract inward investment and maximise untapped resources by working with industry and Local Authorities to support economic development and job creation and thus the wellbeing of our population
- Celebrate success at all levels and draw on talent in every sector to ensure we position this region as an internationally visible centre for excellence in research and innovation

This Strategy has undergone a public consultation exercise via the ICB website and CEO Bulletin, and accordingly has received feedback from several R&I stakeholders, as well as members of the public. The responses are currently being reviewed and thematically analysed, to create a series of recommendations, as well as the identification of any gaps.

Further engagement activities are being planned to ensure cohesive, regional feedback, with the aim of finalising a regional, shared R&I Strategy in the Autumn, ensuring that the statutory duties of the ICB are met. Further, the ICB will create and implement, strategic research and innovation plans based upon these recommendations.

Research

The Research and Evidence Team at the North of England Commissioning Support (NECS) is commissioned and supervised by the ICB to deliver a range of research support services, including research governance, research training, the hosting and management of NIHR research grants, knowledge mobilisation, managing excess treatment costs, and service evaluations. Training in evidence finding and appraising, ensures staff have the tools and skills to support, using the evidence from research, in decision making.

The head of the Team has been linking in nationally to influence policy in research with national stakeholders e.g., NHSE, National Institute for Health and Care Research (NIHR), and Department of Health and Social Care (DHSC) etc. to ensure the voice of NENC research ecosystem and population, are represented, and the national research ecosystem and ICB interface, are connected and add value.

Research governance processes provide assurance to the ICB that research is conducted in line with Health Research Authority requirements and national policy and guidance. NIHR research capability funding (RCF) for ICB was required to be used in 2023/24 to grow primary care research, which is a key priority area where there are identified gaps in the research activity and evidence base, and also an area that supports retaining the workforce with portfolio careers combining research and practice. Working with primary care academic leaders, there is a long-term vision to bring together leading experts within primary and community care systems in a single virtual unit to build academic primary care within the region. RCF was used to fund sessions and capability building for a primary care staff and to grow successful bids from NIHR

Knowledge mobilisation of research into the ICB has been achieved through a number of fora: -

- Evidence and evaluation is one workstream of the ICB Mental Health Programme, bringing together practitioners, ICB leads, academics, librarians HI NENC, the voluntary sector, and those with lived experience together to inform and evaluate priority programmes of work, and these partners supported a NIHR Applied Research Collaboration for the North East and North Cumbria (ARC NENC) dedicated mental health, one day event

- The NIHR ARC, NECS, ICB, & School for Public Health (Fuse) held a one-day event on Integrated Community Care to promote healthy ageing. As well as sharing current research and ICB priorities in this arena, workshops with the multi- stakeholders attending, developed priority areas for future research. One such research question has subsequently been awarded an NIHR research grant

- Joint research work on shared medical appointments led to an event by Newcastle University and NECS, to share new and emerging evidence on this innovative way of working across primary care

- Evidence from research on different staff roles within primary care was the topic of a webinar in March overseen by an ICB leader and researcher and NECS to support evidence based development in that sector

- Work funded by the NIHR CRN NENC in conjunction with NECS and Newcastle University, delivered a project focussing upon the link between recruitment into

research and patients within GP Practices located in deprived communities, seeing less deprived areas but with most need, where lowest in getting involved in research and looking at the barriers to overcome this. This work has been presented to the Deep End Network, as well as many events nationally. Due to the learning from this work, the NIHR CRN NENC have funded a research nurse to support these GP Practices to be more research active, and the learning from the health literacy REN work learning will enhance the opportunities

- Routine use of social media, bulletins, and targeted messaging

The NIHR CRN NENC annual recruitment numbers, as of 17 April 2024, shows a decline in actual patients recruited across NENC compared with 2022/23. However, numbers do not account for the complexity and sites, and importantly all NHS providers and speciality areas were active in research delivery across the NENC. Importantly, also is a move to more research in primary care where a total of 16242 patients were recruited, a rise from 4681 in 2022/23, and over 50% of GP Practices being research active. With regard to the national priority of supporting commercial research, 2947 or 29% of total recruitment across primary care is attributed to commercial studies. The growth in research outside the acute sector is demonstrated in 588 recruits in, for example Dentistry, Ageing, Mental Health, and Public Health.

The NIHR ARC NENC is intertwined with many aspects of ICB priority work as its themes were collectively agreed across the system at its inception. ARC NENC researchers are members of several ICB workstreams particularly across the Healthier and Fairer Programme, Frailty, and Mental Health, bringing new evidence and evaluating key workstreams. The ARC NENC Evidence Hub contains research outputs of relevance to ICB, and is linked and shared.

A number of ICB research " communities " are maintained, North and South of the region, as well as with Allied Health Professions, bringing a wide range of stakeholders across research together, to understand the current state of research, as well as collaborating in order to develop further research.

Shared Data Environment

The NENC region has been funded as a sub national shared data environment (SNSDE) for research with ICB leadership across Digital, Data and Research, shaping this to enhance the research and commercial opportunities once mobilised.

Improving Diversity of Representation in Research

The NENC region successfully secured two individual projects from NHSE to deliver Research Engagement Networks (REN), focussed upon areas of unmet need in research, which are outlined below:

Mental Health Services for Children and Young People (CYP)

Mental health services for CYP are experiencing a significant rise in demand across the country. The NENC health and care system has identified this as a key priority to address for the region. To help reverse this trend, developing a deeper understanding of the experiences of children and young people across the region; the underlying causes of increasing mental health issues; interactions with the health and care system; and the evaluation of interventions (healthcare or non-healthcare) is essential. This is particularly important in relation to the diversity of communities and levels of deprivation in the region and addressing limitations in how representative recruitment to research has typically been, particularly for children and young people.

The 2022/23 application demonstrated the cross organisational working with ICB, NIHR ARC NENC, the NIHR CRN NENC, NECS, as well as new joint working with North East and North Cumbria Voluntary Organisations Network North East (VONNE), building upon existing platforms and relationships, and bringing these together for CYP. Funds were allocated directly into 7 Voluntary, Community and Social Enterprise (VCSE) organisations, across all parts of NENC, and initiated a range of innovative, community developed, engagement strategies to connect and understand more about research in health and care. There was a strong desire and a need for longer-term, sustainable partnerships for communities and community organisations to learn, engage and participate in research activity moved ahead by further successful funding in 2023 (REN Phase 2), which aims to work towards co-developing a Children and Young Peoples' Health Research Network.

This Network will provide a shared space for knowledge exchange, access to training, learning and development opportunities and also opportunities for VCSE organisations to inform, develop and participate in research that reflects the needs and priorities of the communities that they serve, starting with the 7 original VCSE organisations as they progress and learn from their own engagement strategy development. Further, this will integrate with the development of the NIHR ARC NENC Children and Young Peoples' Research Partnership, which focusses on identifying research priorities with young advisors, and utilising intelligence from the CORE20PLUS5 Community Health Champions Programme, to align the NIHR CRN NENC Public Research Champions and Community Champions to increase their diversity and reach, creating a VCSE-driven Champion model, which can be employed across the ICS.

This work has been promoted across the research ecosystem and ICB and outcomes include events, video, and training materials. Independent evaluation of the programme of work by a VCSE will bring the learning into the ICB and partners to help shape future work to engage underserved communities in research. In addition, BOOST will host and spread the learning, outputs, and outcomes.

Health Literacy as a Universal Precaution to improve Patient Access to Research

Led by the health literacy lead for the ICB alongside VONNE, NECS, and academic experts in health literary.

Low patient health literacy is a barrier to informed patient research involvement. Patients with low health literacy are more likely to have long-term health conditions than people with higher skills; thus, reduced involvement in research risks increasing health inequalities. Barriers include patient information and consent materials that are written at a level too complex for patients to understand, and lack of researcher and practitioner skills to present information about research projects in ways that can be understood and acted upon.

This project works with patients, and the public from vulnerable populations, to explore any health-literacy related barriers to research involvement and how these might be overcome. There is engagement with the North-East University Research Ethics Committees to develop templates for researchers to develop lay summaries, information sheets and consent forms that are easy for patients to understand and act upon. This project was showcased at a NHSE learning event.

Both of these projects will feed into involvement, diversity, and research plans for the ICB going forward.

Innovation

The ICB has formerly appointed Health Innovation North East and North Cumbria (HI NENC) formerly the Academic Health Science Network for the North East and North Cumbria, as its regional innovation partner, and a Memorandum of Understanding has been executed between the two organisations. Further, the CEO of HI NENC has been appointed as a strategic advisor to the ICB with regard to innovation, and the CEO of the ICB attends HI NENC Board Meetings. Collectively, these links ensures that our regional innovation portfolio is focussed upon the priority areas defined within the Better Health and Wellbeing for All Strategy.

During the course of 2022/23, the ICB and HI NENC have jointly supported the following initiatives:

Health and Life Sciences Pledge

There is a growing and vibrant Health and Life Sciences sector in the North East and North Cumbria, and accordingly the Pledge aims to bring together this ecosystem to:

- Collectively address regional health and social care challenges, supporting the reduction in health inequalities
- Gain recognition for our unique infrastructure and assets, on both a national and international stage
- Work cohesively to identify opportunities and attract investment to the region
- Collectively celebrate our collective success within the innovation arena.

Launched in March 2023, as a joint initiative between HI NENC and the ICB, the Pledge continues to grow, and now has 136 Pledgees, which span academia, NHS, social care, voluntary sector, industry, and charities. For further details, www.hlspledge.org.uk

Bright Ideas in Health Awards

In late March 2023, HI NENC hosted its Bright Ideas in Health Awards (BIHA) Ceremony and the ICB was the headline sponsor, alongside several other research and innovation-based organisations. The BIHA celebrate the achievements of individuals and teams working within the NHS, social care, industry, and academia, who have risen to the challenge of telling us how, and where, they believe that the services provided to patients can be improved, either through a technical innovation or through better service delivery.

The Awards have a long history within the region and were first launch in 2003 as the Innovation at Work Awards and renamed in 2006. More than 200 new ideas were submitted across seven categories to the Awards and many of these have been triaged and are currently being developed along the Innovation Pathway.

April 2024 sees the launch of the Bright Ideas in Health Awards for the nineteenth time with two new categories being added: (i) Innovative Women's Health, and (ii) Innovation and Improvement in Reducing Health Inequalities. These new categories demonstrate further alignment with ICB priorities. Other categories will include: - MedTech Award, Outstanding NHS Industry Collaboration, Innovation in Clinical Education, Demonstrating an impact in Patient Safety, Towards a Net Zero Award, and Research for Local Need. Further details can be found here https://brightideasinhealth.org.uk

The Innovation Pathway

Back in 2012, HI NENC developed The Innovation Pathway, which has now become a regional, and national mechanism for supporting new ideas, as well as innovators (from both the NHS and industry) with bespoke advice.

During the last year, the ICB has adopted the Innovation Pathway approach across several programmes of work, with a particular focus upon real world evaluation and working with industry. The outputs of the Innovation Pathway include new, and improved products and services for the NHS, the creation and safeguarding of jobs, as well as the securing of investment following the bespoke intervention provided. For further details, please see https://innovationpathway.healthinnovationnenc.org.uk

Innovation for Health Inequalities Programme (InHIP)

The InHIP aims to address local healthcare inequalities experienced by deprived and other under-served populations. This is a national initiative and in the North East and North Cumbria region, the Programme has focussed upon addressing health inequalities relating to cardiovascular disease prevention, within the Middlesbrough area.

The Programme has been delivered by the ICB, HI NENC and the NIHR ARC NENC, where we have delivered a series of behavioural insight focus groups with minority and marginalised communities, to understand their experiences of and barriers to accessing CVD health checks. The views of local communities are key to this work, and insights into their experiences has helped to co-design sustainable, and effective CVD prevention interventions, aimed at reducing avoidable premature CVD deaths and narrowing health inequalities within the local population. https://healthinnovationnenc.org.uk/what-we-do/improving-population-health/healthcare-inequalities-programme-inhip/

Driving Digital Transformation

HI NENC is supporting the ICB to drive inclusive digital transformation across the North East and North Cumbria, with the goal of improving outcomes for patients. The HI NENC Digital Transformation Director is embedded within the ICB Digital Team, and together we are working across the health and care system, to identify, support, and facilitate opportunities to use digital health initiatives to transform pathways of care.

Some of the Programmes of work include: -

- Digital Pioneers - facilitates collaboration, exchange of ideas to support scale and spread of digital innovations across Primary Care
- Digital Champions - a CPD accredited, 12-month education programme to support Primary Care staff looking to embrace digital technology
- Health and Tech Adoption and Accelerator Fund (HTAAF) – in October 2023, the ICB successfully secured £700k from the Department of Health and Social Care. This national Fund aims to support the adoption and spread of health technology, and within the NENC region has focussed upon the creation of a regional Virtual Ward Solution. The ICB is working in partnership with HI NENC, a digital based SME, and five provider organisations as part of this project.
- Sub National Secure Data Environment – the ICB is leading this programme, in partnership with other regional organisations. From the perspective of research and innovation, the relevant organisations comprising this ecosystem are all involved in shaping this agenda. Moreover, two clinical academics leads have just been appointed to help oversee the programme supported by several research and innovation-based advocates. For further details regarding these digital programmes, please see https://healthinnovationnenc.org.uk/what-we-do/driving-digital-transformation

2024 Programme of Work

The ICB is working with HI NENC to finalise the 2024/25 innovation portfolio. The successes of the above programmes of work will be built upon, as well as supporting other priority areas such as Women's Health, Children and Young People, and Respiratory. In addition, we will continue our work to raise the profile of the North East and North Cumbria in terms of its unique assets, infrastructure, and relationships, as well as developing our international links.

Improving Quality

Quality Governance

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

We have established Integrated Place reports, with a standardised quality agenda to ensure a consistent approach. Learning and areas for escalation feed into the ICP quality groups, and are focused on patient experience, patient safety, and clinical effectiveness.
Key learning from these four meetings and areas for escalation are discussed at the Non-Executive Director (NED) chaired sub–board Quality and Safety Committee.

As part of the transition into our new structures and arrangements we are reviewing our quality governance arrangements to ensure they remain suitable and appropriate to support the ICB. In line with the Patient Safety Incident Response framework (PSIRF) we are setting up forums to share learning through communities of practice.

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

All Age Continuing Care (AACC)

All Age Continuing Care encompasses Childrens Continuing Care and their transition to Adult Continuing Healthcare. Governance has developed to have both children and adults' groups all with priority Task and Finish groups reporting into the collaborative All Age Continuing Care Strategic Transformation Group. The overall aim is to reduce unwarranted variation across the ICB and ensure alignment and compliance with statutory duties, the National Framework and associated legislation.

Scoping was completed and the maturity of the AACC service ICB wide analysed to enable prioritisation of work and has led to in year process improvements and increased assurance in consistent decision making.

We have assessed current practice ICB wide for the implementation and reporting of Personal Health Budgets (PHB) for areas which have the right to have a PHB. This includes CHC, S117 and Wheelchair users, however we are keen to embed PHB’s in other areas also and want to provide options to address and improve the delivery of PHB’s. The aim being to improve the process for eligible individuals and meet the national expectation that 85% of all community-based packages of care for Continuing Healthcare eligible patients will be via a PHB. We are also looking at developing our Strength-based practice approach which is a collaborative process between the individual supported by services and those supporting them. It allows them to work together to determine an outcome that draws on the individual’s strengths and assets. Rather than focusing solely on deficits or challenges, this approach values the capacity, skills, knowledge, connections, and potential of individuals and communities.

It aims to promote well-being and self-efficacy by emphasizing what people bring to a problem or crisis. There has been some personalised care training delivered to practitioners within the ICB to strengthen this approach. Commissioned work is ongoing with the development of an ICB wide Personal Health Budget policy and align all AACC processes which provide increased assurance of quality, safety and robust governance and audit. Strategy development is in progress to improve the PHB offer and associated uptake of PHBs and PWB's.

A Joint Funding Task and Finish group is working together to consider potential appropriate approaches to ensure consistency and provide robust rationale to decision making.

Childrens Continuing Care (CCC)

Joint work with Local Authority partners has looked to improve transition arrangements between Children & Young People as they move from Children's Continuing Care (CCC) to Adult services. More robust policies are being developed to achieve partner dispute resolution and a robust appeal process for CCC. A full-service scoping project has been undertaken to identify potential gaps in service provision.

Learning Disabilities Mortality Review (LeDeR)

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

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

Special education needs and disabilities (SEND)

The strategic group has widened its membership to include the voice of parents and carers as part of the ICB commitment to work with children, young people, and their families to improve patient experience and improve health outcomes. Workstreams to deliver the action plan are in place, with a focus on consistency across workforce, engagement, and quality assurance.

The Gateshead and Middlesbrough Partnerships have been inspected with clear areas of strength identified, providing opportunities to share best practice and learning. Peer review meetings with regional teams continue a six-monthly basis and evidence positive progress within SEND arrangements.

Engaging people and communities

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

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

The ICB has an involvement and engagement team that supports commissioners to assess the need for involvement activity as well as practically supporting, advising, planning, project managing and commissioning activity as appropriate. Each project has a specific bespoke involvement plan which sets out objectives, tactics and resources required. Specialist advice and external benchmarking is obtained from the Consultation Institute. This support ensures that all engagement and consultation work undertaken by the ICB follows best practice.

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

The team build and facilitate networks with the public, with public sector partners and with VCSE partners in local areas. The ICB has funded an ICS VCSE Partnership, coordinated by North East and North Cumbria Voluntary Organisations Network North East (VONNE), who attend ICB Board meetings as a formally designated participant to represent the views of the VCSE sector in the North East and North Cumbria. Each of our ICB Locality Teams also works closely with the VCSE sector in each of local authority areas that they cover, to understand their needs and identify opportunities for collaboration.

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

Annual involvement and engagement report

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

Our vision demonstrates our commitment to make the best use of public resources. Important decisions that affect patients are made in partnership with key stakeholders. At the heart of this process are local people.

To ensure that we have person-centred, sustainable services, we work with partners and the public towards to enable the public to influence decision-making in relation to service change and development.

We undertake demographic monitoring in relation to the nine protected characteristics of the Equality Act 2010 and beyond, where appropriate. This helps us to understand who is participating in activity and where targeted work is needed. It also enables analysis of responses by different demographics, where data allows, to support duties in relation to equalities and health inequalities. The ICB's annual involvement and engagement report details all the ways we work with local people to improve access, service delivery and quality. It also includes evidence of local people acting as a catalyst for innovation and change.

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

The annual involvement and engagement report provides a summary and demonstrates the range of some of the key patient and community engagement activities during 2023/24. This report demonstrates how the involvement of patients and public has influenced decisions the ICB has made.

The report will be available on the NENC ICB website following publication.

Overview of involvement activities

Shaping services through listening

- The Waiting Well Programme
- Continuing healthcare and domiciliary care specifications
- Supporting various GPs to engage patients around developments, such as boundary changes and mergers
- Improvements to podiatry in South Tyneside and Sunderland
- Secure Data Environment

Collaborative listening

- Northern Cancer Alliance Oncology review
- Care in Later Life in County Durham, with the Council and Voluntary sector organisations
- Co-producing the Northumberland SEND review with the Parent Carer Forum
- Children and Young People's Mental health Summit
- Work with North Cumbria's Integrated Care Trust to understand how to support patients with additional needs to attend appointments

Working with our communities

- Active participation in a wide variety of community forums and networks
- Working with Healthwatch to hear what communities are saying
- Hearing and learning from complaints and MP enquiries

Supporting staff to involve people

- Raised awareness of involvement across the ICB
- Gather patient stories, using the storyteller process, to inform governance
- Published the Involvement Toolkit
- Supported the development of co-production training

Examples of involvement activity in 2023/24

Newcastle urgent care review

In 2023, we completed the first phase of our listening exercise with the public, patients, community, voluntary organisations, and staff, to help inform the future direction of delivering urgent care services in Newcastle.

Over 1,200 people made their views about the service known, through online and paper surveys, and through a series of public face-to-face meetings in community locations across east, central, and west Newcastle. Surveys were also distributed through GP practices, urgent treatment centres, the Royal Victoria Infirmary, and other key locations (such as libraries and community centres). In addition, over 500 on-street surveys were conducted, and seven independent focus groups were also held.

