NHS
North East and
North Cumbria

Board Meeting (in public)

MEETING
28 March 2023 09:15 BST

PUBLISHED
22 March 2023

Agenda

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Mayors Parlour, City Hall, Sunderland	28 Mar 2023	09:15

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5	Action log	Chair		23
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6.1	Follow up on the data examples from the digital presentation	Executive Chief Digital and Information Officer	09:20	24
6.2	Follow up on the Bill Kirkup presentation on maternity - developing a system approach to tackling the challenges (presentation)	Executive Chief of Strategy and Operations / Executive Chief Nurse	09:25	—
7	STRATEGY			—
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7.2	Learning and Improvement System (presentation)	Executive Director of People	09:50	—
7.3	Interim ICB Equality, Diversity and Inclusion Strategy 2023/24 (presentation)	Director of Health, Equity and Inclusion	10:25	—
7.4	Healthier and Fairer Advisory Group progress (presentation)	Executive Medical Director	10:55	—
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8	INTEGRATED PERFORMANCE			—
8.1	Integrated Delivery Report	Executive Chief of Strategy and Operations	11:30	96
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9	GOVERNANCE AND ASSURANCE			—
9.1	Governance Handbook (Issue 5)	Executive Director of Corporate Governance, Communications and Involvement	12:30	176

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9.2	Highlight reports and confirmed minutes of the Committees of the Board			—
9.2.1	Executive Committee - confirmed minutes 10 January and 14 February 2023	Committee Chair	12:35	343
9.2.2	Quality and Safety Committee - confirmed minutes 15 December 2022	Committee Chair	12:40	379
9.2.3	Finance, Performance and Investment Committee - confirmed minutes 12 January and 2 February 2023	Committee Chair	12:45	383
10	Questions from the Public on Items on the Agenda	Chair	12:50	—
11	Any Other Business from Members	Chair		—
12	Close	Chair		—

Item 4

NHS
North East and North Cumbria

North East and North Cumbria Integrated Care Board
Minutes of the meeting held on 31 January 2023 at 08:45,
The Durham Centre, Belmont

Present:
Professor Sir Liam Donaldson, Chair
Samantha Allen, Chief Executive
Aejaz Zahid, Executive Director of Innovation
Ann Workman, Local Authority Partner Member
Annie Laverty, Executive Chief People Officer
Claire Riley, Executive Director of Corporate Governance, Communications and Involvement
David Chandler, Interim Executive Director of Finance
David Gallagher, Executive Area Director (Central and South)
David Purdue, Executive Chief Nurse
David Stout, Independent Non-Executive Member
Professor Eileen Kaner, Independent Non-Executive Member
Professor Graham Evans, Executive Chief Digital and Information Officer
Dr Hannah Bows, Independent Non-Executive Member
Jacqueline Myers, Executive Chief of Strategy and Operations
Jon Rush, Independent Non-Executive Member
Ken Bremner, Foundation Trust Partner Member
Dr Mike Smith, Primary Medical Services Partner Member
Dr Neil O'Brien, Executive Medical Director
Rajesh Nadkarni, Foundation Trust Partner Member
Dr Saira Malik, Primary Medical Services Partner Member
Tom Hall, Local Authority Partner Member

In Attendance:
David Thompson, North East and North Cumbria Healthwatch Network Representative
Deborah Cornell, Director of Corporate Governance and Involvement
Jane Hartley, Voluntary Organisations' Network North East (VONNE)
Toni Taylor, Governance Officer (minutes)

B/2023/67 Welcome and Introductions

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

The following individuals were in attendance under public access rules:
- Scott Jamieson, Healthcare Development Manager, Eli Lily and Company (pharmaceutical company)
- Colin Donald, Smith and Nephew (medical equipment manufacturer)
- Judith McGuiness, Programme Manager, NHS England
- Robert Hope, Regional Partnership Lead (North), NHS Business Services Authority.

B/2023/68 Apologies for Absence

Apologies were received from Councillor Shane Moore, Local Authority Partner Member, Catherine Mcevoy-Carr, Local Authority Partner Member, Nicola Bailey, Executive Area Director (North and North Cumbria).

It was noted Dr Hannah Bows would be joining the meeting late and Joe Corrigan, Director of Place (Newcastle) was in attendance deputising for Nicola Bailey.

B/2023/69 Declarations of Interest

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

Professor Eileen Kaner highlighted a conflict under item 7.1 with regards to the ICB receiving an award of £250,000 from the Health Foundation to continue the evaluation of Learning and Improvement system. Professor Kaner is currently Director of the National Institute for Health and Care Research (NIHR). The Chair noted the declaration of interest which was already included on the published register.

B/2023/70 Minutes of the previous meeting held on 29 November 2023

As a point of accuracy, the following amendments were to be made to the minutes;

- The inclusion of David Stout, Independent Non-Executive Member and David Purdue, Executive Chief Nurse who had attended the meeting held on 29 November 2022.

- Page 7, elective care, paragraph 1 - there were currently 334,389 patients in the region waiting for elective treatment.

Item 4

B/2023/71 Matters arising from the minutes

There were no matters arising.

B/2023/72 Notification of items of any other business

There were no additional items of business raised.

B/2023/73 Chief Executive's Report

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

National Planning Guidance
Government plans to recover urgent and emergency care services launched 30 January 2023 and the Prime Minister, Health Minister and Chief Executive of NHS England undertook a visit to North Tees Hospital Trust. The trust has been cited nationally as good practice specifically around admission avoidance, out of hospital care and the development of virtual wards. At the heart of this is the relationships with local authorities and the multiple pathways in place to support people to receive care and support at home wherever possible. North Tees Hospital Trust have one of the lowest percentages for non-criteria to reside in hospital, which has attracted significant national interest and the visit from the Prime Minister. It was acknowledged that the challenge will be how to replicate this good work in other areas.

The Prime Minister also visited Teesside University and took the opportunity, with the national press in attendance, to present the Government's plan to recover urgent and emergency care services.

North East and North Cumbria Integrated Care Board will be looking at the Government Plan with focus on priority areas;

- Earlier triage, supporting patients to be signposted into the right support at the right time, with continued focus on discharge and primary care access.
- The national plan announced 800 additional ambulances, 100 of which are mental health ambulances. This is also being explored in North East and North Cumbria.
- Increased capacity of hospital beds.
- Out of hospital / community services including care homes and hospices.

The Chief Executive commended the teams in local authorities and NHS foundation trusts for their ongoing work to maximise the use of resource for the benefit of the system, patients, families and staff.

System Resilience

The urgent and emergency care system across the country and North East and North Cumbria has been significantly challenged due to a combination of demand, capacity in urgent and emergency care, flow and discharge, staff absences and vacancies and industrial action. The whole system is working tirelessly to meet demand across a wide range of service delivery and new initiatives.

The ICB has undertaken some rapid after reviews following the industrial strikes and continues to put the learning to good use. A Board development session has been arranged to look at the strategic control centre and how this is currently being utilised. The ICBs Executive Medical Director recently met with the Chief Officer responsible for emergency planning across England to look at how the strategic control centre was set up and how the data is being used.

Emergency Preparedness, Resilience and Response Framework

As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS-funded services must show they can effectively respond to major, critical and business continuity incidents while maintaining services to patients.

The NENC ICB had undertaken a self-assessment against the 2022 updated core standards as per the NHS England EPRR Core Standards guidance. An overall assurance rating had been assigned based on the percentage of NHS Core Standards which the organisation assessed as being partially compliant at 81%.

A peer review process was undertaken with the regional team at NHS England and noted that the other three ICBs in the region had also been assessed as partially compliant.

The areas which are currently assessed as partially compliant (as well as those fully compliant) for the NENC ICB will be monitored regularly and enhanced and improved as part of an action plan.