An independent report was compiled by Involve North East. The findings were reviewed by the strategic urgent care review group, made up of clinical leads and senior managers from Newcastle's urgent care centres, GP practices, emergency department, as well as from Newcastle Hospitals NHS Foundation Trust and the ICB. The report continues to help influence and inform discussions of the group in 2024.

As a consequence of this review, the engagement team has been asked to establish a patient review group, made up of a small representative sample of patients from across the city, to provide periodic ongoing views and a sounding board, as different scenarios involving the future of urgent care in Newcastle are considered, in 2024 and beyond.

Women’s health hubs

In December 2023, we committed £595,000 to fund new women’s health hubs in Gateshead, North Cumbria, and Sunderland, as part of the NHS’s national Women's Health Strategy for England. To help ensure that the design and delivery initiatives are informed by women themselves, including those who have lived experience of particular health conditions, as well as those from diverse communities.

In one of the pilot sites (Gateshead) we are undertaking an independent listening exercise and survey with members of the community, including women from the local Orthodox Jewish Community. Working through community representatives from Labriut, we will be able to better shape the design and delivery of this innovative new project. In the Sunderland area, there will be some insights work undertaken to inform the communications and branding approach for the hubs.

Rapid response palliative care – County Durham and Darlington

Working collaboratively, commissioners across Durham and Darlington came together to look at their respective rapid response palliative care services. This provided an opportunity to engage, as sensitively as possible, with the families of those people who have used this service to understand; what they valued in the current service, as well as where this type of support might be able to improve in the future.

Working jointly with the two existing service providers, paper copies of the questions were printed and distributed to the providers directly. These were left with families after their interactions with the service, providing families time and space to complete their feedback anonymously when they were able.

The findings from the involvement recognised the high-quality care and personal support that staff delivering this service provide. There was a high regard for the compassion and caring nature of the staff by the family members too.

Podiatry – South Tyneside and Sunderland

A new model for podiatry delivery was proposed following previous engagement with podiatry patients, work with providers and work with professionals. Healthwatch in both South Tyneside and Sunderland undertook work in podiatry clinics on behalf of the ICB to enable patients to give their view on the proposed model. Outcomes include the following:

- In response to concern about continuity of care, this has been strengthened in the specification, particularly for those at high risk
- In response to concerns that location could impact on accessibility, travel and transport commissioners stated that feasibility testing of the model during procurement will include a travel impact assessment and detailed testing around the transport and travel infrastructure
- There were concerns linked to decision making for triage into for self-care and how self-care would work in practice. Comments were also received around the impact on disabled patients. Feedback states that part of the procurement process will be to ensure the decision making in relation to eligibility or self-care will be done in a clinically sound way. The criteria for evaluating providers will include the criteria they use to determine eligibility. This will include what self-care will involve; how it will be monitored to ensure it is clinically safe; what education will be provided; how education will be provided; and provision of equipment or materials. Feedback assured service users that patients with existing physical and mental disabilities will not be impacted by the changes and for those who will be triaged in future, reasonable adjustments will be made. This will be included in the specification and the Procurement Evaluation Strategy
- Points were raised relating to accessibility of the referral process, criteria used to assess need and potential increased demand for service. Commissioners provided reassurance that the single point of access has been designed so that patients are assessed by a suitably trained clinician. There will be one clear, standardised set of criteria to get people to the right service more quickly and make sure clinic access is prioritised on need

Children and young people's mental health summit

The ‘Always the Right Door’ Children and Young People’s Mental Health Summit was held on 25 October 2023. 250 people working in health and care from across the region came together and committed to bringing about the changes we need to give children and young people the best start in life.

Young people, parents and carers shared their experience of mental health services in the North East and North Cumbria. Their stories brought to light the challenges they’ve faced and the importance of finding “the right door” to support those in need. There were sessions showcasing services from across the region and also some problem-solving activities where people got to vote on our top five ‘big ideas’ to take forward.

What came out strongly was the need for integrated teams and posts across all sectors and that our young people should be involved in the commissioning and designing of services. All the rich content and ideas from the event will be pulled together and form part of our plans for action going forward. Work is currently underway on an update in relation to integration and the voice of CYP; involvement of children and young people and their families in redesign of services; commissioning and funding priorities; personalised care and trauma informed workforce; and family hubs.

Oncology- The Northern Cancer Alliance

We are supporting public involvement in a review of oncology services across the North East and North Cumbria, by the Northern Cancer Alliance (NCA), which includes representation from all trusts. The aim of the review is to develop a sustainable clinical model for oncology services which aims to address the current issues being experienced within the existing service delivery model: a national shortage of oncology workforce and increasing demands on oncology services.

While this oncology service review has been taking place, and due to a shortage of oncologists within the service provided by Newcastle Hospitals NHS Foundation Trust the rapid implementation of temporary changes has been necessary within the north of the Integrated Care System region. Whilst most patient care has continued to happen locally within the initial diagnostic pathway, for a relatively small number of patients (estimated to be 114 patients a week out of 630 cancer patient contacts) their first face-to-face outpatient appointment with the consultant oncologist, and for any necessary face-to-face follow up appointments with the consultant oncologist during their chemotherapy treatment, has been taking place at another unit than historically would have been the case. The service is also offering and maximising the use of virtual appointments where this is appropriate.

To understand the impact that these temporary changes have had on patients accessing the oncology service, a four-week piece of engagement was undertaken with patients in July 2023. Patients attending an oncology appointment were given a survey to complete, either on paper or online. This work was followed up with a focus group and phone interviews.

Valuable insight was gained from patients to inform the new model across the North East and North Cumbria including around travel and virtual appointments. We are building on this work with focus groups and interviews with people from ethnically marginalised groups and disabled people.

Involving on our strategies

Integrated Care Strategy

Last year, the NHS, local authorities and the VCSE sectors came together to develop the Better Health and Wellbeing for All plan to improve health and care in the North East and North Cumbria.

There was the opportunity for stakeholders, partners, and members of the public to help shape this strategy through an online survey and by submitting a direct response. The engagement findings report is available on the ICB website and this feedback was used to help finalise the strategy.

We are continuing to listen about the strategy and will take on board feedback we receive at Better health and wellbeing for all survey.

Joint Forward Plan

Following the publication of our Integrated Care Strategy, Better Health and Wellbeing for all, we have been working closely with our partner organisations to produce our Joint Forward Plan. Our Joint Forward Plan is a delivery plan for the parts of our strategy related particularly to NHS delivered or commissioned services, but within the broader partnership context.

In the summer we asked our system partners and communities for their thoughts on the draft Joint Forward Plan, for 2023-2028. We used the feedback people gave us to finalise the Joint Forward Plan, which will be the framework for our work for until 2028, with revisions each March. This is the easy read version of the Joint Forward Plan.

Involvement strategy

The ICB's first involvement strategy was developed through co-production with partner organisations and through conversations with stakeholders to understand what has worked well for involvement, what could work better, and how the ICB can deliver excellence through involvement across the North East and North Cumbria.

Our strategy, based on the five themes below, is built upon these conversations and a shared commitment to continue to involve patients, public, carers, and wider stakeholders in shaping, evaluating, and improving the services we commission. This strategy ensures that we have a clear plan to meet legal duties to engage and consult the public and also the pledges set out in the NHS constitution. The strategy was also produced as an easy read version.

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

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

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

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

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

Over the coming months, we will be reviewing the involvement strategy and will engage with our stakeholders to ensure this is further developed by their feedback. This work has started and Healthwatch, on behalf of the ICB, is engaging with people across the North East and North Cumbria, including those who are seldom heard, to understand what people think of the strategy so far and how this can be strengthened.

How we work with our communities

Listening to lived experience

We are committed to listening to people's experiences of local health services, both

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

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

Working with our communities

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

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

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

Co-production

Co-production is a way of working with people and communities in equal partnership. It is an approach to decision making and service design, rather than a specific method of engagement. It stems from the recognition that if organisations are to deliver successful services, they must understand the needs of their users and work closely with them in the design and delivery of those services. Co-production offers the opportunity for professionals and citizens to work together to ensure that service delivery connects to lived experiences and is therefore meaningful and effective.

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

For example, we have been working with people and communities in Workington, North Cumbria, to encourage an asset-based approach to building a thriving community. We aim to build an ethos that will encourage health and care professionals to work with communities to help generate capability and a sense of agency within Workington community and to drive change.

Co-production training

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

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

Co-production survey and conversation

Our Healthwatch partners in North Cumbria led a survey to consider people's experiences of co-production, to help improve working between the system and citizens. The survey highlighted that people would like to get involved in the future development and improvement of services, even though many had not previously been involved. People wanted to know how to get involved and they wanted to know how what they said had made a difference.

We followed the survey up with a conversation with partners to reflect on what is working well with coproduction and identify areas for improvement. This included local authorities, NHS, Healthwatch, the voluntary sector, education, and local citizens.

From the two pieces of work, it was concluded that we could strengthen working together by:

- supporting staff to collaborate more closely with our communities. Boost, our learning and improvement team, is committed to training staff in co-production methods
- making it clearer how citizens can get involved

The involvement team is developing how we develop and share ways for people to get involved.

Lived Experience Board

The ICB's associate director of lived experience brings a lived experience perspective into the ICB's mental health transformation portfolio and how we can develop an infrastructure to support meaningful co-production that leads to change.

A piece of mapping work has been undertaken to plot out the rich and diverse participation happening across mental health care in our region. This included significant involvement and engagement structures within our two mental health trusts alongside lived experience leadership posts, a growing peer support workforce both inside and outside NHS services, a range of user led and VCSE organisations and networks, a number of recovery colleges and examples of co-production across place-based commissioning. The mapping work identified that there are many ways for patients and families to be heard about their experiences of mental health services and to be part of improvement work but also identified some key recommendations to improve this agenda.

Following the mapping report, the Lived Experience Board for Mental Health was established and is a group of 25 people with lived experience, many of whom work in either the NHS or a VCSE organisation in lived experience roles. The board meets monthly with the aspiration of influencing the mental health transformation portfolio. Each member has links back to broader patient/service user communities whether it is via involvement banks, peer workforces or community lived experience forums. Members of the board are involved with each of the mental health transformation priorities including suicide prevention, inpatient transformation, and community transformation. Our aim to ensure that all the significant pieces of work are happening in partnership with people who have lived experience.

In addition, the board is currently co-creating a lived experience strategy to ensure the aspiration for co-production within mental health becomes embedded at system level and this will be an addendum to the ICB's involvement strategy.

Find out more about how we work to involve people on the ICB website. The ICB is using what people told us to inform the refresh of the ICB Involvement Strategy.

Reducing health inequality

Healthy and Fairer Programme

During 2023-2024 the NENC ICB has discharged its duties associated with health inequalities primarily through the Healthy and Fairer Programme. This system-wide transformation programme continues to strengthen leadership and accountability in addressing health and healthcare inequalities by bringing senior ICB leads (Executive and non-Exec Medical Directors) together with NENC Directors of Public Health, senior leaders from the Office for Health Improvement and Disparities (OHID), Foundation Trust Public Health Consultants, and the VCSE partners across 3 workstreams:

- Prevention
- Healthcare Inequalities
- Broader Social and Economic Determinants

The programme is directly accountable to the NENC ICB Executive Committee.

Insight, Intelligence and Performance

Key to understanding the health and healthcare inequalities experienced by our population has been the increasing use of data and intelligence that has supported the development of a programme dashboard that draws upon Multiple datasets to provide a contemporary oversight of key metrics and measures of health identified as high priority for the population within NENC. In addition to providing insight and intelligence, the work also helps identify gaps in data and potential data quality issues, supporting work to ensure datasets are complete and timely. This dashboard includes metrics associated with Alcohol, Cardiovascular Disease, Maternity, Tobacco, and Weight Management. The dashboard allows for the data to be presented at system, place, and (where applicable) Foundation Trust level.

In addition, the ICB Executive receive bi-monthly updates on performance metrics against the CORE20PLUS5 10 clinical pathways for both Adults and Children & Young People, having turned national ambitions into measurable outcomes.

Further to the development of the dashboard and regular performance reporting, a detailed response to the NHSE legal statement on health inequalities has identified the position of the ICB in regard to the 35 metrics detailed within the statement.

Where inequalities are identified on the basis of ethnicity and deprivation (where the available data enables this), and detailed narratives on the causes of each inequality gap and the actions being undertaken to address these.

These can be seen via this link. This work has extended beyond the Healthy and Fairer Programme into other ICB workstreams, including Urgent and Emergency Care, Mental Health Transformation, Elective Recovery, and the Local Maternity and Neonatal System, ensuring that the identification of, and actions to address healthcare inequalities, becomes embedded across all ICB workstreams ensuring that services are restored inclusively.

Current position

Many of the metrics contained with the legal statement have demonstrated improvement compared with the baseline position, and although inequalities remain a reduction has been reported. The top three metrics to highlight as demonstrating improvement are:

- Halving the difference in the suicide rate in the NENC compared to England.
- The percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy.
- Reducing smoking from 13% of adults in 2020 to 5% or below

Other metrics have not demonstrated a positive change compared with the baseline position, in both overarching figures and inequalities. The three areas of concern are:

- An increase in the number of people with a healthy weight.
- The number of preterm births under 37 weeks.
- The number of severe mental illness (SMI) physical health checks.

Prevention Workstream

The prevention workstream continues to support the acceleration of preventative programmes across Cardiovascular Disease, Alcohol, Tobacco, and Healthy Weight and Treating Obesity. Work over the past year includes

- Innovative approaches to the engagement of inclusion health groups at risk of cardiovascular disease, in collaboration with NENC Health Innovation
- The establishment of funded Alcohol Care Teams in all NENC Foundation Trusts
- Embedding of tobacco dependency treatment services in inpatient settings and maternity services
- The development of specialist weight management services in areas of deprivation

Healthcare Inequalities Workstream

The healthcare inequalities workstream supports the delivery of the CORE20PLUS5 for both Adults and Children & Young People through a clinical network-led approach, ensuring that subject matter expertise and whole-system partnerships are at the forefront of delivering the service transformation required to reduce healthcare inequalities, focusing on the most deprived communities within the NENC. This work extends to collaboration with Local Authority Public Health Teams on supporting people with multiple and complex healthcare needs and supporting General Practice working in areas of blanket deprivation through the NENC Deep End Network.

The workstreams is developing a NENC Approach to Inclusion Health to deliver the newly published NHSE Framework for Inclusion Health. This approach will ensure that the needs of socially excluded groups facing multiple challenges like poverty and trauma are identified and addressed. Inclusion Health communities that are within scope of the work include veterans, people experiencing or at risk of homelessness, people in contact with the criminal justice system, and rural and coastal communities.

The NHS Contribution to the Broader Social and Economic Determinants of Health Workstream

The NHS Contribution to the Broader Social and Economic Determinants of Health workstream has been established over the past year to develop approaches to ensure:

- The information we provide to our population is understood by them, through the development of a Health Literacy approach
- We are mitigating against digital exclusion
- The NHS understands and maximises its role as an Anchor Institution
- The impact of poverty in our service is mitigated

Healthier and Fairer Learning Academy

The programme is developing a workforce academy to increase the understanding and ownership of the Healthier and Fairer agenda. Programmes of studies for each workstreams and project are being developed alongside communities of practice and interactive digital spaces, encouraging dynamic learning and development.

Building on local good practice, a health inequalities module is also under development with Sunderland University. This will afford practitioners from across the system the

opportunity to develop their academic knowledge of health inequalities and take this into the workplace.

Workforce Equality, Diversity, and Inclusion (EDI)

The ICB has implemented 1 year ICB EDI Strategy that has improved EDI capability and knowledge, ensuring that the ICB is confident in meeting its legal requirements through being consciously inclusive. This has included publicly publishing the ICBs response to the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and the Gender Pay Gap, Disability Pay Gap, and Ethnicity Pay Gap reports.

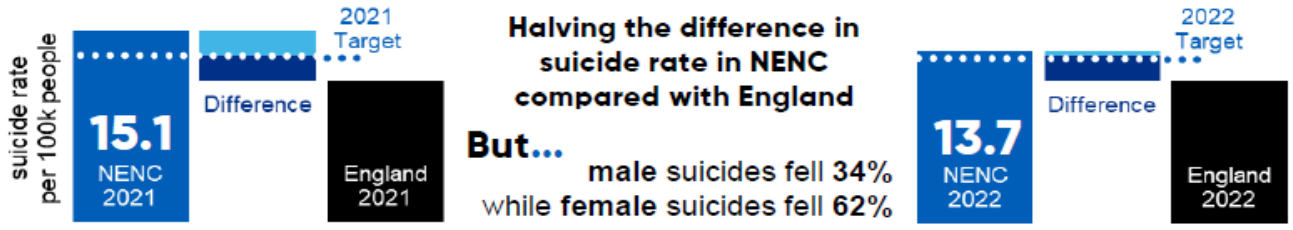
The ICB has developed an annual EDI comms calendar, to raise awareness of EDI across the year and characteristics and is working in collaboration with ICB Comms to highlight lesser-known days and underrepresented groups.

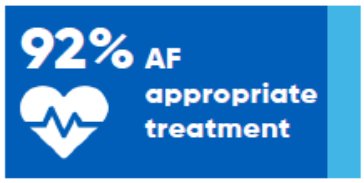
Mirroring the ICB 2.0 process the ICB has utilised the comms opportunity to ask and encourage staff declaration rates across all characteristics, and has reported an increase across characteristics, including an 8.5% increase in Black, Asian and Minority Ethnic people declaring their personal information.

The ICB have drawn up a system Equality Monitoring Form, to ensure we are capturing and monitoring the same consistent information to fulfil the public sector equality duty and monitor usage and uptake from all people across our region. We are currently piloting this with the Boost community and with involvement colleagues, before sharing more widely in the system.

NHS North East and North Cumbria

Impact we are making...





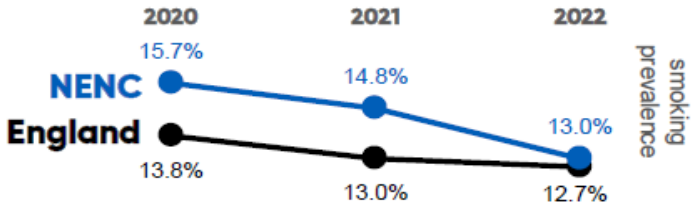
Proportion of patients aged 18+ with atrial fibrillation who are currently treated with anticoagulation drugs

No difference for people living in the **most and least deprived areas**

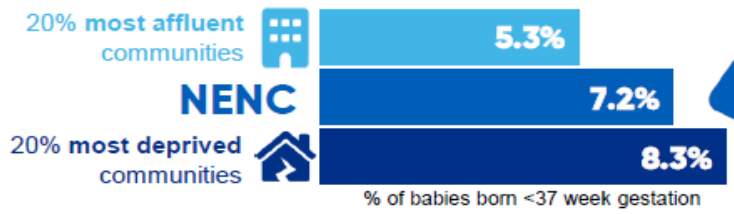
But...
in **ethnic minority** groups the percentage is only **86%**

Smoking prevalence

Smoking in NENC has **reduced** considerably since 2020, it is also **reducing faster** than the **England** average



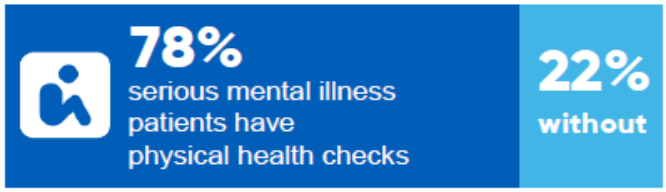
...and areas to improve



Reduce the number of babies born before 37 weeks

To improve outcomes for babies from **disadvantaged** and **minority** communities

All people with serious mental illness have a physical health check each year

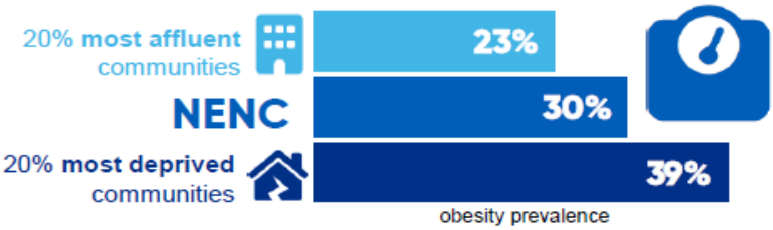


NENC (78%) has a **higher** percentage than the **England** average (76%) but far from meeting the **100% target**

Obesity prevalence

Adults are considered **obese** if they have a **BMI** (body mass index) of **30 or above**

Obesity is **more common** in **deprived** communities



Primary care achievements

Many NHS patient interactions are delivered in primary care through general practice, dentistry, optometry, and community pharmacy. Across Northeast & North Cumbria (NENC) we are seeing a steady increase in the number of appointments offered and the total number of patients seen, compared to pre-COVID levels. This is all despite continuing pressures for primary care providers.

Several national programmes have been launched to improve access to services for patients. The year 2023/24 marked the first year of a multi-year Primary Care Access Recovery Plan (PCARP) for the Integrated Care Board (ICB). This recovery will aim to reduce the 8am rush for appointments in general practice and develop the service model to improve patient experience and empower patients to make the right choice of care for their needs.

Following the transfer on 1 April 2023 of pharmacy, optometry, and dentistry (POD) functions from NHS England to the ICB, we focussed on ensuring business continuity. The emphasis has gradually shifted to service transformation with the development and implementation of the ICB dental recovery plan. This plan recognises the challenges with dental provision across the region and specifies solutions to increase access and stabilise the provider landscape. The ICB has also developed planning and prioritisation for the utilisation of community pharmacy as a first port of call for our population's health and care, supporting access to general practice.

Moving forward we aim to establish further plans to ensure community optometry improves access for eye care, supporting care closer to home and reducing waiting times at hospital.

Primary care does not work in isolation, and we are seeing greater integration of our General Practices and Pharmacies with Community and mental health services. Collectively these providers play a vital role in meeting patient needs in the community, often working in partnership with social care and the voluntary sector.

The strategic and delivery priorities for NENC ICB for Primary Care during 2023/24, have focussed on the following:

Stability and Resilience; **Improving Access**; **Integration** and enabler services such as **workforce, estates, and premises.**

The ICB has a statutory duty to assure the quality and safety of the services it commissions and the GP Quality Assurance Framework will provide a method for monitoring and improving the quality general practice across the NENC ICB footprint. The GPQAF has been developed and will be implemented in the first quarter of 2024/25.

A primary care collaborative has been established to support strategic working with primary care providers across the system. It will ensure primary care has a strong voice in the health and care system and ensures the views of our local providers are at the heart of all discussions around the delivery of stable, high-quality services.

Environmental matters

Our health and care system is committed to playing its part in tackling climate change, and launched its Green Plan in July 2022. This three-year plan sets out targets and actions to meet the sustainability challenge through a programme of activity and by exploiting synergies between member organisations. A healthier environment means healthier people, and healthier people have a lower impact on the environment by requiring less treatment and/or fewer medicines. The NHS has committed to reaching carbon net zero in response to the profound and growing threat to health posed by climate change, as illustrated in some of the following examples:

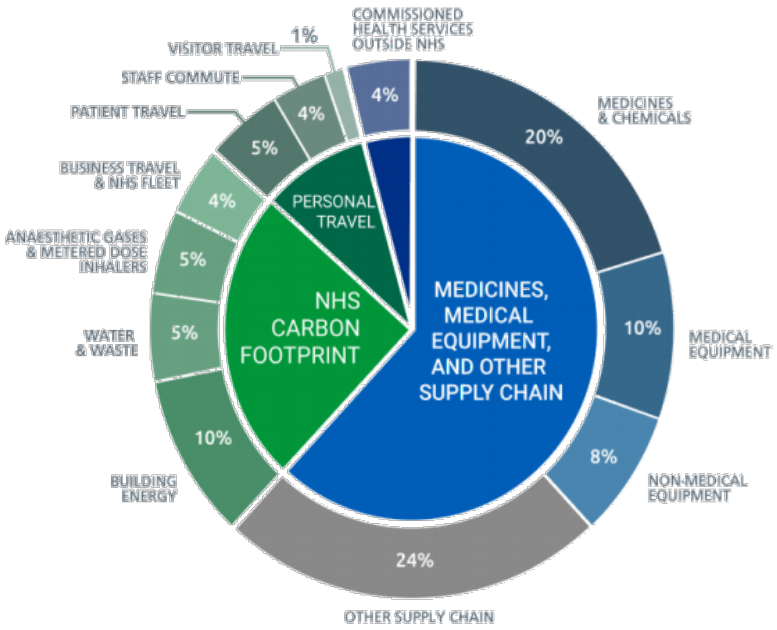
- 4-5% of UK road traffic is on NHS Business (Emissions, brake pad dust, tyre particles)
- Air pollution is the 8th leading risk factor for death (WHO)
- Plastic in the environment (endocrine disruptors)
- Drugs end up in watercourses (antibiotic resistance)
- Anaesthetics and inhalers (direct global warming effects)
- Volume of resources
- Waste

The Health and Care Act 2022 has placed new duties on NHS bodies including foundation trusts and integrated care boards to contribute towards statutory emissions and environmental targets. The NHS has set out top level targets for carbon emissions as follows:

- For the emissions we control directly (the NHS carbon footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- For the emissions we can influence ('NHS carbon footprint plus'), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.1 We aim to go beyond this and have a vision of being England's greenest region by 2030

As an enabler to meet the vision and align our ambition with climate science and the majority of local authorities in the region, the ICB and its members will have to cut their carbon footprint at a faster rate than the NHS national targets of 2040/2045. The diagram below illustrates the wide-ranging impact NHS activities have on caron emissions.

NHS Carbon Emissions by Area



Our key work programmes

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

As a health and care system, we are committed to developing a consistent approach with our partners in the public and voluntary sectors to sustainability, recycling, improving air quality and carbon reduction, as well as increasing access to green spaces. We are part of a cross-sector coalition working to enable our vision. Our Green Plan has identified a range of key targets and actions for delivery to support the following key focus areas which reflect the priority action areas in ‘Delivery a Net Zero NHS’ strategy:

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

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

Financial review

Two distinct funding streams are provided to ICBs:

- Programme Budget Allocation – this funding relates to direct health care expenditure,
- Running Cost Allowance – this funding is to cover the administrative costs of running the ICB.

The funding resources available to the ICB during the year were as follows:

	Programme allocation £'000	Running Cost allowance £'000	Total funding allocation £'000
Total initial ICB Funding allocation	6,949,396	57,406	7,006,802
Additional in-year allocation adjustments	624,514	4,965	629,479
Total ICB funding for the year	**7,573,910**	**62,371**	**7,636,281**

Reflecting the significant financial challenges facing the system, an overall deficit financial plan of £50m for the ICS for 2023/24 was agreed at the start of the year. This included a planned surplus of £32.4m within the ICB, which partially offset planned deficits across provider trusts. During the year, the overall ICS forecast position was revised to a deficit of £35m which was approved by ICB Board.

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

Financial targets and performance for the period

The ICB has several financial duties under the NHS Act 2006 (as amended). Performance against these duties is reported in note 19 of the annual accounts and is summarised in the table below.

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

The ICB financial performance is reported on an in-year basis. As can be seen from the table below, all relevant financial duties were met for 2023/24:

Target	Target Met?
Revenue resource use does not exceed the amount specified in Directions ICBs are required to manage overall revenue expenditure within the revenue resource limit (the 'break-even duty'). For 2023/24, the ICB delivered an overall surplus of £4.489m.	✓
Revenue administration resource use does not exceed the amount specific in Directions A separate running cost allowance is provided to all ICBs to cover the administrative costs of running the ICB. There is a requirement to manage administrative costs within this allowance. Total running costs for the year amounted to £60.811m, which was within the running cost allowance of £62.371m.	✓
Capital resource use does not exceed the amount specified in Directions The ICB is required to manage capital spending within the capital resource limit. The ICB received no direct capital resource during the year and incurred no capital expenditure.	✓

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

The overall ICB surplus of £4.489m was planned in order to offset deficits in NHS provider trusts within the system. The original planned ICB surplus was £32.4m. The ICB Board approved in March 2024 a reduction to the ICB surplus of £28m, enabling a reduction in the provider deficit position within the ICS to the same value, with no net effect on the overall ICS position. This resulted in a revised planned surplus for the ICB of £4.4m which has been delivered.

Efficiencies totaling £101.774m (compared to a plan of £94.944m) were delivered by the ICB during the year, which has supported delivery of the overall financial position. This has included in particular efficiencies in medicines optimisation and the in delivery of individual packages of care.

Other financial targets

The ICB, along with other system partners, also has a shared responsibility for achievement of financial balance at an ICS level. The ICB has collaborated collectively with partners to manage financial risks across the system in line with the agreed approach to system financial management. This has included monthly review of the financial position and potential financial risks, with targeted actions agreed during the year to successfully mitigate and manage risks.

For 2023/24, an overall deficit financial plan of £50m for the ICS was agreed with NHS England at the start of the year. The ICS subsequently improved this position to a deficit of £35m during the year.

An additional funding allocation was received from NHS England in month 11 which has allowed the ICS to report an overall break-even position for the year. The final outturn position for the ICS is a slight surplus of £0.43m in total.

The ICB agreed a joint capital resource use plan for the year along with partner NHS Foundation Trusts, which is published on the ICB website, along with the plan for 2024/25. Although the ICB received no direct capital resource, overall capital expenditure across the ICS for 2023/24 before the impact of International Financial Reporting Standard (IFRS) 16 was managed within the agreed ICS capital allocation. Including the impact of IFRS 16, the ICS capital position was a slight overspend of £1.5m which was managed by NHS England at a regional level.

Compliance with Better Payment Practice Code

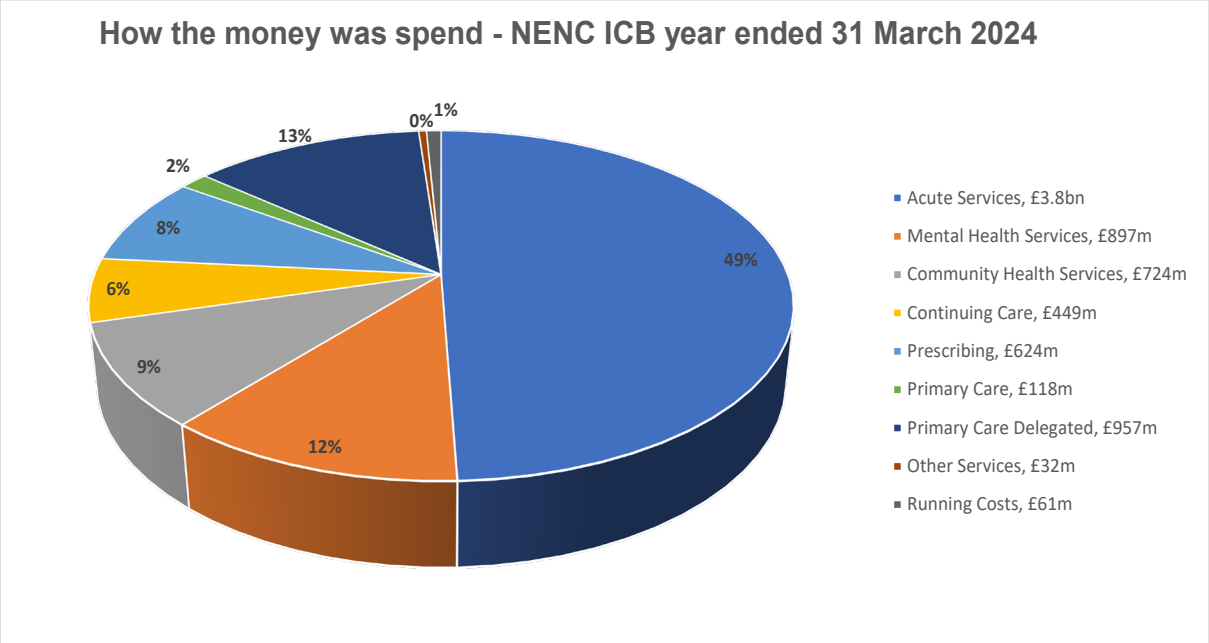
In addition to the above statutory duties, ICBs have similar responsibilities to other NHS organisations in respect of the Better Payment Practice Code (BPPC). The BPPC requires the payment of all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The ICB is deemed to be compliant if it pays at least 95% of invoices within 30 days of receipt, or within agreed contract terms. Details of compliance with the code are given in note 5 to the annual accounts.

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

How was the money spent?

The ICB works hard to ensure that the revenue allocation it receives is spent wisely, and that it supports the aim of commissioning high quality healthcare whilst ensuring effectiveness and value for money. The chart below shows how the ICB funding allocation was utilised in 2023/24:



Looking ahead

A deficit financial plan for the wider ICS was agreed in 2023/24 recognising the substantial financial pressures facing the system. This position included significant non-recurring efficiencies and benefits across both the ICB and wider ICS, including substantial additional non-recurring funding from NHS England.

The non-recurring nature of these savings and underlying financial deficit position contributes to a considerable financial challenge to develop balanced financial plans for 2024/25.

Considerable work has been undertaken during 2023/24, across both the ICB and in collaboration with NHS Provider Trusts across the ICS, to develop a medium-term financial plan for the system and detailed financial plans for 2024/25.

The final financial plan for 2024/25, submitted in May 2024, showed an overall deficit position across the ICS of £75.6m in total. This included the impact of a technical accounting change relating to Private Finance Initiative (PFI) contracts, excluding that we estimated the overall ICS deficit would be £49.9m. This position includes extremely challenging efficiency plans and a number of currently unidentified mitigations. Work continues as a priority across the system to review the position and seek to identify potential further options to reduce the system deficit.

ACCOUNTABILITY REPORT

Samantha Allen

Chief Executive of North East and North Cumbria Integrated Care Board

26 June 2024

Accountability Report

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

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2023 to 31 March 2024 including membership and organisation of our governance structures and how they supported the achievement of our objectives.

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

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

Corporate Governance Report

Members' Report

Member profiles

Membership of the ICB Board is summarised in table 1 below. Profiles of members are given on the ICB website.

Composition of ICB Board

The membership of NHS North East and North Cumbria Integrated Care Board (the ICB) is set out in the ICB's Constitution. The composition of the ICB Board from 1 April 2023 to 31 March 2024 is shown in table 1 below.

Table 1 - Membership of NHS the ICB's Board.

All members were in post on 1 April 2023 until 31 March 2024, unless shown.

Position	Name	Gender	Status
Chair	Professor Sir Liam Donaldson	Male	Voting
Chief Executive	Mrs Sam Allen	Female	Voting
Executive Area Director (North & North Cumbria)	Mr Levi Buckley (from 2 May 2023)	Male	Voting

Position	Name	Gender	Status
Executive Director of Finance	Mr David Chandler	Male	Voting
Executive Chief Digital and Information Officer	Professor Graham Evans	Male	Voting
Executive Area Director (Central & South)	Mr Dave Gallagher	Male	Voting
Executive Director of Improvement and Experience	Mrs Annie Laverty (until 31 March 2024)	Female	Voting
Executive Chief of Strategy and Operations	Ms Jacqueline Myers	Female	Voting
Executive Medical Director	Dr Neil O'Brien	Male	Voting
Executive Chief Nurse and People Officer	Mr David Purdue	Male	Voting
Executive Director of Corporate Governance, Communications & Involvement	Mrs Claire Riley	Female	Voting
Executive Director of Innovation	Mr Aejaz Zahid (until 15 August 2023)	Male	Voting
Foundation Trust Partner Member	Mr Ken Bremner	Male	Voting
Foundation Trust Partner Member	Dr Rajesh Nadkarni	Male	Voting
Independent Non-Executive Member Patient and Public Involvement (PPI)	Dr Hannah Bows	Female	Voting
Independent Non-Executive Member	Professor Eileen Kaner	Female	Voting
Independent Non-Executive Member	Mr Jon Rush	Male	Voting
Independent Non-Executive Member (Audit)	Mr David Stout	Male	Voting
Independent Non-Executive Member	Professor Pali Hungin (from 1 March 2024)	Male	Voting
Local Authority Partner Member	Mrs Catherine McEvoy-Carr	Female	Voting
Local Authority Partner Member	Mr Tom Hall	Male	Voting
Local Authority Partner Member	Cllr. Shane Moore (until 25 May 2023)	Male	Voting

Position	Name	Gender	Status
Local Authority Partner Member	Mrs Ann Workman (until 31 July 2023)	Female	Voting
Primary Medical Services Partner Member	Dr Saira Malik	Female	Voting
Primary Medical Services Partner Member	Dr Mike Smith	Male	Voting
North East and North Cumbria Voluntary Organisations Network North East (VONNE) Representative	Jane Hartley (until 31 March 2023) Lisa Taylor (from 3 August 2023)	Female	Non-Voting
North East and North Cumbria Healthwatch Representative	Mr David Thompson (until 30 June 2023) Mr Christopher Akers-Belcher (from 3 August 2023)	Male	Non-Voting

*Nicola Bailey, Executive Area Director (North & North Cumbria) was employed by the ICB until 6 April 2023, however her Board and Committee roles were relinquished on 31 March 2023.

Committee(s), including Audit Committee

Membership of the ICB Audit Committee

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

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

Table 2: Membership of the ICB Audit Committee

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

Membership of the Executive Committee

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

Table 3: Membership of the ICB Executive Committee

Position	Name	Gender
Chief Executive	Mrs Sam Allen	Female
Executive Chief of Strategy and Operations	Ms Jacqueline Myers	Female
Executive Area Director (North & North Cumbria)	Mr Levi Buckley (from 2 May 2023)	Male
Executive Director of Finance	Mr David Chandler	Male
Executive Chief Digital and Information Officer	Professor Graham Evans	Male
Executive Area Director (Central & South)	Mr Dave Gallagher	Male
Executive Director of Improvement and Experience	Mrs Annie Laverty (until 31 March 2024)	Female
Executive Medical Director	Dr Neil O'Brien	Male
Executive Chief Nurse and People Officer	Mr David Purdue	Male
Executive Director of Corporate Governance, Communications & Involvement	Mrs Claire Riley	Female
Executive Director of Innovation	Mr Aejaz Zahid (until 11 August 2023)	Male

Membership of the Remuneration Committee

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

Table 4: Membership of the ICB Remuneration Committee

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

Membership of the Finance, Performance, and Investment Committee

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

Table 5: Membership of the ICB Finance, Performance, and Investment Committee

Position	Name	Gender
Executive Director of Finance	Mr David Chandler	Male
One of the Executive Area Directors	Mr Levi Buckley (from 2 May 2023)	Male
	Mr Dave Gallagher	Male
Vice Chair and Independent Non-Executive Member	Professor Eileen Kaner	Female
Executive Chief of Strategy and Operations	Jacqueline Myers	Female
Executive Medical Director	Dr Neil O'Brien	Male
Chair and Independent Non-Executive Director	Mr Jon Rush	Male
Foundation Trust Partner Member	Mr Ken Bremner	Male
Foundation Trust Partner Member	Mr Rajesh Nadkarni	Male
Primary Medical Services Partner Member	Dr Mike Smith (from 5 October 2023)	Male

Membership of the Quality and Safety Committee

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

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

Table 6: Membership of the ICB Quality and Safety Committee

Position	Name	Gender
Non-Executive Member (Chair)	Professor Eileen Kaner	Female
Non-Executive Member (Vice Chair)	Professor Hannah Bows	Female
Executive Chief of Strategy and Operations	Jacqueline Myers	Female
Executive Medical Director	Dr Neil O'Brien	Male
Executive Chief Nurse and People Officer	David Purdue	Male
Foundation Trust Partner Member	Ken Bremner	Male
Primary Medical Care Partner Member	Dr Saira Malik	Female
Local Authority Director of Public Health or Partner Member	Tom Hall	Male
Director of Allied Health Professions	Maria Avantaggiato-Quinn	Female
Director of Medicines	Ewan Maule	Male
Place Director of Nursing (North)	Richard Scott	Male
Place Director of Nursing (North Cumbria)	Louise Mason-Lodge	Female
Place Director of Nursing (Central)	Ann Fox / Jeanette Scott (job share)	Female
Place Director of Nursing (South)	Jean Golightly	Female

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

Register of Interests

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

Personal data related incidents

There were no personal data related incidents reported to the Information Commissioner's Office in the period 1 April 2023 to 31 March 2024.