RESOLVED:

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

The Board **ENDORSED** the submission to NHS England as part of the Emergency Preparedness, Resilience and Response annual assurance process for 2022-23.

B/2023/74 Integrated Delivery Report

The report provided an overview of quality, performance and finance.

An error was noted on page 112 – the six reported never events related to South Tees Hospital Foundation Trust rather than South Tyneside and Sunderland NHS Foundation Trust.

Key points were highlighted as follows:

Ambulance handover delays
Data currently shows a concerning trend in handover delays. Target is 18 minutes, but some instances have seen this reach up to 60 minutes. In the month of December, the national average was 90 minutes. Improvements have been made since data was published and delays decreasing to 20 minutes. The target for the coming year is expected to be 30 minutes; it is anticipated that the North East and North Cumbria are in a position to meet this target.

NHS England escalation for cancer and elective
The target to eliminate waits of 78 weeks is set nationally. County Durham and Darlington NHS Foundation Trust are under enhanced national surveillance due to the 78+ week waiters' reduction being behind plan. As a result, the trust has been moved into Tier 2 escalation with additional support regionally and nationally. This provides risk overall in the ICB meeting the national target. Work is underway with the trust to put a recovery plan in place.

ACTION:
A further update to be brought to a future Board meeting with regards to County Durham and Darlington NHS Foundation Trust.

There has been a sustained and significant reduction in the number of people waiting beyond 104 weeks for elective procedures, complex spinal procedures being the remaining area of pressure with 24 currently on the waiting list.

The Provider Collaborative is taking the lead in a system wide approach to return waiting times back to the national standards. A fundamental point will be restoring diagnostic and treatment capacity to beyond pre-pandemic levels. It was recognised that this will be challenging should the numbers referred exceed the numbers treated. There are currently significant issues around

capacity, and planning guidance is expected to include new mechanisms for incentivising capacity.

A further area of work is in relation to mutual aid and providers working together to share capacity across the region.

Work is underway to look at innovative ways to respond to the demand in care, redesigning pathways to be more efficient, getting people rapidly to a diagnosis and looking at treatment pathways. Clinical networks are being established with clinical specialities and input looking at primary, secondary and tertiary care. The Provider Collaborative will set out plans for the ICB to show how interventions coming together can reduce waiting times.

Primary Care Appointments

Reported a record number of general practice appointments occurring specifically for the month of October. 1.7 million appointments took place in October across North East and North Cumbria compared to 1.5 million in September. It was noted the demand being managed within general practice is generating pressures on primary care services.

The reported was welcomed and the detail noted. The lack of indicators for primary care under the quality section of the report was raised. The current indicators report the number of appointments attended face to face and the number of appointments not attended. The development of a set of primary care indicators was requested and therefore the Board should start to see the changes in the next reporting period.

There is opportunity for more detailed reports to be made more openly available to both the Board and the public. The reports could provide commentary linking a set of data with the strategy and improvement plans to see the progress made against them.

Health inequalities

It was noted 25% of patient records for those on acute waiting lists do not have ethnicity status recorded and it was queried what steps could be taken to increase this. Questions around inequalities are still being developed.

Improving Access to Psychological Therapies (IAPT) waiting times have increased. It was suggested this waiting list be monitored from a health and inequalities perspective in the same way as the acute waiting lists.

Performance management arrangements

Performance management arrangements have now been implemented with a set of oversight meetings scheduled with foundation trust providers. Monthly touch point meetings have

been arranged in addition. A first meeting had taken place with good feedback on the initial process and further actions identified.

Oversight arrangements with the eleven foundation trusts has been rolled out, with a view to do a full cycle and review. Further work is to be carried out to provide oversight over the wider system including primary care and placed based committees which are in the process of formally established.

The ICB is working closely with NHS England, who have approved the proposed memorandum of understanding, and are reshaping some of the ways they work in response.

It was noted the current metrics and focus is on the supply rather than demand. Further work to be undertaken.

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

B/2023/75 Finance Report

The report provided an update on the financial performance of the Integrated Care Board and Integrated Care System for the period to 30 November 2022.