Modern Slavery Act

The Modern Slavery Act 2015 introduced changes in UK law focused on increasing transparency in supply chains, to ensure our supply chains are free from modern slavery (that is, slavery, servitude, forced and compulsory labour and human trafficking). As both a local leader in commissioning health care services for the population of the ICB and as an employer, the ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking and has produced a statement in respect of its commitment to, and efforts in, preventing slavery and human trafficking practices in the supply chain and employment practice.

The statement was approved by the ICB's Quality and Safety Committee on 14 March 2024 and is available here.

Statement of Accountable Officer's Responsibilities

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

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and
- Prepare the accounts on a going concern basis; and

- Confirm that the Annual Report and Accounts as a whole is fair, balanced, and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced, and understandable.

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

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

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

Governance Statement

Introduction and context

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

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

Between 1 April 2023 and 31 March 2024, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

ICB Constitution

The ICB's Constitution describes how the ICB is organised to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and public we serve. The Constitution is underpinned by the duty that requires NHS bodies to consider the effects of their decisions on the health and wellbeing of the people of England, the quality of services and the sustainable and efficient use of resources.

The ICB Constitution, which incorporates the ICB's Standing Orders and has been assessed as compliant by NHS England and is available here.

ICB Governance Handbook/Structure

The ICB's Governance Handbook combines all the ICB's governance documents and includes:

- The Scheme of Reservation and Delegation which sets out key functions reserved to the Board of the ICB, and functions delegated to committees and individuals
- Functions and Decisions Map
- Financial Delegation
- Financial Limits
- Standing Financial Orders
- Terms of reference for all committees of the Board that exercise ICB functions
- Standard of Business Code of Conduct
- Communities and People Involvement and Engagement Strategy
- Register of Interests
- North East and North Cumbria Integrated Care Partnership (ICP) Terms of Reference

- ICB Overall Governance Map
- List of eligible providers of primary medical services
- Subcommittee Terms of Reference
- North East and North Cumbria ICB Remuneration Guidance

The ICB's Governance Handbook/Structure is available here.

ICB Board

The Board met six times in the period 1 April 2023 to 31 March 2024. The main items of business were:

- CCG Annual Reports and Accounts 2022/23
- ICB Annual Report and Accounts 2022/23
- Chief Executive Report
- Integrated Delivery
- ICB and ICS Financial Plan 2023/24
- Board Assurance Framework
- Approval of Constitution and Standing Orders
- Approval of Governance Handbook
- Primary Care Access Recovery Plan
- Primary Care Dental Access Recovery
- Finance Reports
- Review of the Spring Covid Immunisation Programme
- North East Ambulance Service (NEAS) Independent Investigation Report
- Winter Planning
- Neonatal Regional Position
- Peer Review of Freedom to Speak up Arrangements
- Foundation Trust Collaboration Across Teesside
- Fit and Proper Person Test Framework
- Joint Forward Plan 2024/25
- A Strategic Focus on Mental Health in North East and North Cumbria
- Learning Disabilities Mortality Review (LeDeR) Annual Report
- Artificial Intelligence and Health
- Delivering out Strategy for Children and Young People
- Digital, Data and Technology Strategy
- Emergency Preparedness, Resilience and Response Self-Assessment
- Executive Medical Director Report
- Water Fluoridation
- Medication use and practice in North East and North Cumbria
- Newcastle Upon Tyne Hospitals NHS Foundation Trust Care Quality Commission Inspection
- Committee Highlight Reports and Minutes
- Standards of Business Conduct and Declarations of Interest Policy
- Voluntary, Community and Social Enterprise Memorandum of Understanding
- Strategic Plans
- Martha's Rule

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

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

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

We continuously monitor our process for managing conflicts of interest to ensure any actual or potential interests are managed effectively and robustly. The ICB has robust processes in place to manage conflicts of interest and has not had any breaches at the time of writing this statement. The declarations of interest register is publicly available on the ICB's website.

The annual appraisal process and future development of all board members supports the ongoing assessment of board member skills, knowledge and experience and forms part of the NHS England Fit and Proper Person Test Framework for all board members.

With the introduction of the NHS Leadership Competency Framework from 01 April 2024 we will be reviewing how we assess the performance of all board members inline with the six competency domains and continue to support the board members to perform at their best.

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

The Board met six times for development sessions times in the period 1 April 2023 to 31 March 2024. The main items of business were:

- Financial Plan 2023/24
- Medium Term Financial Plan
- Board Health and Preparing for CQC System Inspections
- Patient Safety
- Safeguarding
- Cyber Awareness
- Digital, Data and Technology Strategy
- Feedback from CQC Experience
- Learning from Maternity Ockenden Visits
- Operating Model and new ways of working

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

Executive Committee

The Executive Committee is a committee of the ICB. It was in operation throughout the twelve-month period from 1 April 2023 to 31 March 2024.

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

The Committee reviewed its effectiveness during the last twelve months of operation and concluded that the organisation has followed and applied the principles and standards of best practice. The Committee will continue to explore improvements to its effectiveness and efficiency of management to ensure that the meetings are productive and committee member time is effectively utilised. Processes have been put in place to support this and ensure all essential business is conducted appropriately and provide assurance to the Board on delivery of its delegated functions.

The annual review has identified the Committee has delivered its responsibilities as set out in its terms of reference.

The Executive Committee met twelve times in the period 1 April 2023 to 31 March 2024.

The main items of business were:

- Terms of Reference including:
  - Place Subcommittees x 12
  - Mental Health, Learning Disabilities and Autism Subcommittee
- Integrated Delivery
- Finance Reports
- Financial Sustainability
- Medium Term Financial Plan
- Governance Assurance including Governance Map & Cycle of Business
- Policy Reviews including:
  - Corporate Policies
  - HR Policies
  - Health and Safety Policies
  - Investment Business Case Policy
  - Continuing Healthcare and Safeguarding Policies
  - Value Based Clinical Commissioning Policy
  - Menopause Policy
  - Standards of Business and Declarations of Interest Policy
- Priority Areas
- Placed Based Delivery
- Business Cases
- Procurement Exercises and Strategies
- Information Governance
- Risk Management
- Board Assurance Framework 2023/24
- Senior Information Risk Officer (SIRO) Cyber Awareness and Assurance Report

- Winter Planning
- COVID Medicine Delivery Units
- Corporate Risk Register
- System Development Funding
- Voluntary, Community, and Social Enterprise Engagement & Infrastructure Review
- Provider Collaborative Responsibility Agreement
- Research and Innovation Draft Strategy
- Delivery of Prescribing Efficiencies 2023/24
- Waiting Well Programme Plans for 2023/24 and 2024/25
- DHSC Work and Health Project
- Primary Care Dental Access Crisis Plan
- EDI Implementation Plan
- Organisational Development Plan
- Women's Health Strategy Development
- Joint Forward Plan
- Neuro Rehabilitation Pathway Review
- Primary Care Recovery Access Plan
- Modern General Practice Access Model
- Learning Disability & Autism Service Development Fund Spending Plans for 2023-24
- Acute Respiratory Infection Hub Funding
- Children and Young People Palliative End of Life Strategy
- Emergency Preparedness Resilience Response Self-Assessment
- Strategy Deployment
- Digital Enablement for Virtual Wards
- Contract Mandates
- North East Commissioning Support Unit Service Level Agreement People and Culture Strategy

Remuneration Committee

The Remuneration Committee is a committee of the ICB. It was in operation throughout the twelve-month period from 1 April 2023 to 31 March 2024.

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

The Committee reviewed its effectiveness during the twelve-month period of operation and concluded that the organisation has followed and applied the principles and standards of best practice.

The annual review has identified the Committee has delivered its responsibilities as set out in its terms of reference.

The Remuneration Committee met eight times in the period 1 April 2023 to 31 March 2024. The main items of business were:

- Agenda for Change Pay Award 2022/23 and 2023/24
- Clinical Leadership Pay Award 2022/23
- Exit and Severance Business Cases
- Acting up Payments
- Terms of Reference amendments
- Fit and Proper Persons Test Assurance
- ICB 2.0 Change Management Programme
- Remuneration Committee Annual Effectiveness Review
- Application of South Tyneside PCT Pay Protection Policy
- Very Senior Manager Pay Award 2023/24
- Voluntary Redundancy Scheme Application
- Compulsory Redundancy Proposal
- Compulsory Redundancy Update

Finance, Performance, and Investment Committee (FPI)

The FPI Committee is a committee of the ICB. It was in operation throughout the twelve-month period from 1 April 2023 to 31 March 2024.

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

The FPI Committee was established by the ICB Board on 1 July 2022 and has met ten times during 2023/24. A year end committee effectiveness survey was completed by members and attendees asking their views on how effective the committee had been this year. There has been a further review and amendments to the Committees Terms of Reference (TOR) to ensure that they were effective and reduction in any duplication of some of the activities of the Executive Committee. For 2024/25 the Committee will undertake more of a scrutiny and assurance methodology. In addition, an ICB Board Primary Care Partner Member joined the Committee to strengthen the breadth of clinical representation and provider organisations. Following consideration of the survey results and suggested improvements, the committee agreed to maximise the time and effectiveness by ensuring performance items are considered in more detail.

The FPI Committee met ten times in the period 1 April 2023 to 31 March 2024. The main items of business were:

- Operational Planning Submission 2023/24
- ICB Performance Position
- ICB Financial Performance
- Elective Recovery Funding Approach 2023/24
- ICB Business as Usual Capital Plan 2023/24
- Children and Young People Access
- Risk Management Report
- Medium Term Finance Plan
- Prescribing Cost Risks

- ICB Capital Departmental Expenditure Limit Plan
- Capital Oversight Arrangements
- 2024/25 Planning Process
- Resource Allocation Group update
- Elective Recovery Fund
- Infrastructure Board Update

Audit Committee

The Audit Committee is a committee of the ICB. It was in operation throughout the twelve-month period from 1 April 2023 July to 31 March 2024.

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

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

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

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

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

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

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

The Audit Committee meets quarterly and on each occasion the Audit Committee Chair extends an invitation to the internal and external auditors to meet with him privately prior to the ICB officers joining the meetings. The Chair was present at all meetings.

A self-assessment checklist survey was conducted with the Audit Committee members discussing their views on the effectiveness and performance as a Committee during this year. The feedback was positive, and the Committee concurred there was evidence of good practice to demonstrate the Audit Committee is discharging its own statutory duties in line with reporting and robust decision making.

Following consideration of the survey results and suggested improvements, the Committee agreed to implement an improvement plan to progress their objectives in training and development for the members during 2024/25.

The Committee has effectively conducted its business in line with the terms of reference.

The Audit Committee met seven times in the period 1 April 2023 to 31 March 2024. The main items of business were:

- Board Assurance Framework
- Risk Management Report
- Data Security and Protection Toolkit 2022/23
- Conflicts of Interest Compliance
- Review of Audit Committee Effectiveness
- Finance Update
- Internal Audit Progress Report
- Internal Audit Strategic/Annual Plan and Programme
- Internal Audit Annual Report 2022/23
- Head of Internal Audit Opinion
- Counter Fraud Update
- Counter Fraud 2023/24 Annual Plan
- Review of Counter Fraud Annual Report and Self-Review Assessment
- CCG Annual Reports and Accounts 2022/23
- ICB Annual Report and Accounts 2022/23
- External Audit Plan
- External Audit Completion Report
- ICB Audit Strategy Memorandum
- Audit Committee Annual Cycle of Business
- Self-Assessment Improvement Plan
- ICB Freedom to Speak Up Arrangements
- Annual Report and Accounts 2023/24: Timetable
- Review of Audit Committee Terms of Reference
- Mental Health Investment Standard Independent Review 2022/23
- Data Protection and Security Toolkit Update 2023/24

Quality and Safety Committee

The Quality and Safety Committee is a committee of the ICB. It was in operation throughout the twelve-month period from 1 April 2023 July to 31 March 2024.

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

The Committee is responsible for ensuring the appropriate governance systems and processes are in place to commission, monitor and ensure delivery of high quality, safe patient care in services commissioned by the ICB. It provides assurance to the Board about the quality of the services being commissioned, and the overall risks to the organisation’s strategic and operational plans.

Members of the Committee were asked to complete a short survey and provide their reflections on the Committee's work. The survey sought views on the terms of reference; meeting frequency; chairing arrangements; the skills and experience of its

members; management of conflicts of interest; meeting papers/information format; and Committee successes and improvements to consider.

Most members agreed that the terms of reference were appropriate noting that the responsibilities within scope of the Committee were vast. Members agreed that the meeting frequency seemed appropriate, and meetings are well chaired but there are challenges with such a full agenda and being able to give sufficient time to each agenda item.

Members did note the volume of papers presented to the Committee were very comprehensive which could make it difficult to read and process all of the papers in advance of the meeting. Members also noted the work that had been carried out within the year to refine the quality exception reports which had improved the presentation.

Members noted the success of the introduction of patient stories within the meeting agenda, championing patient voice and lived experience. Further work was suggested to define the terms of reference and the focus of the Committee, along with a vision for what constituted quality and how this would be achieved.

The Quality and Safety Committee met six times in the period 1 April 2023 to 31 March 2024. The main items of business were:

- Area Quality Reports
- Patient Involvement and Experience update
- Complaints
- Primary Care (Pharmacy, Optometry and Dental) update
- Transforming Care Programme for people with Learning Disabilities and Autistic People
- Excess Mortality and the Summary Hospital-Led Mortality Indicator
- NICE Recommendations
- Board Assurance Framework and Risk Register
- Terms of Reference
- Integrated Quality, Performance and Finance Report
- Patient Stories
- Maternity Report
- ICB response to Lucy Letby Verdict
- Equality Impact Assessment
- Medicines Optimisation Annual Report
- IT Related Serious Incidents
- Special Education Needs and Disabilities (SEND)
- Transforming Care
- Paediatric Hearing Services
- Patient Safety Incident Response Framework
- Cancer Alliance Report
- Subcommittee Minutes
- Modern Slavery Statement
- Never Events Analysis
- Clinical Strategic Plan
- North East and Quality Observatory Service Hospital Mortality Monitoring Infection, Prevention and Control

Subcommittees

The Subcommittees are established by their parent committees and their terms of reference are detailed within the ICB's Governance Handbook which is available here.

The Subcommittees established under the Executive Committee are:

- **Healthier and Fairer Advisory Group Subcommittee**:

  The purpose of the North East North Cumbria (NENC) Healthier and Fairer Advisory Group Subcommittee is to provide strategic advice across the Integrated Care System (ICS) to ensure that action on population health, prevention and health inequalities is embedded into our planning and decision-making arrangements.

- **Individual Funding Request (IFR) Panel Subcommittee**

  The main function of IFR Panel is to consider Individual Funding Requests and make decisions to either support or not support the requests on the basis of the information provided to the IFR Panel. Requests will be assessed for access to treatments within the commissioning authority of the ICB.

- **Investment Oversight and Vacancy Control Panel Subcommittee**

  The purpose is of the Panel is to support the Executive Committee with the application of additional financial controls within the ICB. This will satisfy the requirements of the standard financial controls and associated conditions required by NHS England, in line with the approach agreed across the ICS, and support delivery of the financial plan for 2023/24.

  The Panel will review and consider approval of any new discretionary non-pay spend between £10k and £250k, in line with the process agreed by Executive Committee.

  The Panel will consider both recurrent items (e.g., between £10k and £250k on a recurrent basis) and non-recurrent one-off items within the same limits. All proposals should have an agreed funding source per NHSE expectations.

  Investments over £250k will be considered by either the Executive Committee or the Board as appropriate (following where relevant consideration and recommendation at a Place Committee or similar). A record of decisions and relevant papers will be shared with NHSE Regional Team.

  The Panel will review and consider approval of all vacancies within the ICB, following sign off by the responsible executive director.

- **Medicines Subcommittee**

  The purpose of the Subcommittee is to support the Executive Committee to discharge its duties relating to quality assurances of medicines safety, medicines quality, efficient use of medicines and clinical governance for the use of medicines within the ICS.

- **Mental Health, Learning Disabilities and Autism Subcommittee**

  The Mental Health, Learning Disabilities and Autism Subcommittee 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 the North East and North Cumbria.

- **Pharmaceutical Services Regulations (PSRC) Subcommittee**

  The PSRC has been established to receive and determine, on behalf of the ICB, applications submitted under the NHS (Pharmaceutical Services) Regulations 2013 as amended ('the Regulations').

- **Primary Care Strategy and Delivery Subcommittee**

  The purpose is of the Subcommittee is to support the Executive Committee to discharge its duties relating to primary care including Primary Medical Services, Pharmacy, Optometry and Dentistry.

- **Place Subcommittees**

  - County Durham Place Subcommittee
  - Darlington Place Subcommittee
  - Gateshead Place Subcommittee
  - Hartlepool Place Subcommittee
  - Newcastle Place Subcommittee
  - North Cumbria Place Subcommittee
  - North Tyneside Place Subcommittee
  - Northumberland Place Subcommittee
  - South Tees Place Subcommittee
  - South Tyneside Place Subcommittee
  - Stockton Place Subcommittee
  - Sunderland Place Subcommittee

  The purpose of the ICB Place Subcommittees is to discharge, on behalf of the ICB Executive Committee, the statutory commissioning responsibilities of the ICB which have been delegated to Place and to carry out responsibility for executive actions and decisions on behalf of the ICB Executive Committee.

- **People and Organisational Development (OD) Subcommittee**
  The People & OD Subcommittee has been established to provide assurance to the Executive Committee that adequate and appropriate governance structures, processes and controls are in place in respect of the ICB workforce and organisation development.

  The Subcommittee is responsible for ensuring that effective People & OD programmes are developed and deliver continuous improvement in organisational effectiveness, within the context of system transformation and organisational change.

The Subcommittees established under the Quality and Safety Committee are:

- **Antimicrobial Resistance (AMR) and Healthcare Associated Infections (HCAI) Subcommittee**

  The purpose is of the Subcommittee is to support the Quality and Safety Committee to discharge its duties relating to bringing together key stakeholders across health and social care from the North East and North Cumbria (NENC) Integrated Care System (ICS) to deliver the national strategy tackling antimicrobial resistance 2019-2024, HCAI reduction objectives, information sharing and best practice and system level (ICB) assurance.

  The Subcommittee will be primarily concerned with AMR and HCAI, particularly Gram-negative blood stream infections, Clostridium difficile and Methicillin-resistant Staphylococcus Resistant MRSA bacteraemia reduction) in services commissioned by health and social care across NENC but will be reactive to new and emerging pathogens.

- **Quality and Safety Area Subcommittees**

  - Central Area Quality and Safety Subcommittee
  - North Area Quality and Safety Subcommittee
  - North Cumbria Area Quality and Safety Subcommittee
  - Tees Valley Area Quality and Safety Subcommittee

  The Subcommittees have been established to provide the Quality and Safety Committee with assurance that is delivering its functions in a way that delivers high quality safe patient care in commissioned services and secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the 'Shared Commitment to Quality' and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care.

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

- **Safeguarding Subcommittee**

  The purpose of the Subcommittee is to support the Quality and Safety Committee to discharge its duties relating to safeguarding and care for children.

- **Special Educational Needs and Disabilities (SEND) Subcommittee**

  The SEND Subcommittee provides a single oversight of compliance of the health responsibilities relating to the statutory duties for SEND across the ICB.

- **Clinical Effectiveness Subcommittee**

  The purpose of the Subcommittee is to support the Quality and Safety Committee to review data and intelligence, implementing continuous service improvement, making informed decisions (based on the data), and ensuring the

delivery of high-quality care. The Subcommittee will develop an audit plan for the year ahead, based on priorities identified through the measurement of compliance with national standards including NICE, mortality reviews and Getting It Right First Time. The Subcommittee will identify, manage, and escalate risks to the Quality and Safety Committee.

Attendance records for the ICB's Board and Committees

Table 7 Attendance records for NENC ICB and Committees 1 April 2023 – 31 March 2024

			BOARD		EXECUTIVE COMMITTEE		REMUNERATION COMMITTEE		FINANCE, PERFORMANCE & INVESTMENT COMMITTEE		AUDIT COMMITTEE		QUALITY AND SAFETY COMMITTEE	
Surname	**Forename**	**Post Held**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**
Donaldson	Sir Liam	Chair	8	8										
Allen	Sam	Chief Executive	8	8	12	11								
Avantaggiato-Quinn	Maria	Director of Allied Health Professionals											6	4
Buckley	Levi	Executive Area Director (North & North Cumbria) **Started 2 May 2023**	8	7	12	11 1 x deputy			10	6				
Bows	Dr Hannah	Independent Non-Executive Member (PPI)	8	6			8	7					6	6
Bremner	Ken	Foundation Trust Partner Member	8	6					10	6			6	3
Chandler	David	Executive Director of Finance	8	8	12	11 1 x deputy			10	9				
Evans	Professor Graham	Executive Chief Digital and Information Officer	8	7	12	12								
Fox	Ann	Director of Nursing											6	3
Gallagher	Dave	Executive Area Director (Central & South)	8	6 1 x deputy	12	9 1 x deputy			10	8			6	5
Golightly	Jean	Director of Nursing											6	3
Hall	Tom	Local Authority Partner Member	8	6									6	0
Hungin	Professor Pali	Independent Non-Executive Member **Started 1 March 2024**	8	1									6	1
Kaner	Professor Eileen	Independent Non-Executive Member	8	7			8	5	10	8	7	6	6	4
Laverty	Annie	Executive Chief People Officer **Left ICB 31 March 2024**	8	5	12	8							6	2
Malik	Dr Saira	Primary Medical Services Partner Member	8	7									6	5

			BOARD		EXECUTIVE COMMITTEE		REMUNERATION COMMITTEE		FINANCE, PERFORMANCE & INVESTMENT COMMITTEE		AUDIT COMMITTEE		QUALITY AND SAFETY COMMITTEE	
Surname	**Forename**	**Post Held**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**	**No. of Meetings Held**	**No. of Actual Attendance**
Mason-Lodge	Louise	Director of Nursing											6	5
Maule	Ewan	Director of Medicines											6	2
Mcevoy-Carr	Catherine	Local Authority Partner Member	8	4										
Myers	Jacqueline	Executive Chief of Strategy and Operations	8	8	12	10 1 x deputy			10	9				
Nadkarni	Rajesh	Foundation Trust Partner Member	8	6					10	5			6	2
O'Brien	Dr Neil	Executive Medical Director	8	8	12	11			10	7			6	4 1 x deputy
Piercy	Chris	Director of Nursing											6	4
Purdue	David	Executive Chief Nurse	8	8	12	10 1 x deputy							6	6
Riley	Claire	Executive Director of Corporate Governance, Communications & Involvement	8	7 1 x deputy	12	10 1 x deputy							6	4 1 x deputy
Rush	Jon	Independent Non-Executive Member	8	8			8	7	10	10	7	7		
Scott	Jeanette	Director of Nursing											6	3
Scott	Richard	Director of Nursing											6	6
Smith	Dr Mike	Primary Medical Services Partner Member **FPIC member from October 2023**	8	8					10	4			6	2
Stout	David	Independent Non-Executive Member (Audit)	8	7							7	7		
Topping	Annie	Director of Nursing											6	3
Wall	Jenna	Director of Midwifery											6	5
Workman	Ann	Local Authority Partner Member **Left 31 July 2023**	8	0										
Zahid	Aejaz	Executive Director of Innovation **Left 11 August 2023**	8	4	12	3								

UK Corporate Governance Code

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

Discharge of Statutory Functions

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

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

Risk management arrangements and effectiveness

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

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

Key elements of the strategy include:

- Clear statements on the responsibilities of the Board and its subcommittees as well as individual accountability for delivery of the strategy.
- Clear principles, aims and objectives of the risk management process.
- Clear processes for the management of risk in commissioned services, partnership working and delivery of the quality, innovation, productivity, and prevention programme.
- A clearly defined process for assessing and managing risks, including implementation and dissemination of the framework for all staff.
- Details of the approach to be undertaken to assess and report risks, including incident reporting, serious incidents, and safeguarding.

- Confirmation of the arrangements for reporting and managing risks through the risk register process.
- A documented process for escalating risks identified at Place to the corporate risk register.
- Arrangements for monitoring and review of the framework.
- The process for embedding risk management in the ICB's activities includes:
- Ongoing review of the risk management framework with a supporting strategy and procedures.
- A Board Assurance Framework, regularly updated and presented to the Board and supporting committees.
- A committee structure with clear accountabilities for risk management
- A robust incident reporting system through staff are actively encouraged to report incidents to help identify risks.
- A clear policy and process for staff to raise concerns in relation to potential fraud risk.

Risk assessment

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

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

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

The ICB uses a standard matrix methodology in the application of a risk rating to ensure a consistent approach to the prioritisation of risks and effective targeting of resources. Risks are assessed using the consequence and likelihood of the risk occurring, giving an overall rating of extreme, high, moderate, or low. The rating is recorded against the risk and managed via a series of controls and actions with progress monitored via the ICB's governance processes.
The ICB recognises the risk that fraud, bribery, and corruption pose to its resources. This risk is included in the corporate risk register with an appropriate internal risk owner identified. Operational management and recording of detailed fraud, bribery and corruption risks will be conducted by the ICB’s counter fraud provider and as agreed in the counter fraud workplan and using a bespoke fraud, bribery, and corruption risk planning toolkit. Regular reports will be provided to the Audit Committee to ensure effective executive and non-executive level monitoring of fraud, bribery, and corruption risks.

Key risks managed from 1 April 2023 to 31 March 2024:

- Significant financial pressures faced by the ICB and wider ICS including the reduction in ICB running cost allocation and the challenge of achieving a balanced financial position through delivery of efficiencies and transformational change.
- Commissioned services are not of sufficiently high quality.
- Risk of failure to delivery of the 2023/24 operational planning objectives.
- Risk that the ICB is not fulfilling the requirement to identify adults, children, and young people with increasing and/or complex health and care needs who may require extra support, care, and treatment in the community as a safe and effective alternative to admission to a mental health hospital.
- Lack of appropriate support in the region to meet the complex needs of people with a learning disability and autistic people.
- Quality of primary care across the ICB.
- Widespread challenges to recruitment nationally and particularly of clinical and social care staff could impact on the delivery of safe services and lack of access to specific services driving up waiting times and leading to poorer outcomes for patients.
- Without robust planning for surges, business continuity incidents and outbreaks, there would be significant rises in demand across the healthcare sector leading to inability to deliver core services.
- That delayed ambulance handovers impact negatively on patient safety and patient flow.
- Challenge of meeting the needs of refugees and asylum seekers placed in the North East and North Cumbria without appropriate provision could lead to worsening of health conditions and impact on sustainability of services.
- Access to mental health services for adults and for children and young people resulting in delays to appropriate treatment and leading to crises.
- Variation in Continuing Healthcare (CHC) practice and workforce capacity issues leading to negative user experience.

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

The ICB has effectively managed its risks in 2023/24. Its systems have been in place for the year under review and up to the date of approval of the annual report and accounts. At 31 January 2024 the ICB carried one extreme (red) risk and 28 high (amber) risks.

ICB's risk profile

All risks are assessed in terms of their potential impact to the achievement of the goals of the ICS strategy *Better Health and Wellbeing for All* and each risk is aligned to an appropriate directorate and lead director and individual risk owners have been identified to manage the risks.

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

Risk Focus	Controls
ICB public accountability duties	Risk management strategy Annual audit plan ICB policy review and approval framework ICB Constitution and governance structure
Conflict of interest	Signed declarations of interest. Register of interests Gifts and Hospitality Register Minutes of meetings (showing declared interests, exclusions etc.) Conflicts of Interest training
Economy, efficiency, probity	Financial Plan QIPP in place Financial reporting and monitoring process Financial governance arrangements, policies, and schemes of delegation
Delivery of NHS constitutional standards	Contract management processes Performance management processes
Safeguarding duties	Quality and safety Committee Designated and named professionals in place Partnership arrangements with Local Safeguarding Children Boards and Local Safeguarding Adults Boards
Effective patient and public involvement	People and communities strategy Protocols in place to work with Healthwatch on delivery of involvement activities
System resilience and escalation planning	System-wide surge and escalation plan ICB business continuity plan Emergency planning, resilience, and response (EPRR) compliance Place-based delivery urgent and emergency care groups

Other risk management processes

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

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

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

Risk appetite

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

The ICB tries to reduce risks to the lowest level reasonably practicable however where risks cannot reasonably be avoided, every effort is made to mitigate the remaining risk. A clear risk appetite statement was approved by the Board in December 2023.

The risk appetite statement defines the appetite levels for ten categories of risk: financial risk; patient safety; information sharing; information security; legal and regulatory compliance; partnership working; people and workforce; reputational; innovation; and health and safety. The agreed appetite levels help owners set target risks in line with the Board's agreed level within each category.

Capacity to Handle Risk

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

Understanding, monitoring, and mitigating risks are fundamental tasks in a successful organisation, as well as basic aspect of good governance. As such, it is the responsibility of the Board to determine the best place for risk management to be positioned ensuring effective management and assurance processes are in place. The overall risk management approach ensures that the strategy is coordinated across the whole organisation. Resources available for managing risk are finite. The ICB will aim to achieve a prioritised and effective response to risk, whilst striking a balance between cost and benefit. The ICB will therefore take action to manage risk to a level which the ICB can justify as being tolerable. This will be achieved by the Board agreeing and reviewing the ICB’s ‘risk appetite’ regularly.

As a formal committee of the Board, the Audit Committee provides assurance to the Board that systems are in place and operating effectively for the identification, assessment, and prioritisation of risks, potential and actual, and to report on any major strategic issues to the Board and other external agencies as appropriate.

The Committee’s specific responsibilities relating to risk management are to:

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

The Audit Committee also reviews the Board Assurance Framework (BAF) to ensure the Board receives assurances that effective controls are in place to manage all strategic risks. The BAF provides assurance with regards to risks relating to services being commissioned

as well as risks to the organisation's strategic and operational plans and also takes into account any extreme (red) or high (amber) risks that have been identified at Place.

The Executive Committee receives a monthly report with details of strategic and operational risks relating to the Committee's area of focus. On a quarterly basis the committee reviews the full ICB risk register to provide the executive team with a regular updated position on all risks facing the organisation and also reviews the BAF and corporate risk register each quarter.

The Quality and Safety Committee and Finance, Performance and Investment Committee review and manage any strategic or operational risks relating to the committees' area of focus.

All members of the executive team are responsible for:

- Maintaining awareness of the main risks facing the organisation.
- Taking or delegating ownership of relevant risks that pose a threat to the achievement of objectives or the business of the organisation and ensure appropriate action is taken to mitigate and manage risks, ensuring regular updates are added to the risk register.
- Ensuring the processes for managing risk within the ICB are clearly understood, appropriately delegated and effective.

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

Other sources of assurance

Internal Control Framework

The ICB has in place a robust internal control framework which is built up on a set of procedures and processes to ensure we deliver our policies, statutory duties and aims and objectives.

It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Control mechanisms are embedded within all aspects of the ICB's governance, with the oversight of risk management within the organisation being one of them. The ICB's system of internal controls include:

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

- A committee structure, where each committee has a vital role in contributing to the establishment of an effective governance infrastructure and reporting mechanisms to raise and escalate risks or decisions
- An approved ICB Constitution, incorporating Standing Orders which is underpinned by the duty that requires NHS bodies to consider the effects of their decisions on the health and wellbeing of the people we serve.
- A Governance Handbook which includes key documents that underpin our governance framework, including (but not exhaustive) the Scheme of Reservation and Delegation (SoRD), Prime Financial Policies, and ICB committee structures to ensure the Board is fully informed and sighted its statutory decision making and effective stewardship of NHS spending for all the residents of the ICB.
- An appointed Accountable Officer (the ICB Chief Executive) who is responsible (amongst other duties) for ensuring that the ICB fulfils its duties to exercise its functions effectively, efficiently, and economically thus ensuring improvement in the quality of services and the health of the local population which maintaining value for money
- The Accountable Officer, working closely with the chair of the ICB, ensures that proper constitutional, governance, and development arrangements are put in place to assure the Board of the organisation's ongoing capability and capacity to meet its duties and responsibilities.
- An appointed Executive Director of Finance who is responsible for (amongst other duties) overseeing robust audit and governance arrangements leading to propriety in the use of the ICB's resources.
- Staff members who are responsible for reporting problems of operations, monitoring and improving their performance, and monitoring non-compliance with the corporate policies and various professional codes, or violations of policies, standards, practices, and procedures.
- There is a clear process for reporting, management, investigation and learning from incidents. The ICB has a Senior Information Risk Owner (SIRO) to support the arrangements for managing and controlling risks relating to information/ data security. The Executive Medical Officer is the Caldicott Guardian to ensure that patient confidentiality is protected.

Internal audit service

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

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

Policies

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

The ICB has a suite of policies in place, including corporate policies, HR policies, and Information Governance policies. Each policy has a named executive director lead and staff are advised and reminded of the ICB's polices. Polices are scheduled for review at their due date and approved by the Executive Committee and staff are informed of updates/changes. The ICB also has a number of Standard Operating Procedures to ensure staff understand the procedures that must be followed in certain areas e.g., to establish the ICB's Subcommittees and Groups; how to obtain legals services.

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

The ICB is committed to an open and honest culture whereby all staff feel able and are supported to raise concerns at work. The ICB has a Freedom to Speak Up (FTSU) Policy and Guardian who is supported in their role by the ICB's FTSU Executive Lead and Non-Executive Director.

The Audit Committee is scheduled to review the arrangements annually.

Data Quality

The ICB has a data quality policy. This policy defines data and explains data standards and the importance of data validation.

The North England Commissioning Support Unit (NECS) Data Management service has processes and systems in place to assess the quality and completeness of commissioning data managed on behalf of the ICB. Data is checked at all stages of processing through NECS systems and finally on publication of reports/analysis. Data is compared against historic and planned levels to provide assurance on completeness as well as with peer organisations in the form of benchmarking analysis.

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

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

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

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit (Data Security and Protection Toolkit [DSPT] and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.
The Data Security and Protection Toolkit (DSPT) is the officially recognised self-assessment tool on data protection and cyber security. It was originally developed by NHS Digital for all NHS organisations to measure compliance against the ten National Data Security Standards (DSSP), and in turn compliance with their statutory responsibilities and Data Protection legislation. Within the ten data standards there are mandatory assertions items to meet to ensure compliance with their statutory responsibilities.

The ICB published a 'Standards Met' DSPT for 2022/2023. The ICB will submit its Data Security and Protection toolkit for 2023/24 will be published by 30 June 2024.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the DSPT toolkit. The ICB has a named Senior Information Risk Owner (SIRO) and Caldicott Guardian appointed from our Executive team. The ICB also has a named Data Protection Officer. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We have developed and introduced information and data impact risk assessments and management procedures to fully embed an information risk culture throughout the organisation against identified risks.

Business Critical Models

In line with best practice recommendations of the MacPherson (2013) review into the quality assurance of analytical models, I can confirm that a framework and environment is in place to provide assurance of business-critical models. The ICB's Information Governance framework ensures that business critical systems are identified and managed effectively.

The ICBs Information Governance framework ensures that business critical systems are identified and managed effectively. Information asset owners have been appointed and trained to cover a range of business systems used by the ICB. Their responsibility in relation to business-critical systems will involve the maintenance of an information asset register relevant to their organisational remit, the maintenance of service continuity plans and the continuity of key skills to operate such systems.

Third party assurances

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

- The provision of Oracle financial system and financial accounting support from NHS Shared Business Services. The use of NHS Shared Business Services is mandated by NHS England for all ICBs and is fundamental in producing NHS England group financial accounts through the use of an integrated financial ledger system
- The provision of a wide range of commissioning support services from the North of England Commissioning Support Unit
- The provision of payroll services from Northumbria Healthcare NHS Foundation Trust
- The provision of the ESR payroll systems from NHS Business Services Authority (BSA)
- The provision of the Prescription Pricing Service operated by the NHS BSA
- The provision of Primary Care Support Services from Capita Business Services Limited
- The GP extraction and processing of GP data services operated by NHS England (formerly NHS Digital)

Assurance over the relevant control environments in place for these systems has been gained from independent service auditor reports for the year ended 31 March 2024, in accordance with ISAE 3000 or 3402 (International Standard on Assurance Engagements), together with additional testing of controls by the ICB's internal auditors. The outcome from these audits is reported to the Audit Committee.

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

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

Control Issues

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

The ICB has in place a robust system of internal control. The ICB has assurances from the Head of Internal Audit and from other sources to support this assessment.

Since the Month 9 submission the significant pressures have continued to be evident in certain standards, particularly in respect of:

- Healthcare associated infections
- Category 2 ambulance response times
- Accident and emergency 4 hour waiting times
- Elective activity levels
- Units of dental activity
- Cancer 62-day backlog
- Access to talking therapies
- Mental health support for children and young people

Any failure to deliver the objectives has the potential to adversely impact on patient care, as well as posing a reputational harm.

In addition, the system continues to face recruitment challenges in the clinical and social care workforce, and a workforce working group has continued to monitor and action as required.

Monitoring has continued through the contract management processes to manage the delivery of objectives. A performance management process remains in place to support relevant strategic programmes and where needed Elective recovery plans have been developed with main provides.

The ICB continues to monitor delayed ambulance handovers. Mitigations include ICB winter plan and surge plan in place; monitoring through the local delivery boards at Place; system situation reports (SitReps) are used during surge periods and a system wide surge exercise has been undertaken. A new North East and North Cumbria Performance Improvement and Oversight Group was established in December 2023 and Chief Operating Officers from the acute trusts are in attendance. Monitoring also continues through the Quality and Safety Committee and Audit committee (via the corporate risk register). Exception reports are also highlighted to the Executive Committee.

During 2023/24 Place Subcommittees have been established to ensure that providers come together to work in an integrated way to support the delivery of the ICB's objectives.

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

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

The ICB budget comprises the commissioning budget and the running cost budget. The Board received regular finance reports throughout the period 1 April 2023 to 31 March 2024.

The ICB commissioning budget is deployed to commission healthcare for the population of the North East and North Cumbria, in line with national guidance.
During the period 1 April 2023 to 31 March 2024 the ICB worked in close partnership with healthcare providers across the ICS to ensure that resources were utilised in the most effective way possible.

The ICB external auditors have not identified any significant weaknesses in ICB arrangements in place for securing economy, efficiency, and effectiveness in its use of resources.

During the financial year the ICB received 'substantial assurance' for 1 audit, 'good assurance' for 8 audits, 'reasonable assurance' for 4 audits, and 'limited assurance' for 2 audits from the 15 audits undertaken by internal audit, and the Head of Internal Audit Opinion also provided an overall assessment of ' good assurance '.

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

During the period 1 April 2023 to 31 March 2024, the ICB delivered a substantial efficiency programme, realising total efficiencies of around £98m.

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

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

Delegation of functions

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

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

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

Counter fraud arrangements

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

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

A counter fraud plan was agreed by the Executive Director of Finance and approved by the Audit Committee for the period 1 April 2023 to 31 March 2024, which focuses on the deterrence, prevention, detection, and investigation of fraud. Progress against this plan was regularly monitored by the Audit Committee within the counter fraud report

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

Between 1 April 2023 and 31 March 2024 was not subject to an NHSCFA engagement or assurance inspections therefore no recommendations have been made to the ICB where action was required and reported to the Audit Committee.

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

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2023 to 31 March 2024 for the ICB the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance, and internal control.