The full financial report for the period was reviewed in detail by the Finance, Performance and Investment Committee at its meeting on 5 January 2023.

Key points were noted as follows:

ICS duty to break-even
NHS England have officially agreed to allocate £19.9m towards pressures of the ICS duty to breakeven this year.

Working with Chief Executive Officers and ICB leads, a financial plan has been agreed to deliver a break-even plan and reduce those risks to a minimal level. The plan reduces the risk of organisations failing into a deficit. This plan will be discussed at the next Finance, Performance and Investment Committee.

NHS England has reported that the ICB will receive an additional £17m capital funding should the organisation achieve a breakeven position. It was noted that the ICBs capital departmental expenditure limit is circa £187m each year.

ICB duty to break-even
Financial pressures are being reported around independent activity, prescribing pressures and care packages. Mitigations

have been put in place to manage some of these pressures through the overall plan for the ICS. The ICB continues to seek additional funding from NHS England for independent sector activity. The latest forecast for the ICB is the independent sector activity will increase by £25 from 2019/20 – 2022/23. The system is working closely to manage risks that may arise from now until year end.

ICS capital position
There is a potential forecast pressure of almost £14m on capital spending plans across the ICS in comparison to the confirmed ICS capital departmental expenditure limit (CDEL) allocation. Assurance from the Provider Collaborative is expected by year end that a break-even position will be achieved.

ICB running costs
Running costs for 2022/23 are expected to be around £2m. It was noted that ICB costs are not increased for inflation or pay awards which in turn causes year on year pressure.

2023/24 planning
Financial planning for 2023/24 to achieve break even or better will be extremely challenging for the ICB and ICS. Working closely with system partners on the production of financial plans including system and ICB planning leads. The draft plan is due in February with the final plan due in March. An infrastructure is in place with partners to allow these deadlines to be met.

Growth funding is a key instrument in terms of financial health for a system. Growth funding for next year will be below average at 2.92%, nationally, the average is 3.4%. The growth funding, alongside inflation pressures means there is additional pressures in producing the financial plan.

Elective recovery funding
Elective recovery funding will increase from £105m to £140m next year, resulting in a £35m increase. Activity is expected to increase by 9%.

Covid funding
Covid funding will be reduced from £125m this year to £25m next year, this is a significant reduction which will impact on the parts of the system still dealing with the aftermath of the pandemic.

RESOLVED:
The Board **RECEIVED** the report for assurance and **NOTED** there were potential financial risks across the ICS still to be mitigated.

B/2023/76 Integrated Care Strategy

The Integrated Care Strategy was approved by the Integrated Care Partnership (ICP) Board on 15 December 2022.

The Board was asked to receive the strategy and note that the date of the Board meeting will be marked by a public launch of the strategy.

Once agreed for publication, the ICB will, on behalf of the ICP, develop a range of materials to support the communication of the strategy which will be made available to all partners and interest groups. This includes commissioning easy read versions of this document.

The strategy set out clear ambitions and goals for better health and wellbeing, namely:

1. Longer and healthier lives for all
2. Fairer health outcomes for all
3. Best start in life for our children and young people
4. Improving health and care services

It was reported that the Healthier and Fairer Advisory Group will meet for the first time February and a progress update will be reported to the Board. It was acknowledged that one of the main workstream for this group is prevention, looking to reduce alcohol and tobacco consumption and promote healthy weight and active lives.

ACTION:
The Healthier and Fairer Advisory Group update to be presented at Board on 28 March 2023.

The ICP will work closely with the primary care networks (PCNs) which have been established to support primary care development.

It was noted that enabling strategies to help achieve these goals include;

- A skilled, compassionate and efficient workforce
- Working together to strengthen our neighbourhoods and places
- Innovating with improved technology, data, equipment and research
- Making the best use of our resources
- Protecting the environment
- Involving people

To support the delivery of this strategy delivery plans will be developed including frameworks to support delivery at local authority place level.