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

During the period, Internal Audit issued the following audit reports:

Table 8 - Summary of internal audit assurance work undertaken

Audit area	Assurance			
	Substantial	Good	Reasonable	Limited
Assurance Areas				
Governance, Risk and Performance				
Governance at Place (Final report)			✓	
System Oversight Framework (Final Report)		✓		
Risk Management and Board Assurance Framework (Final Report)		✓		
Finance, Contracting and Capital				
Cost Improvement Programme (Final Report)			✓	
Primary Care Delegated Commissioning Governance (Draft Report)			✓	
Key Financial Controls (Final Report)		✓		
Human Resources and Workforce				
Recruitment and Appointment (Draft Report)				✓
Digital Systems, Processes, and Information Governance				
Business Intelligence and Data Services (Final Report)		✓		
Digital Strategy (Final Report)	✓			

Audit area	Assurance			
	Substantial	Good	Reasonable	Limited
Core Assurance: Quality and Clinical Governance				
Quality Governance Framework (Final Report)				✓
Complaints (Draft Report)			✓	
Additional Assurance and Advisory: Governance, Risk and Performance				
Health and Safety *(Final Report)*		✓		
Additional Assurance and Advisory: Human Resources and Workforce				
Salary Overpayments (*Final Report*)		✓		
Additional Assurance and Advisory: Quality and Clinical Governance				
Individual Funding Requests (IFRs) (*Final Report*)		✓		
Maternity Incentive Scheme Assurance (*Final Report*)		✓		
Totals	1	8	4	2

Key

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

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

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

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

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

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

In particular, there are some key processes that the ICB uses throughout the year to be assured that the system of internal control is effective:

Board
The Board Assurance Framework has been regularly reviewed by the Board. The Board also receives minutes from the Executive Committee who have responsibility for the approval of new and updated policies throughout the year.

Audit Committee
The annual internal audit plan, as approved by the Audit Committee, enables the ICB to be reassured that key internal financial controls and other matters relating to risk are regularly reviewed. The Committee has reviewed the internal and external audit reports and has kept the assurance framework under review throughout the year.

Executive Committee
The Committee oversees the day-to-day operational management and performance of the ICB in support of the Chief Executive in the delivery of their duties and responsibilities to the Board. The Committee provides a forum to inform ICB's strategies and plans and in particular the Committee will undertake any commissioning and planning activity on behalf of the Board, helping to secure continuous improvement of the quality of services. The Committee also provides assurance on the implementation of the approved ICB strategies and plans.

Quality and Safety Committee
The Committee provides assurance to the Board that there are adequate controls in place to ensure the ICB is delivering on its statutory and non-statutory clinical duties and responsibilities.

Finance, Performance, and Investment Committee
The Committee provides assurance around financial planning and in-year performance monitoring alongside monitoring central management costs and efficiency controls.

Assurances of outsourced services
The ICB relies on several external support services providers in respect of some of its business functions, including the North of England Commissioning Support (NECS), the NHS Shared Business Service (SBS), Capita (primary care support services), the GP extraction and processing of GP data services operated by NHS England (formerly NHS Digital) and the NHS Business Services Authority (BSA).

These organisations provide service auditor reports as part of the evidence of assurance on their internal system of controls as required by their customers. These service auditor reports are considered by the Audit Committee and internal audit also consider service auditor reports as part of the overall year-end internal audit opinion.

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

Subcommittees

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

Conclusion

The system of control described in this report has been in place in the ICB for the period 1 April 2023 to 31 March 2024 and up to the date of the approval of the annual report and accounts. I have concluded that the ICB did have a generally sound system of internal control in place continuously throughout the period, designed to meet the organisation’s objectives and that the controls are being applied consistently. No significant internal control issues have been identified.

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The Remuneration Committee is a committee of NENC ICB. It was in operation throughout the twelve-month period from 1 April 2023 to 31 March 2024.

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

Pay ratio information [subject to audit]

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

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

The banded remuneration of the highest paid director in the ICB in the reporting period 1 April 2023 to 31 March 2024 was £265-270k (2022/23 comparator for 9-month period: £255-260k). ICB prior year is for 9 months only from 1 July 2022 to 31 March 2023.

The relationship to the remuneration of the organisation's workforce is disclosed in the table below:

	25th percentile	Median pay ratio	75th percentile pay ratio
2023/24:			
Total remuneration (£)	38,901	50,952	81,138
Salary component of total remuneration (£)	37,350	50,952	81,138
Pay ratio information	6.9:1	5.3:1	3.3:1
2022/23 (for the period 1 July 2022 to 31 March 2023):			
Total remuneration (£)	35,571	48,788	82,508
Salary component of total remuneration (£)	35,571	48,526	81,599
Pay ratio information	7.2:1	5.3:1	3.1:1

During the reporting period 2023/24, no employees received remuneration in excess of that of the highest paid director (2022/23 comparator for 9-month period: none). Excluding the

highest paid director, banded remuneration ranged from £10-15k up to £180-185k (2022/23 comparator for 9-month period: £5-10k up to £175-180k).

Total remuneration includes salary, non-consolidated performance-related pay, and benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Accordingly, the total remuneration figures reflected here exclude the pension related benefits shown in the salaries and allowances table on pages 149-152.

There have been no significant changes to the ratio of highest paid director remuneration to the rest of the ICB's workforce during the year. The increase in remuneration levels of both the highest paid director and other ICB staff reflects the 5% pay award agreed for 2023/24.

The percentage change from the previous financial period in respect of both the highest paid director and the average percentage change in respect of employees of the ICB as whole, is shown in the table below:

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial period in respect of the highest paid director	3.88%	Not applicable
The average percentage change from the previous financial period in respect of employees of the ICB, taken as a whole	0.45%	Not applicable

The increase in the highest paid director remuneration reflects a nationally agreed 5% pay award together with a minor change in the estimated value of taxable benefits (estimated benefit in kind on lease car).

Other ICB employees as a whole also received a nationally agreed 5% pay award under Agenda for Change arrangements. The average percentage change for ICB employees as a whole was impacted by staff turnover during the period. This included the departure of a number of individuals with higher-than-average annualised salaries following the transition of predecessor organisations into the ICB, and the appointment of staff and transfer in of staff, with lower-than-average salaries.

Policy on the remuneration of senior managers

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

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

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

Termination payments are limited to those laid down in statute and those provided for within NHS terms and conditions of service and under the NHS Pension Scheme Regulations for those who are members of the scheme. No awards have been made during the year to past senior managers.

Remuneration of Very Senior Managers

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

Senior manager remuneration

For the purpose of this remuneration report, the ICB has considered the definition of 'senior managers' within the 2023/24 Group Accounting Manual published by the Department of Health and Social Care Group Accounting Manual and considers that the Board members represent the senior managers of the ICB.

Details of the relevant salaries and allowances for all of the senior managers of the ICB can be found in the table below. Prior year comparative figures are included for the 9-month period 1 July 2022 to 31 March 2023.

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

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

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

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

NENC ICB senior officers' salaries and allowances - 2023/24 [subject to audit]:

Name	Position	1 April 2023 to 31 March 2024						
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) (to nearest £100)	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)	*Full time equivalent salary (bands of £5,000)*
		£000	£	£000	£000	£000	£000	*£000*
Professor Sir Liam Donaldson	Chair	70 - 75	-	-	-	-	70 - 75	*70 - 75*
Sam Allen	Chief Executive	260 - 265	4,700	-	-	50 - 52.5	315 - 320	*260 - 265*
David Chandler	Executive Director of Finance	175 - 180	1,100	-	-	420 - 422.5	595 - 600	*175 - 180*
Dr Neil O'Brien	Executive Medical Director	180 - 185	-	-	-	-	180 - 185	*180 - 185*
David Purdue	Executive Chief Nurse and People Officer	180 - 185	1,000	-	-	95 - 97.5	280 - 285	*180 - 185*
Claire Riley	Executive Director of Corporate Governance, Communications & Involvement	170 - 175	2,500	-	-	-	170 - 175	*170 - 175*
Professor Graham Evans	Executive Chief Digital and Information Officer	170 - 175	-	-	-	105 - 107.5	275 - 280	*170 - 175*
Aejaz Zahid	Executive Director of Innovation *Until 15/08/2023*	45 - 50	200	-	-	12.5 - 15	60 - 65	*120 - 125*
Annie Laverty	Executive Director of Improvement and Experience	170 - 175	1,100	-	-	40 - 42.5	210 - 215	*170 - 175*
Jacqueline Myers	Executive Chief of Strategy and Operations	170 - 175	1,500	-	-	-	170 - 175	*170 - 175*
Dave Gallagher	Executive Area Director (Central & South)	170 - 175	-	-	-	492.5 - 495	660 - 665	*170 - 175*
Levi Buckley	Executive Area Director (North & North Cumbria) *From 02/05/2023*	150 - 155	-	-	-	-	150 - 155	*165 - 170*

Name	Position	1 April 2023 to 31 March 2024						
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) (to nearest £100)	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)	*Full time equivalent salary (bands of £5,000)*
		£000	£	£000	£000	£000	£000	*£000*
Dr Hannah Bows	Independent Non-Executive Member	10 - 15	-	-	-	-	10 - 15	*10 - 15*
Professor Eileen Kaner	Independent Non-Executive Member	15 - 20	-	-	-	-	15 - 20	*15 - 20*
Jon Rush	Independent Non-Executive Member	15 - 20	-	-	-	-	15 - 20	*15 - 20*
David Stout	Independent Non-Executive Member	15 - 20	-	-	-	-	15 - 20	*15 - 20*
Professor Pali Hungin	Independent Non-Executive Member *From 01/03/2024*	0 - 5	-	-	-	-	0 - 5	*15 - 20*
Dr Saira Malik	Primary Medical Services Partner Member	20 - 25	-	-	-	-	20 - 25	*20 - 25*
Dr Mike Smith	Primary Medical Services Partner Member	20 - 25	-	-	-	2.5 - 5	30 - 35	*20 - 25*

NENC ICB senior officers' salaries and allowances comparative figures for 2022/23 (9 months to 31 March 2023)

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

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

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

Notes:

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

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

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

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

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

Name	Position
Ken Bremner	Foundation Trust Partner Member
Dr Rajesh Nadkarni	Foundation Trust Partner Member
Catherine McEvoy-Carr	Local Authority Partner Member
Tom Hall	Local Authority Partner Member
Cllr. Shane Moore	Local Authority Partner Member (until 25/05/2023)
Ann Workman	Local Authority Partner Member (until 31/07/2023)

The following senior officers were employed in multiple roles during the period. The remuneration shown above for these individuals represents only that relating to their role as Board members. The total remuneration earned by each individual for all work across the ICB in 2023/24 is shown below:

Name	Position	2023/24		
		Salary (bands of £5,000) £000	Expense payments (taxable) (to nearest £100) £	Total (bands of £5,000) £000
Dr Saira Malik	Primary Medical Services Partner Member	70 - 75	-	70 - 75
Dr Mike Smith	Primary Medical Services Partner Member	55 - 60	-	55 - 60
Jon Rush	Independent Non-Executive Member	20 - 25	-	20 - 25

NENC ICB senior officers' pension benefits - 2023/24 [subject to audit]:

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2024 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2023	(f) Real increase in Cash Equivalent Transfer value	(g) Cash Equivalent Transfer Value at 31 March 2024	(h) Employer's contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sam Allen Chief Executive	0 - 2.5	60 - 62.5	75 - 80	200 - 205	1,253	363	1,651	-
David Chandler Executive Director of Finance	17.5 - 20	90 - 92.5	65 - 70	180 - 185	878	632	1,533	-
Dr Neil O'Brien Executive Medical Director	-	37.5 - 40	25 - 30	55 - 60	459	77	561	-
David Purdue Executive Chief Nurse and People Officer	2.5 - 5	55 - 57.5	80 - 85	225 - 230	1,583	378	1,985	-
Claire Riley Executive Director of Corporate Governance, Communications & Involvement	-	20 - 22.5	25 - 30	65 - 70	525	76	622	-
Professor Graham Evans Executive Chief Digital and Information Officer	5 - 7.5	7.5 - 10	40 - 45	110 - 115	17	27	67	-
Aejaz Zahid Executive Director of Innovation *Until 15/08/2023*	0 - 2.5	-	10 - 15	20 - 25	194	9	233	-
Annie Laverty Executive Director of Improvement and Experience	2.5 - 5	-	30 - 35	-	379	80	480	-
Jacqueline Myers Executive Chief of Strategy and Operations	-	37.5 - 40	50 - 55	135 - 140	943	210	1,174	-

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2024 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2023	(f) Real increase in Cash Equivalent Transfer value	(g) Cash Equivalent Transfer Value at 31 March 2024	(h) Employer's contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dave Gallagher Executive Area Director (Central & South)	20 - 22.5	87.5 - 90	80 - 85	230 - 235	1,423	-	108	-
Levi Buckley Executive Area Director (North & North Cumbria) *From 02/05/2023*	-	-	55 - 60	60 - 65	893	81	1,003	-
Dr Mike Smith Primary Medical Services Partner Member	0 - 2.5	-	15 - 20	0	149	45	199	-
Dr Saira Malik Primary Medical Services Partner Member	-	-	15 - 20	40 - 45	305	17	331	-

Note – Dave Gallagher is affected by the public service pensions remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995 to 2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

NENC ICB senior officers' pension benefits comparative figures for 2022/23 (9 months to 31 March 2023)

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2023 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 July 2022	(f) Real increase in Cash Equivalent Transfer value	(g) Cash Equivalent Transfer Value at 31 March 2023	(h) Employer's contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Sam Allen Chief Executive	5 - 7.5	12.5 - 15	65 - 70	130 - 135	964	105	1,138	-
Jacqueline Myers Executive Chief of Strategy and Operations	2.5 - 5	2.5 - 5	45 - 50	90 - 95	728	44	856	-
Annie Laverty Executive Chief People Officer	2.5 - 5	-	20 - 25	-	290	25	345	-
Mark Adams Executive Area Director (North & North Cumbria). *From 01/07/2022 to 24/11/2022*	-	-	-	-	1,275	-	-	-
Nicola Bailey Executive Area Director (North & North Cumbria). *From 05/09/2022*	0 - 2.5	-	105 - 110	-	1,626	30	1,700	-
Dave Gallagher Executive Area Director (Central & South)	-	-	55 - 60	130 - 135	1,604	-	1,292	-
Professor Graham Evans Executive Chief Digital and Information Officer	-	-	-	-	-	-	-	1
David Purdue Executive Chief Nurse	7.5 - 10	20 - 22.5	70 - 75	155 - 160	1,142	194	1,438	-
Claire Riley Executive Director of Corporate Governance, Communications & Involvement	2.5 - 5	2.5 - 5	25 - 30	40 - 45	395	46	477	-

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

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

The figures included above reflect total pension benefits accrued within the NHS Pension Scheme, not just those accrued from employment within the ICB. No lump sum is shown for employees who only have membership in the 2008 section of the NHS Pension Scheme. No cash equivalent transfer value (CETV) is shown for pensioners or senior managers above normal pension age.

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

Cash Equivalent Transfer Values

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

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

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

Real Increase in Cash Equivalent Transfer Values

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

Compensation on early retirement or for loss of office

No compensation has been paid by the ICB during the year for early retirement (2022/23 comparator for 9-month period: none).

An exit package was agreed during the year for compulsory redundancy of the following senior officer:

Name	Position	Cost of compulsory redundancy (£)
Annie Laverty	Executive Director of Improvement and Experience (up to 31 March 2024)	160,000

This exit package was agreed during the year but will not be paid until the individual's employment ends in 2024/25 and is not included within the table of salaries and allowances for 2023/24 on page 149.

Payments to past directors

No payments have been made by the ICB to past directors (2022/23 comparator for 9-month period: none).

Staff Report

Number of senior managers

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

Staff numbers and costs

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

Staff composition

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

	Female	Male
Board members	10	16
Total employees	543	169

Sickness absence data

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

The ICB sickness absence rate was 3.29%

Staff turnover percentages

The staff turnover for the ICB was 20.16%

Staff engagement percentages

The ICB staff survey has been undertaken in this reporting period with a 60% response rate from staff.

Staff policies

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

NENC ICB Staff Policies

Policy number	Policy / Version
NENC ICB HR01	Equality, Diversity, and Inclusion
NENC ICB HR04	Work Life Balance
NENC ICB HR05	Annual Leave Policy
NENC ICB HR06	Family Policy
NENC ICB HR06A	Adoption Leave Policy
NENC ICB HR06B	Maternity Leave
NENC ICB HR06C	Parental Leave Policy
NENC ICB HR06D	Paternity Leave Policy
NENC ICB HR06E	Shared Parental Leave
NENC ICB HR06F	Pregnancy and Baby Loss
NENC ICB HR08	Volunteers
NENC ICB HR09	Working Time Directive Policy
NENC ICB HR10	Induction and Probation
NENC ICB HR12	Secondment Policy
NENC ICB HR13	Freedom to Speak Up
NENC ICB HR16	Managing Allegations Against Staff
NENC ICB HR20	Professional Registration Policy
NENC ICB HR21	Job Evaluation
NENC ICB HR22	Organisational Change
NENC ICB HR2A	Redeployment Policy
NENC ICB HR23	Domestic Abuse and the Workplace
NENC ICB HR24	Retirement Policy

NENC ICB HR25	Armed Forces, Reserves & Cadets
HR52	Pay Protection
HR02	Absence Management
HR07	Disciplinary Policy
HR10	Further Education, Training & Development Policy
HR11	Grievance and Disputes Procedures
HR12	Harassment and Bullying Policy
HR16	Managing work performance (Capability)
HR18	Appraisal/Ongoing review and objectives policy
HR19	Other Leave Policy
HR25	Recruiting Ex-Offenders Policy & DBS
HR26	Recruitment and Retention Premia
HR27	Recruitment and Selection
HR31	Substance Misuse Policy
HR32	Temporary Promotion
HR34	Travel Expenses & Subsistence
HR37	Incremental pay progression
HR43	Promoting Mental Health & Wellbeing at Work
HR45	Work Experience
HR46	Relocation Expenses

Trade Union Facility Time Reporting Requirements

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

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

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

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

Expenditure on consultancy
Details of expenditure on consultancy services can be found in note 4 of the financial statements. For 2023/24, the value of consultancy services expenditure is £365k (9 month period to 31 March 2023: £352k).

Off-payroll engagements

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

For all off-payroll engagements as at 31 March 2024 for more than £245 per day:

	Number
Number of existing engagements as of 31 March 2024	7
Of which, the number that have existed:	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	-
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	4

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

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

For all off-payroll engagements between 1 April 2023 and 31 March 2024, for more than £245 per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2023 and 31 March 2024	7
Of which:	
No. not subject to off-payroll legislation[2]	-
No. subject to off-payroll legislation and determined as in-scope of IR35[1]	-
No. subject to off-payroll legislation and determined as out of scope of IR35[1]	7
the number of engagements reassessed for compliance or assurance purposes during the year	-
Of which: no. of engagements that saw a change to IR35 status following review	-

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

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

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024:

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

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

Table 1: Exit Packages for the year ended 31 March 2024

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	-	-	1	4,867	1	4,867	-	-
£10,000 - £25,000	-	-	6	86,843	6	86,843	-	-
£25,001 - £50,000	3	112,611	12	422,833	15	535,444	-	-
£50,001 - £100,000	-	-	12	855,291	12	855,291	-	-
£100,001 - £150,000	1	106,667	6	698,364	7	805,031	-	-
£150,001 –£200,000	1	160,000	5	793,333	6	953,333	-	-
>£200,000	-	-	-	-	-		-	-
TOTALS	**5**	**379,278**	**42**	**2,861,531**	**47**	**3,240,809**	**-**	**-**

This table reports the number and value of exit packages agreed in the financial year. All exit packages agreed relate to the restructure of the ICB in response to the national requirement to reduce ICB running costs by 30% in real terms by 2025/26.

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

One exit package related to a senior officer included within the remuneration report. Refer to remuneration report for further details.

Table 2: Analysis of Other Departures for the year ended 31 March 2024

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	42	2,862
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
TOTAL	**42**	**2,862**

All 'other departures' relate to voluntary redundancies agreed during the year under the ICB's voluntary redundancy scheme which was approved by NHS England.

Parliamentary Accountability and Audit Report

The ICB is not required to produce a Parliamentary Accountability and Audit Report.

The ICB has no disclosures on remote contingent liabilities, gifts and fees and charges. Relevant disclosure on losses and special payments can be found in note 18 of the financial statements.

An audit report is also included in this annual report on page 194 onwards.