This Board were reminded that the strategy will not replace individual organisation or health and wellbeing board strategies but should complement them and provide overarching goals.

The ICB is required to produce a five year forward plan that sets out how the strategy will be delivered. The first year of the five year forward plan will be in more detail when developed, than previous years; the plan will be refreshed on an annual basis. It is essential that this plan includes the support of both the foundation trusts and the local authority partners in the ICB. A draft is required by the end of March with a final approved version by the end of June 2023.

The Board wished to note their thanks to colleagues involved in producing the comprehensive and ambitious strategy document.

RESOLVED:
The Board **NOTED** the oversight arrangements set out within the report.

B/2023/77 The use and development of information systems for the work of the ICB

The Executive Chief Digital and Information Officer presented the use and development of information systems for the work of the ICB.

The United Kingdom (UK) Government presented a National Data Strategy in 2019 which was mandated to improve data and hopefully improve UK economy.

In 2022 the Department of Health and Social Care published the Data Saves Lives policy paper.

The ICS produced a Digital Strategy 2020 – 2024 well in advance of the National Data Strategy and The Data Saves Lives policy paper.

Following the publication of the Better Health and Wellbeing Strategy in December 2022, the Data and Digital Strategy will be refreshed. It is the intention to have a combined Digital and Data Strategy referencing the key elements of the overarching ICS strategy by March 2023. Following which this combined strategy will inform the five year forward plan. In addition to this a bid for Sub National Secure Data Environment had been successful which will help improve health outcomes of our population and is integral to the data strategy.

It was reported that lessons from past failings of programmes that were not developed or deliver the outcomes originally intended are being used to ensure learning as a health system.

The Board noted that there are six components to the digital infrastructure;

1. Data use cases and domains
2. Data visualisation and presentation/tooling
3. Data security and governance
4. Data storage
5. Data management
6. Data sources

The ICB work in partnership with North East Commissioning Support, utilising business intelligence and analytic services, a 5-tier model and subject matter / domain experts to help understand the data.

The Board was made aware that the ICB is currently working with NHS England to produce an academic programme across the North East and North Cumbria and have been identified as a potential vanguard of developing this programme of work.

A Chairman's Challenge paper shared with the Board presented a series of questions that will be used to determine the current data provision capabilities. Three questions were selected and explored;

<u>Are people with diabetes receiving a standard of care that gives the lowest possible level of avoidable complications of their disease?</u>
There are 9 key care processes for diabetes.
28% of adult diabetics had all 9 in the past year.
57% had at least 8.

<u>What is known about levels of incapacity and frailty of older people living at home?</u>
67,000 people aged 65+ are moderately or severely frail.
50% of people aged 95+ have moderate or severe frailty.

<u>What progress is being made in controlling tobacco-related disease?</u>
The Covid-19 pandemic has impacted the capture of carbon monoxide reading confirmed quits, improvement should be monitored from 2022/23 onwards as service returns to some level of normality. Hartlepool has had no stop smoking service since 2019/20. The North Cumbria service has been declining following the Covid-19 pandemic however they are looking to reinvest the service from quarter four 2022/23. Smoking prevalence has a target of 5.0% by 2030.

The recent successful bid for the Secure Data Environment is already enabling the mobilisation of opportunities, taking learning as a measurement and feedback into the system to improve data sets.

Further work is required around patient engagement giving them a platform around patient preference, but also to gain understanding and trust around the benefits of this. It is important to ensure the eight Caldicott Principles are linked into this work. The priority over the next six months is to build the confidence of stakeholders.

With the infrastructure in place, there is capability to gather data from all sources with relevant controls including crime, social care, domestic abuse and link together providing opportunity to involve and work with different organisations and communities.

ACTION
Chief Executive Digital and Information Officer to present the use and development of information systems for the work of the ICB at the Integrated Care Partnership meeting.

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

B/2023/78 Managing and improving hospital discharge: a system overview

The Executive Chief Nurse presented managing and improving hospital discharge: a system overview.

Acute hospital care for older patients saves lives and planned care for older patients helps them to remain independent. Large numbers of older patients stay in hospital longer than appropriate because meeting their health and social needs in the community is not always possible.

The Board were informed that the adverse effects of prolonged hospitalisation are;

- Pre-admission level of independence is lost quickly
- With three or more nights delay, 1 in 10 will suffer actual harm
- With a delay of five or more nights, 1 in 5 deteriorate so badly they cannot be discharged
- By 28 days, 1 in 3 will suffer harm

Discharge is rated on the number of patients who no longer 'meet the criteria to reside'. There is a large variation across the system ranging from 25% - 3% of beds occupied.

A key factor in safe effective discharge is making sure care is tailored to the needs of the individual.

From a national context, in March 2020 due to the pandemic the Covid 19 Hospital Discharge Service Requirements was published, the focus being to free up hospital beds, putting discharge to assess in place and set out timescales.

In August 2020 the document became a Hospital Discharge Policy with further updates to include reference to community, designated settings, funding changes, and an increased focus on carers.

An updated Hospital Discharge and Community Guidance was published in March 2022 setting out how health and care systems should support the safe and timely discharge of people who no longer need to stay in hospital. A further update was expected summer 2022, however it was noted that the update is still awaited.

There is still no requirement to discharge to assess but is seen as best practice. There is currently no national funding and is therefore reliant on local area agreement.

There are currently four discharge pathways for people of 65 years and over which were noted as follows:-

<u>Pathway 0 – able to return home with no support</u>
50% discharges for people over 65.
Path determined by ward staff.

<u>Pathway 1 – need support to return home</u>
45% discharges for people over 65.
Path determined by ward based staff with support from the transfer of care hub.

<u>Pathway 2 – further rehabilitation is required in a bedded setting</u>
4% discharges for people over 65.
Path determined by therapists and transfer of care hub lead professionals.

<u>Pathway 3 – new placement into a nursing or residential care home</u>
1% discharges for people over 65.
Path determined by transfer of care hub. Clarification must be given as to why pathways 1 or 2 are not an option.
As a system there is a lot of learning and good practice being shared including learning from people's experience. Daily director of place meetings chaired by the Executive Chief Nurse are proving to be useful and helpful for the system to provide oversight of the key issues at an early stage. Multi-agency

working also provides opportunity to look at issues and what can be done differently.

The Board was advised that the Government has made a special funding allocation through the Better Care Fund, of which £26m is allocated to North East and North Cumbria. The Better Care Fund Framework 2022/23 was established to enable the right care in the right place at the right time. Implementation will introduce capacity and demand planning for intermediate care to help winter system preparation. The special funding has been allocated across the thirteen North East and North Cumbria places.

New nationally specified monitoring metrics will be introduced, along with additional funding and a complex data template which requires completion on a two week basis.

The two current mental health trusts in the region have very different data information in terms of people in delayed discharge. £1.3m funding has been dedicated to mental health provision. There has been recent development in the appointment of a Chief Information Officer to work across both trusts, which will provide opportunity for standardisation.

The strategic priorities to improve services were noted as follows:-

- Improving data accuracy (use of Optica)
- 7 day working
- Workforce planning
- Escalation

As part of the presentation the Board was given opportunity to view a short film regarding Optica, a secure cloud application which tracks patient discharges in real time and supports patient flow by minimising avoidable delayed discharges during which it was explained how Optica is used within an acute setting.

A further short film was presented, created by Stockton on Tees Borough Council regarding their hospital discharge process and integrated work with health colleagues.

It was highlighted to the Board that in terms of the existing National Institute for Health and Care Excellence (NICE) guidelines around transition between inpatient hospitals settings and community settings and an associated quality standard, that the importance of ensuring the right information is brought into hospital, especially with regards to mental health patients, is key.