ANNUAL ACCOUNTS

CONTENTS **Page Number**

The Primary Statements:

NHS North East and North Cumbria ICB - Financial Statements for the year ended 31 March 2024

Statement of Comprehensive Net Expenditure for the year ended 31 March 2024

	Note	12 months to 31 March 2024 £000	9 months to 31 March 2023 £000
Income from sale of goods and services	2	(99,661)	(712)
Other operating revenue	2	(1,643)	(245)
Total operating income		**(101,304)**	**(957)**
Employee benefits	3.1	48,697	33,677
Purchase of goods and services	4	7,682,901	5,136,558
Depreciation and impairment charges	4	653	527
Other operating costs	4	806	1,252
Total operating expenditure		**7,733,057**	**5,172,014**
Finance costs	6	39	33
Net operating costs for the financial period		**7,631,792**	**5,171,090**
Net loss on transfer by absorption	8	-	465
Comprehensive net expenditure for the period		**7,631,792**	**5,171,555**

Statement of Financial Position as at 31 March 2024

	Note	31 March 2024 £000	31 March 2023 £000
Non-current assets:			
Right of use assets	7	3,788	4,441
Total non-current assets		**3,788**	**4,441**
Current assets			
Contract and other receivables	9	19,049	14,701
Cash and cash equivalents	10	1,430	1,624
Total current assets		**20,479**	**16,325**
Total assets		**24,267**	**20,766**
Current liabilities			
Trade and other payables	11	(533,412)	(471,564)
Lease liabilities	7	(602)	(667)
Total current liabilities		**(534,014)**	**(472,231)**
Total assets less current liabilities		**(509,747)**	**(451,465)**
Non-current liabilities			
Lease liabilities	7	(3,250)	(3,813)
Total non-current liabilities		**(3,250)**	**(3,813)**
Assets less Liabilities		**(512,997)**	**(455,278)**
Financed by taxpayers' equity			
General fund		(512,997)	(455,278)
Total taxpayers' equity		**(512,997)**	**(455,278)**

The notes on pages 172 to 193 of the Annual Report form part of this statement.

The financial statements on pages 168 to 193 were approved and authorised for issue by the Board on 25 June 2024 and signed on its behalf by:

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

Accountable Officer
26 June 2024

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2024

	General fund £000	Total reserves £000
Changes in taxpayers' equity for the year to 31 March 2024:		
Balance at 1 April 2023	(455,278)	(455,278)
Changes in ICB taxpayers' equity for the year to 31 March 2024		
Net operating costs for the financial year	(7,631,792)	(7,631,792)
Net recognised ICB expenditure for the financial year	**(7,631,792)**	**(7,631,792)**
Net funding	7,574,073	7,574,073
Balance at 31 March 2024	**(512,997)**	**(512,997)**

	General fund £000	Total reserves £000
Changes in taxpayers' equity for the nine months to 31 March 2023:		
Balance at 1 July 2022	-	-
Transfer by modified absorption from CCGs	(324,820)	(324,820)
Adjusted ICB balance at 1 July 2022	**(324,820)**	**(324,820)**
Changes in ICB taxpayers' equity for the nine months to 31 March 2023		
Net operating costs for the financial period	(5,171,090)	(5,171,090)
Transfers by absorption from other bodies	(465)	(465)
Net recognised ICB expenditure for the financial period	**(5,171,555)**	**(5,171,555)**
Net funding	5,041,097	5,041,097
Balance at 31 March 2023	**(455,278)**	**(455,278)**

Statement of Cash Flows for the year ended 31 March 2024

	Note	12 months to 31 March 2024 £000	9 months to 31 March 2023 £000
Cash flows from operating activities			
Net operating costs for the financial period		(7,631,792)	(5,171,090)
Depreciation and amortisation	4	653	527
Movement due to transfer by modified absorption	8	-	(465)
Interest paid	6	39	33
(Increase) / decrease in trade and other receivables	9	(4,348)	2,388
Increase in trade and other payables	11	61,848	135,998
Net cash outflow from operating activities		**(7,573,600)**	**(5,032,609)**
Net cash outflow before financing		**(7,573,600)**	**(5,032,609)**
Cash flows from financing activities			
Net funding received		7,574,073	5,041,097
Repayment of lease liabilities	7	(667)	(527)
Net cash inflow from financing activities		**7,573,406**	**5,040,570**
Net increase / (decrease) in cash and cash equivalents	10	**(194)**	**7,961**
Cash and cash equivalents (including bank overdrafts) at the beginning of the financial period		1,624	(6,337)
Cash and cash equivalents (including bank overdrafts) at the end of the financial period		**1,430**	**1,624**

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICB) shall meet the accounting requirements of the Department of Health and Social Care's Group Accounting Manual, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2023 to 2024. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to ICBs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of certain financial assets and financial liabilities to fair value when appropriate. For right of use assets, the depreciated historical cost is considered to give an appropriate proxy of current value in existing use or fair value.

1.3 Movement of Assets within the Department of Health and Social Care Group

As public sector bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 business combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care Group Accounting Manual requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

NHS North East and North Cumbria ICB (the ICB) was formed on 1st July 2022 by the absorption of 100% of eight former CCGs. For transfers of assets and liabilities from those bodies that closed on 30 June 2022 a modified absorption approach was applied. This therefore applies to the assets and liabilities transferred from the former CCGs. For these transactions only gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries. Refer to note 8 for further details.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.4 Pooled Budgets

Where the ICB has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006, the ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The ICB has assessed that joint control does not exist for any of these arrangements, refer to note 15 for further details.

1.5 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the ICB's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 *Critical Judgements in Applying Accounting Policies*

The following are the critical judgements, apart from those involving estimations (see below), that management has made in the process of applying the ICB's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- determining whether a provision or contingent liability should be recognised in respect of certain potential future obligations, particularly in respect of continuing healthcare.

1.5.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the ICB's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

(a) the estimate of prescribing and community pharmacy expenditure for the final two months of the year; this is informed by scenario analysis undertaken by management, utilising the forecast expenditure profile provided by the NHS Business Services Authority, historical prescribing patterns and profile of dispensing days, together with local intelligence and analysis of the impact of price concessions for example. The total accrual recognised in the financial statements amounts to £123,139k of which prescribing is £103,762k and community pharmacy is £19,377k.

(b) the estimate of potential future liabilities in respect of individual packages of care (including continuing healthcare); the primary source of information to estimate the forecast spend is the lists of patients held for each type of package. An assessment is made in respect of the likely number of cases and associated costs where care is being provided but funding has not yet been agreed due to delays between assessment and notification to the ICB or agreement of the level of costs. This includes where there are funding disputes or reconciliation issues in packages numbers and costs. The total accrual for continuing healthcare costs recognised in the financial statements amounts to £112,142k.

(c) the assumptions applied in the estimation of activity not yet invoiced as at the Statement of Financial Position date; estimates are based on provisional costed activity data provided by relevant healthcare providers together with historic experience and any additional intelligence available. Total estimated accrual recognised in the financial statements amounts to £16,809k with data subject to final verification and validation.

1.6 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the ICB.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.7 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• the ICB is not required to disclose information regarding performance obligations that are part of a contract that has an original expected duration of one year or less;

• the ICB is not required to disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with the value of the performance completed to date.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

The main sources of income in the ICB are prescription fees and charges and dental fees and charges following delegation of pharmacy and dental services on the 1st April 2023.

1.8 Employee Benefits

1.8.1 *Short-term Employee Benefits*

Salaries, wages and employment-related payments including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 *Retirement Benefit Costs*

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.10 Leases

Under IFRS16, the distinction between finance leases and operating leases is only applicable where the ICB is the lessor. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 The ICB as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year and 4.72% to new leases commencing in 2024 under IFRS 16.

Lease payments included in the measurement of the lease liability comprise
- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use. Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

The ICB considers all of its right-of-use assets to be low value or short term and accordingly employs the depreciated historical cost model for subsequent measurement of the right-to-use assets, as an appropriate proxy for current value in existing use or fair value.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.11 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management. Cash, bank and overdraft balances are recorded at current values.

1.12 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the ICB.

1.13 Non-clinical Risk Pooling

The ICB participates in the Properties Expenses Scheme and Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses as and when they become due.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.14 Financial Assets

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred and the ICB has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income;
- Financial assets at fair value through profit and loss;

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

All ICB assets have been classified as financial assets at amortised cost.

1.14.1 *Financial Assets at Amortised cost*

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.14.2 *Impairment*

For all financial assets measured at amortised cost, lease receivables and contract assets, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.15 Financial Liabilities

Financial liabilities are recognised on the Statement of Financial Position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished, that is, the obligation has been discharged or cancelled or has expired.

After initial recognition, all financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Notes to the financial statements (continued)

1. Accounting Policies (continued)

1.16 Value Added Tax

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.18 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

- IFRS 14: Regulatory Deferral Accounts - not UK endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to Department of Health and Social Care group bodies.
- IFRS 17: Insurance Contracts (application from 1 January 2021) is being applied by HMT in the FREM from 1 April 2025 with limited options for early adoption.
- IFRS 18: Presentation and Disclosure in Financial Statements (application from 1 January 2027) but not yet adopted by the FREM.

The application of the Standards as revised would not have a material impact on the accounts for 2023/24, were they applied in that year.

Notes to the financial statements (continued)

2. Operating Income

	12 months to 31 March 2024 Total £'000	9 months to 31 March 2023 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	-	315
Prescription fees and charges	50,361	-
Dental fees and charges	48,768	-
Other contract income	532	397
Total Income from sale of goods and services	**99,661**	**712**
Other operating revenue		
Other non contract revenue	1,643	**245**
Total other operating revenue	**1,643**	**245**
Total operating Income	**101,304**	**957**

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the ICB and credited to the General Fund.

Notes to the financial statements (continued)

3. Employee benefits and staff numbers

3.1 Employee benefits

	12 months to 31 March 2024			9 months to 31 March 2023		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee benefits:						
Salaries and wages	34,828	34,297	531	26,071	25,683	388
Social security costs	4,050	4,048	2	2,884	2,884	-
Employer contributions to NHS Pension scheme	6,312	6,308	4	4,183	4,183	-
Other pension costs	17	17	-	67	67	
Apprenticeship levy	155	155	-	92	92	-
Termination benefits	3,335	3,335	-	380	380	-
Gross employee benefits expenditure	**48,697**	**48,160**	**537**	**33,677**	**33,289**	**388**

No amounts were recovered in respect of employee benefits and no employee benefits were capitalised during the year (2022/23: none).

3.2 Average number of people employed

	12 months to 31 March 2024			9 months to 31 March 2023		
	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Total	**575**	**566**	**9**	**556**	548	8

None of the above people were engaged on capital projects (2022/23: none).

3.3 Exit packages agreed in the financial period

	2023/24 Compulsory redundancies		2023/24 Other agreed departures		2023/24 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	1	4,867	1	4,867
£10,001 to £25,000	-	-	6	86,843	6	86,843
£25,001 to £50,000	3	112,611	12	422,833	15	535,444
£50,001 to £100,000	-	-	12	855,291	12	855,291
£100,001 to £150,000	1	106,667	6	698,364	7	805,031
£150,001 to £200,000	1	160,000	5	793,333	6	953,333
Over £200,001	-	-	-	-	-	-
Total	**5**	**379,278**	**42**	**2,861,531**	**47**	**3,240,809**

2022/23 Comparative figures

	2022/23 Compulsory redundancies		2022/23 Other agreed departures		2022/23 Total	
	Number	£	Number	£	Number	£
Less than £10,000	28	102,586	-	-	28	102,586
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	1	46,667	-	-	1	46,667
£50,001 to £100,000	1	71,068	-	-	1	71,068
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	1	160,000	-	-	1	160,000
Over £200,001	-	-	-	-	-	-
Total	**31**	**380,321**	**-**	**-**	**31**	**380,321**

3.4 Analysis of Other Agreed Departures

	2023/24		2022/23	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	42	2,861,531	-	-
Total	**42**	**2,861,531**	**-**	**-**

This table reports the number and value of exit packages agreed in the financial period. All exit packages agreed during 2023/24 relate to the restructure of the ICB in response to the national requirement to reduce ICB running costs by 30% in real terms by 2025/26. All exit packages agreed during 2022/23 related to the transition of eight predecessor organisations into the ICB.

All redundancy costs have been paid in accordance with Agenda for Change requirements, contractual requirements or statutory provisions as appropriate.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

The Remuneration Report includes the disclosure of any exit payments payable to individuals named in that Report.

Notes to the financial statements (continued)

3. Employee benefits and staff numbers (continued)

3.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded, defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care, in England and Wales. The Schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each Scheme is accounted for as if it were a defined contribution scheme: the cost to the ICB of participating in the Scheme is taken as equal to the contributions payable to that Scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FREM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

3.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as at 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

3.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay (previously 20.6% from April 2019).

The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The employer contribution rate for NHS Pension Schemes increased from 14.3% to 20.6% from 1st April 2019. For 2023/24, the ICB continued to pay over contributions at the former rate with the additional amount being paid by NHS England on behalf of the ICB. The full cost and related funding has been recognised in these accounts

The value of employers contributions to the NHS pension scheme for the next annual reporting period is estimated to be £7.2m.

Notes to the financial statements (continued)

4. Operating expenses

	12 months to 31 March 2024 £000	9 months to 31 March 2023 £000
Purchase of goods and services		
Purchase of healthcare from NHS and DHSC bodies:		
· other ICBs and NHS England	42,589	27,631
· foundation trusts	4,845,169	3,359,410
· other NHS trusts	31,236	22,169
· other WGA bodies	2	2
Purchase of healthcare from non-NHS bodies	922,314	701,928
Purchase of social care	156,078	109,179
General dental services and personal dental services	209,622	-
Prescribing costs	623,712	455,114
Pharmaceutical services	146,123	616
General ophthalmic services	31,996	21
Primary Medical Services Costs (GPMS/APMS and PCTMS)	630,879	433,086
Supplies and services – clinical	11,426	3,037
Supplies and services – general	1,561	5,779
Consultancy services	365	352
Establishment	5,702	3,828
Transport	50	18
Premises	18,701	12,269
Audit fees	297	340
Other non statutory audit expenditure		
· Other services	12	65
Internal audit expenditure	371	293
Other professional fees	2,163	234
Legal fees	1,558	489
Education and training	975	698
Total Purchase of goods and services	**7,682,901**	**5,136,558**
Depreciation and impairment charges		
Depreciation	653	527
Total Depreciation and impairment charges	**653**	**527**
Other operating expenses		
Chair and Non Executive Members	215	112
Capital grants	-	980
Clinical negligence	19	25
Expected credit loss on receivables	551	122
Other expenditure	21	13
Total other operating expenses	**806**	**1,252**
Total operating expenses	**7,684,360**	**5,138,337**

The total of £297k under Audit Fees consists of:
- Mazars LLP's Audit Fee of £239k (including VAT at 20%) for the ICB's 23/24 External Audit.
- Additional Mazars LLP Audit Fees of £16k (including VAT at 20%) in respect of additional audit work carried out on the predecessor CCG 2022/23 accounts.
- Residual Ernst & Young LLP Audit Fees of £42k (including VAT at 20%) for the predecessor CCG 2022/23 (Q1) external audit of Tees Valley CCG. Delivery of this work commenced during the ICB's financial period, therefore these costs have been incurred by the ICB.

The total of £12k under Non-Statutory Audit Expenditure consists of:
- Mental Health Investment Standard (MHIS) fee of £42k (including VAT at 20%) for work to be completed by Mazars LLP for 2023/24.
- Residual release of 2022/23 estimated Mental Health Investment Standard (MHIS) fee of £30k (estimated £72k less £42k actual)

Notes to the financial statements (continued)

5. Better Payment Practice Code

Measure of compliance	12 months to 31 March 2024 Number	12 months to 31 March 2024 £000	9 months to 31 March 2023 Number	9 months to 31 March 2023 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the period	159,190	1,850,268	104,653	1,180,680
Total Non-NHS Trade invoices paid within target	158,215	1,834,151	103,788	1,171,898
Percentage of Non-NHS Trade invoices paid within target	**99.39%**	**99.13%**	**99.17%**	**99.26%**
NHS Payables				
Total NHS Trade invoices paid in the period	4,884	4,869,327	4,439	3,406,734
Total NHS Trade invoices paid within target	4,847	4,868,655	4,426	3,406,620
Percentage of NHS Trade invoices paid within target	**99.24%**	**99.99%**	**99.71%**	**100.00%**

The Better Payment Practice Code requires the payment of all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The ICB is deemed to be compliant if it pays at least 95% of invoices within 30 days of receipt, or within agreed contract terms.

6. Finance costs

	12 months to 31 March 2024 £000	9 months to 31 March 2023 £000
Interest		
Interest on lease liabilities	39	33

Notes to the financial statements (continued)

7. Leases

7.1 Right of use assets

	12 months to 31 March 2024 Buildings £000	12 months to 31 March 2024 Total £000	9 months to 31 March 2023 Total £000
Cost or valuation at 1 April 2023 / 1 July 2022	5,130	5,130	-
Transfer from other public sector body	-	-	5,130
Cost/Valuation at 31 March	**5,130**	**5,130**	**5,130**
Depreciation 1 April 2023 / 1 July 2022	(689)	(689)	-
Charged during the period	(653)	(653)	(527)
Transfer from other public sector body	-	-	(162)
Depreciation at 31 March	**(1,342)**	**(1,342)**	**(689)**
Net Book Value at 31 March	**3,788**	**3,788**	**4,441**
Net Book Value by Counterparty:			
Leased from other group bodies		**3,788**	**4,441**

7.2 Lease liabilities

	12 months to 31 March 2024 £000	9 months to 31 March 2023 £000
Lease liabilities at 1 April 2023 / 1 July 2022	(4,480)	-
Interest expense relating to lease liabilities	(39)	(33)
Repayment of lease liabilities (including interest)	667	527
Transfer from other public sector body	-	(4,974)
Lease liabilities at 31 March	**(3,852)**	**(4,480)**

7.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	31 March 2024 £000	31 March 2023 £000
Within one year	(607)	(667)
Between one and five years	(1,570)	(1,808)
After five years	(1,873)	(2,242)
Balance at 31 March	**(4,050)**	**(4,717)**
Effect of discounting	198	237
Included in:		
Current lease liabilities	(602)	(667)
Non-current lease liabilities	(3,250)	(3,813)
Balance at 31 March	**(3,852)**	**(4,480)**

7.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	12 months to 31 March 2024 £000	9 months to 31 March 2023 £000
Depreciation expense on right-of-use assets	653	527
Interest expense on lease liabilities	39	33
Expense relating to short-term leases	94	164

7.5 Amounts recognised in Statement of Cashflows

	12 months to 31 March 2024 £000	9 months to 31 March 2023 £000
Total cash outflow on leases under IFRS 16	(667)	(527)

Notes to the financial statements (continued)

8. Net gain/(loss) on transfer by absorption

The ICB was established on 1 July 2022 and took on the commissioning functions of eight former CCGs across the North East and North Cumbria, which were abolished. All of the assets and liabilities of those former CCGs were transferred to the ICB on 1 July 2022.

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Balances from CCGs to ICBs were transferred under "Modified Absorption" in 2022/23 and are shown below within NHS England Group Entities, for these transactions only gains and losses were recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

The transfer from NHS England to the ICB for Previously unassessed period of care (PUPOC) liability was recorded in 2022/23 as a Transfer by Absorption.

There were no further transfers and no gain/(loss) on transfer by absorption during 2023/24.

	2022/23		
	Total £'000	NHS England Parent Entities £'000	NHS England Group Entities (non parent) £'000
Transfer of right of use (ROU) assets	4,968	-	4,968
Transfer of cash and cash equivalents	564	-	564
Transfer of receivables	17,089	-	17,089
Transfer of payables	(335,566)	-	(335,566)
Transfer of right of use (ROU) liabilities	(621)	-	(621)
Transfer of borrowings	(6,901)	-	(6,901)
Transfer of previously unassessed period of care (PUPOC) liability	(465)	(465)	
Transfer of lease liabilities (Non Current)	(4,353)	-	(4,353)
Net loss on transfers by absorption / modified absorption	**(325,285)**	**(465)**	**(324,820)**

9. Contract and other receivables

	Current 31 March 2024 £000	Current 31 March 2023 £000
NHS receivables: Revenue	8,813	4,437
NHS accrued income	756	1,650
Non-NHS and Other WGA receivables: Revenue	7,299	5,803
Non-NHS and Other WGA prepayments	3,071	3,029
Non-NHS and Other WGA accrued income	78	83
Expected credit loss allowance - receivables	(1,072)	(631)
VAT	92	304
Other receivables	12	26
Total contract and other receivables	**19,049**	**14,701**
Total current and non current	**19,049**	**14,701**

The great majority of trade is with other NHS bodies, including other ICBs as commissioners for NHS patient care services. As ICBs are funded by Government to commission NHS patient care services, no credit scoring of them is considered necessary.

9.1 Receivables past their due date but not impaired

	31 March 2024 £000	31 March 2023 £000
By up to three months	2,949	1,194
By three to six months	909	134
By more than six months	142	346
Total	**4,000**	**1,674**

£2,525k of the amount above has subsequently been recovered post the Statement of Financial Position date.

The ICB did not hold any collateral against receivables outstanding at 31 March 2024 (31 March 2023: none).

9.2 Expected credit losses on financial assets

	Contract and other receivables - Non DHSC Group Bodies £000	Total £000
Balance at 1 April 2023	**(631)**	**(631)**
Lifetime expected credit losses on trade and other receivables-Stage 2	(551)	**(551)**
Amounts written off	110	**110**
Allowance for credit losses at 31 March 2024	**(1,072)**	**(1,072)**

The ICB has reviewed all receivables to determine whether an impairment value is required. In determining the recoverability of a receivable, the ICB considers any change in credit quality of the receivable from the date credit was initially granted up to the reporting date. The overall level of credit risk is considered to be relatively low due to the proportion of the customer base which is comprised of NHS bodies.

Notes to the financial statements (continued)

10. Cash and cash equivalents

	12 months to 31 March 2024 £000	9 months to 31 March 2023 £000
Balance at 1 April 2023 / 1 July 2022	1,624	(6,337)
Net change in period	(194)	7,961
Balance at 31 March	**1,430**	**1,624**
Made up of:		
Cash with the Government Banking Service	1,430	1,624
Cash and cash equivalents as in Statement of Financial Position	**1,430**	**1,624**

The ICB held £nil cash and cash equivalents at 31 March 2024 on behalf of patients (31 March 2023: none).

11. Trade and other payables

	Current 31 March 2024 £000	Current 31 March 2023 £000
NHS payables: revenue	918	3,022
NHS accruals	82,084	18,176
Non-NHS and Other WGA payables: Revenue	65,437	99,189
Non-NHS and Other WGA accruals	366,394	335,020
Social security costs	582	479
Tax	815	508
Other payables	17,182	15,170
Total trade and other payables	**533,412**	**471,564**
Total current and non-current	**533,412**	**471,564**

At 31 March 2024, the ICB had no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2023: none).

Other payables include £5,210k in respect of outstanding pension contributions at 31 March 2024 (31 March 2023: £4,776k).

12. Commitments

There were no contracted or non-cancellable contracts entered into by the ICB at 31 March 2024 which are not otherwise included in these financial statements (31 March 2023: none).

13. Financial instruments

13.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

As the ICB is financed through Parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The ICB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the ICB's standing financial instructions and policies agreed by the Integrated Care Board. Any treasury activity would be subject to review by the ICB's internal auditors.

13.1.1 Currency risk

The ICB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The ICB has no overseas operations. The ICB therefore has low exposure to currency rate fluctuations.

13.1.2 Interest rate risk

The ICB has no borrowings and has only limited powers to borrow funds from government for capital expenditure, subject to affordability as confirmed by NHS England. The ICB therefore has low exposure to interest rate fluctuations.

13.1.3 Credit risk

Because the majority of the ICB's revenue comes from Parliamentary funding, the ICB has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

13.1.4 Liquidity risk

The ICB is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The ICB draws down cash to cover expenditure, as the need arises. The ICB is not, therefore, exposed to significant liquidity risks.

13.1.5 Financial Instruments

As the cash requirements of the ICB are met through the estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with the ICB's expected purchase and usage requirements and the ICB is therefore exposed to little credit, liquidity or market risk.

Notes to the financial statements (continued)

13. Financial instruments (continued)

13.2 Financial assets

	Financial Assets measured at amortised cost 31 March 2024 £000	Total 31 March 2024 £000	Financial Assets measured at amortised cost 31 March 2023 £000	Total 31 March 2023 £000
Contract and other receivables:				
· NHSE bodies	1,608	1,608	5,752	5,752
· Other DHSC group bodies	8,122	8,122	515	515
· External bodies	6,156	6,156	5,101	5,101
Cash and cash equivalents	1,430	1,430	1,624	1,624
Total Financial assets	**17,316**	**17,316**	**12,992**	**12,992**

13.3 Financial liabilities

	Other 31 March 2024 £000	Total 31 March 2024 £000	Other 31 March 2023 £000	Total 31 March 2023 £000
Trade and other payables:				
· NHSE bodies	2,272	2,272	2,727	2,727
· Other DHSC group bodies	90,107	90,107	31,529	31,529
· External bodies	442,849	442,849	440,067	440,067
Total Financial liabilities	**535,228**	**535,228**	**474,323**	**474,323**

14. Operating segments

The ICB has considered the definition of an operating segment contained within IFRS 8 in determining its operating segments, in particular considering the internal reporting to the Integrated Care Board, considered to be the 'chief operating decision maker' of the ICB, which was used for the purpose of resource allocation and assessment of performance.

All activity performed by the ICB relates to its role as a commissioner of healthcare for its relevant population. As a result, the ICB considers that it has only one operating segment, being the commissioning of healthcare services.

An analysis of both the income and expenditure and net assets relating to the segment can be found in the Statement of Comprehensive Net Expenditure and Statement of Financial Position respectively.

Notes to the financial statements (continued)

15. Pooled budgets

Individual pooled budget arrangements exist between the ICB and each of the 13 Local Authorities across the North East and Cumbria in respect of the Better Care Fund, through a section 75 agreement. The ICB contribution to the pooled budget was used to commission a range of health and social care services in line with the agreed objectives of the Better Care Fund. During 2023/24, the BCF agreements also include an allocation from the Adult Social Care Discharge Fund. This contribution to the Better Care Fund is recognised within the financial statements as ICB expenditure.

A number of other pooled budget arrangements exist with Local Authorities across the North East and Cumbria as set out below.

Management have assessed that joint control does not exist for any of these arrangements. The ICB's share of expenditure handled by the pooled budget in the financial period are shown below.

			Amount recognised in entity's books only 2023/24		Amount recognised in entity's books only 2022/23	
Name of arrangement	Parties to the arrangement	Description of Prinicipal Activities	Income £000	Expenditure £000	Income £000	Expenditure £000
Better Care Fund	NENC ICB / Durham County Council	See note (1) below on Better Care Fund	-	55,888	-	40,151
Better Care Fund	NENC ICB - Northumberland County Council	See note (1) below on Better Care Fund	-	30,943	-	22,496
Better Care Fund	NENC ICB / South Tyneside Council	See note (1) below on Better Care Fund	-	25,710	-	17,907
Better Care Fund	NENC ICB / Sunderland City Council	See note (1) below on Better Care Fund	-	32,789	-	125,746
Better Care Fund	NENC ICB / Lancashire & South Cumbria ICB / Cumbria County Council	See note (1) below on Better Care Fund	-	32,518	-	22,714
Better Care Fund	NENC ICB / Newcastle Local Authority	See note (1) below on Better Care Fund	-	29,912	-	21,466
Better Care Fund	NENC ICB / Gateshead Local Authority	See note (1) below on Better Care Fund	-	20,802	-	15,029
Better Care Fund	NENC ICB / Darlington Borough Council	See note (1) below on Better Care Fund	-	10,057	-	7,290
Better Care Fund	NENC ICB / Stockton Council	See note (1) below on Better Care Fund	-	18,227	-	13,218
Better Care Fund	NENC ICB / Hartlepool Council	See note (1) below on Better Care Fund	-	9,457	-	6,808
Better Care Fund	NENC ICB / Redcar & Cleveland Council	See note (1) below on Better Care Fund	-	14,340	-	10,365
Better Care Fund	NENC ICB / Middlesbrough Council	See note (1) below on Better Care Fund	-	14,989	-	10,749
Better Care Fund	NENC ICB / North Tyneside MBC	See note (1) below on Better Care Fund	-	21,284	-	15,397
Gateshead Carers	NENC ICB / Gateshead Local Authority	Carers Service	-	510	-	341
Section 75	NENC ICB / South Tyneside Council	Care of Learning Disability Clients	-	11,426	-	7,079
Section 75	NENC ICB / South Tyneside Council	Delivery of legal advice in respect to CHC, Joint packages and S117	-	25	-	19
Section 75	NENC ICB / South Tyneside Council	Equipment Store	-	761	-	520
Section 76	NENC ICB / South Tyneside Council	Joint Commissioning Unit	-	612	-	423
Children's Preventative Care	NENC ICB / Sunderland City Council	Children's Preventative Care and improving commissioning initiatives	-	2,272	-	2,256
Gateshead Equipment Service	NENC ICB / Gateshead Local Authority	Purchase of home loans equipment for Gateshead residents	-	1,822	-	1,210
Tees Community Equipment Service	NENC ICB / Middlesbrough Council / Hartlepool Council / Stockton Council / Redcar & Cleveland Council	Tees Community Equipment Service	-	1,328	-	842

(1) The Better Care Fund is a Section 75 Agreement designed to integrate health and social care services, reduce hospital based care and promote community based services.

Notes to the financial statements (continued)

16. Related party transactions

During 2023/24, the ICB has undertaken transactions with the following Integrated Care Board members or members of the key management staff, or parties related to any of them:

Integrated Care Board Members	Declaration	Related Party	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
S Allen						
Chief Executive	Board Member	Health Innovations NENC (formerly Academic Health Sciences Network)	4,000	(60)	1,989	-
D Chandler						
Executive Director of Finance	Chair of Northern Branch	HFMA	20	-	15	-
	GP Partner	Cestria Health Centre	2,521	-	119	-
	Practice is a member	Chester-le-Street Primary Care Network	2,209	-	90	-
	Practice is a member	Chester-le-Street Health Ltd	252	-	51	-
Dr N O'Brien	Practice is member of Central Durham GP Providers Ltd	Coxhoe Medical Practice	1,250	-	37	-
Executive Medical Director	Practice is a member	Central Durham GP Providers Ltd	1,927	-	65	-
L Buckley						
Executive Area Director (North Cumbria and North)	Partner is Chief Executive of Healthworks	Healthworks	508	-	52	-
Professor G Evans						
Executive Chief Digital & Information Officer	Wife is a Trustee	Butterwick Hospice Trust	534	-	-	-
D Gallagher						
Executive Area Director (Central and South)	Non-Executive Director (until 17 August 2023)	Health Innovations NENC (formerly Academic Health Sciences Network)	4,000	(60)	1,989	-
Dr M Smith	GP Partner and PCN Clinical Director	Claypath & University Medical Group	4,822	-	285	-
Partner Member - PMS	Practice is member of Central Durham GP Providers Ltd	Central Durham GP Providers Ltd	1,927	-	65	-
J Rush						
Partner Member - NHS	Trusteee for Cumbria CVS	Cumbria CVS	519	-	-	-
A Workman						
Local Authority Partner Member	LA Partner Member (until 31 July 2023)	Stockton Borough Council	30,976	-	10,397	(70)
T Hall						
Local Authority Partner Member	LA Partner Member	South Tyneside Council	28,920	-	12,259	(56)
S Moore						
Local Authority Partner Member	LA Partner Member (until 25 May 2023)	Hartlepool Borough Council	17,142	-	4,509	(9)
C McEvoy-Carr						
Local Authority Partner Member	LA Partner Member	Newcastle City Council	61,931	-	18,937	(743)
K Bremner						
Foundation Trust Partner Member	Board member	Health Innovations NENC (formerly Academic Health Sciences Network)	4,000	(60)	1,989	-

The Department of Health and Social Care (DHSC) is regarded as the parent department. During the period the ICB has had a significant number of material transactions with entities for which the DHSC is regarded as the parent Department. For example:

- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Resolution; and,
- NHS Business Services Authority.

In addition, the ICB has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Local Authorities across the North East and North Cumbria.

Notes to the financial statements (continued)

16. Related party transactions (continued)

2022/23 comparative figures:
During the 9 month period to the 31 March 2023, the ICB undertook transactions with the following Integrated Care Board members or members of the key management staff, or parties related to any of them:

Integrated Care Board Members	Declaration	Related Party	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
S Allen Chief Executive	Board Member	Academic Health Science Network	1,388	(143)	1,217	(131)
D Chandler Executive Director of Finance	Chair of Northern Branch	HFMA	51	-	43	-
Dr N O'Brien Executive Medical Director	GP Partner	Cestria Health Centre	1,769	-	147	-
	Practice is a member	Chester-le-Street Primary Care Netwo	751	-	-	-
	Practice is a member	Chester-le-Street Health Ltd	1,123	-	68	-
	Practice is member of Central Durham GP Providers Ltd	Coxhoe Medical Practice	880	-	35	-
	Practice is a member	Central Durham GP Providers Ltd	1,369	-	93	-
C Riley Executive Director of Corporate Governance, Communications and Involvement	Non Executive Director	Explain Market Research	27	-	-	-
Professor G Evans Executive Chief Digital & Information Officer	Wife is a Trustee	Butterwick Hospice Trust	349	-	215	-
D Gallagher Executive Area Director (Central and South)	Non-Executive Director	Academic Health Science Network	1,388	(143)	1,217	(131)
Dr M Smith Partner Member - PMS	GP Partner and PCN Clinical Director	Claypath & University Medical Group	3,174	-	231	-
	Practice is member of Central Durham GP Providers Ltd	Central Durham GP Providers Ltd	1,369	-	93	-
M Adams Executive Director of Place Based Delivery - North Cumbria and North	Director	Goalseeker Ltd	-	(35)	-	-
A Workman Local Authority Partner Member	LA Partner Member	Stockton Borough Council	23,830	-	11,734	-
T Hall Local Authority Partner Member	LA Partner Member	South Tyneside Council	27,236	-	16,159	(99)
S Moore Local Authority Partner Member	LA Partner Member	Hartlepool Borough Council	13,311	-	3,933	-
C McEvoy-Carr Local Authority Partner Member	LA Partner Member	Newcastle City Council	43,668	-	19,744	(703)
K Bremner Foundation Trust Partner Member	Board member	Academic Health Science Network	1,388	(143)	1,217	(131)

Notes to the financial statements (continued)

17. Events after the end of the reporting period

There are no post balance sheet events which would have a material effect on the financial statements of the ICB.

18. Losses and special payments

There have been a total of eighteen losses recorded during the year for the total value of £110k, in relation to administrative write offs of seventeen aged debts and one salary overpayment. In 2022/23 there were seventeen ex gratia payments made for the total value of £13k in relation to lease car VAT repayments.

19. Financial performance targets

ICBs have a number of financial duties under the NHS Act 2006 (as amended).

The ICB's performance against those duties was as follows:

	12 months to 31 March 2024 Target £000	12 months to 31 March 2024 Performance £000	Duty Achieved?
Capital resource use does not exceed the amount specified in Directions	-	-	**Yes**
Revenue resource use does not exceed the amount specified in Directions	7,636,281	7,631,792	**Yes**
Revenue administration resource use does not exceed the amount specified in Directions	62,371	60,811	**Yes**
Additional directions on resource use: funding for agenda for change pay offer	-	-	**Yes**

Prior period comparatives:

	9 months to 31 March 2023 Target £000	9 months to 31 March 2023 Performance £000	Duty Achieved?
Capital resource use does not exceed the amount specified in Directions	-	-	**Yes**
Revenue resource use does not exceed the amount specified in Directions	5,173,834	5,171,090	**Yes**
Revenue administration resource use does not exceed the amount specified in Directions	47,427	41,850	**Yes**
Additional directions on resource use: funding for agenda for change pay offer	1,372	1,372	**Yes**

ICB financial performance is reported on an in-year basis. The figures within this note reflect only the in-year position, being the difference between the in-year allocation (plus any pre-approved surplus drawdown) and total expenditure.

The ICB received no capital resource during 2023/2024 and incurred no capital expenditure (2022/23: none).

Performance against the revenue expenditure duties is further analysed below:

	12 months to 31 March 2024 Programme Resource £000	12 months to 31 March 2024 Administration Resource £000	12 months to 31 March 2024 Total £000
Revenue resource	7,573,910	62,371	**7,636,281**
Net operating cost for the financial period	7,570,981	60,811	**7,631,792**
Underspend against revenue resource	**2,929**	**1,560**	**4,489**

The ICB has delivered an in-year surplus of £4,489k for 2023/24. This was planned in order to offset deficits within other organisations within the Integrated Care System.

Prior period comparatives:

	9 months to 31 March 2023 Programme Resource £000	9 months to 31 March 2023 Administration Resource £000	9 months to 31 March 2023 Total £000
Revenue resource	5,126,407	47,427	**5,173,834**
Net operating cost for the financial year	5,129,240	41,850	**5,171,090**
(Over)/underspend against revenue resource	**(2,833)**	**5,577**	**2,744**

The ICB delivered an in-year surplus of £2,744k for the nine months to 31 March 2023.

Independent auditor's report to the Board of NHS North East and North Cumbria Integrated Care Board

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of NHS North East and North Cumbria Integrated Care Board ('the ICB') for the year ended 31 March 2024, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2023/24 as contained in the Department of Health and Social Care Group Accounting Manual 2023/24, and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to Integrated Care Boards in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2024 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2023/24; and
- have been properly prepared in accordance with the requirements of the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, and taking into account the requirements of the Department of Health and Social Care Group Accounting Manual, we have not identified any

material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on regularity

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Responsibilities of the Accountable Officer for the financial statements

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

The Accountable Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2023/24 and prepare the financial statements on a going concern basis, unless the ICB is informed of the intention for dissolution without transfer of services or

function to another public sector entity. The Accountable Officer is responsible for assessing each year whether or not it is appropriate for the ICB to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice and as required by the Local Audit and Accountability Act 2014.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the ICB, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health Care Act 2022) and we considered the extent to which non-compliance might have a material effect on the financial statements.

To help us identify instances of non-compliance with these laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- inquiring with management and the Audit Committee, as to whether the ICB is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the ICB which were contrary to applicable laws and regulations, including fraud.

We evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, significant one-off or unusual transactions and the risk of fraud in financial reporting

relating to expenditure recognition due to the potential to inappropriately record expenditure in the wrong period.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected, or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud;
- addressing the risks of fraud through management override of controls by performing journal entry testing; and
- addressing the risk of fraud in expenditure recognition through testing payments in the pre and post year end period to ensure they were recognised in the right year, sample testing material period-end payables and provisions and reviewing intra-NHS reconciliations and data matches provided by the Department of Health and Social Care.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls.

We are also required to conclude on whether the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in February 2023.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at **www.frc.org.uk/auditorsresponsibilities**. This description forms part of our auditor's report.

Report on the ICB's arrangements for securing economy, efficiency, and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2024.

We have nothing to report in this respect.

Responsibilities of the Accountable Officer

As explained in the Statement of Accountable Officer's responsibilities, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency, and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency, and effectiveness in the use of resources

We are required under section 21 of the Local Audit and Accountability Act 2014 to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency, and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in May 2024.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Health and Care Act 2022; and
- the other information published together with the audited financial statements in the Annual Report for the period for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the ICB under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

Use of the audit report

This report is made solely to the members of the Board of NHS North East and North Cumbria ICB, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the ICB, as a body, for our audit work, for this report, or for the opinions we have formed.

Certificate

We certify that we have completed the audit of NHS North East and North Cumbria ICB in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Cameron Waddell, Key Audit Partner

For and on behalf of Forvis Mazars LLP

The Corner

Bank Chambers

26 Mosley Street

Newcastle upon Tyne

NE1 1DF

26 June 2024