NHS England personalised care leads commissioned a twelve-month piece of research on carers experience of discharge carried out by Northumbria University and Voluntary Organisations Network North East. This involved eight trusts across North East and Yorkshire and a number of carers. The report sets out

patients and carers experiences but also drawing together the discharge practice, best practice and production of the toolkit around how to which will hopefully be showcased and used to improve practice.

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

B/2023/79 Governance Handbook

The Governance Handbook (issue 1) was approved by the Board on 1 July 2022, with further amendments approved by Board on 27 September (issue 2) and 29 November 2022 (issue 3).

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

The Board was asked to note the proposed changes to the governance documents and approve the updated versions for insertion into the Governance Handbook (issue 4) as follows;

- Scheme of Reservation and Delegation version 2.0
- Standing Financial Instructions version 2.0
- Financial Delegations version 2.0
- Financial Limits version 2.0
- Executive Committee Terms of Reference version 2.0
- Quality & Safety Committee Terms of Reference version 2.0
- Finance, Performance & Investment Committee Terms of Reference version 2.0
- Audit Committee Terms of Reference version 2.0
- Governance Structure version 2.0

RESOLVED:
The Board **NOTED** the proposed changes to the governance documents and **APPROVED** the updated versions for insertion into the Governance Handbook (issue 4).

B/2023/80 Highlight Report and Minutes from the Executive Committee meetings held on 15 November and 13 December 2022.

An overview of the discussions and decisions at the Executive Committee meetings held on 15 November and 13 December 2022 was provided.

The Committee identified a risk to be added to the risk register in relation to the healthcare needs of asylum seekers.

RESOLVED:

The Board **RECEIVED** the highlight report and minutes for assurance.

B/2023/81 **Highlight Report from the Quality and Safety Committee meeting held on 15 December 2022**

An overview of the discussions at the meeting of the Committee held on 15 December was presented.

Members suggested that risk reporting be provided at each meeting, previously it was suggested as a quarterly report.

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

B/2023/82 **Highlight Report from the Finance, Performance and Investment Committee and minutes of 3 November and 1 December 2022 and 5 January 2023.**

An overview of the discussions and decisions at the Finance, Performance and Investment Committee meetings held on 3 November 2022, 1 December 2022 and 5 January 2023 was presented.

Board members were welcomed to attend a short update session scheduled prior to each committee whereby a subject expert will present on topics such as pharmacy or prescribing. It was acknowledge that this is useful for committee members to maintain knowledge and understanding.

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

B/2023/83 **Highlight Report from the Audit Committee and minutes of 13 October 2022 and 12 January 2023.**

An overview of the discussions and decisions at the Audit Committee meetings held on 13 October 2022 and 12 January 2023 was presented.

The Audit Committee received several assurance reports at its meeting on 12 January 2023 and did not identify any concerns with the assurances received.

The committee received a report outlining the timetable for the ICB to submit its Data Security & Protection Toolkit 2022/23 and

discussed with internal audit the arrangements for the audit of the toolkit. No issues were identified at this stage of the process.

The Audit Committee reviewed the proposed amendments to the Scheme of Reservation and Delegation (SORD) and agreed to recommend them to Board for approval.

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

B/2023/84 Maternity and Neonatal Services in East Kent Independent Investigation

The Chair welcomed Dr Bill Kirkup to the meeting.

Dr Bill Kirkup first worked in the NHS as a ward orderly in 1968, and qualified as a doctor in 1974. After 35 years of clinical, public health and NHS management practice in the North East and London, he retired as Associate Chief Medical Officer for England at the end of 2009. He subsequently led investigations in major organisational failures and chaired the independent investigation into East Kent maternity services.

Dr Bill Kirkup presented the findings from the East Kent Independent Investigation, which covered the period 2009 – 2020, and highlighted some underlying themes identified;

Failures of team working
- Lack of trust and respect
- Dominant egos, informal hierarchies
- Bullying and intimidation
- Inexperienced clinicians left isolated
- Lack of common purpose
- Conflicts played out publicly

Failures of professionalism
- Disrespecting women
- Disparaging colleagues
- Shifting blame to colleagues
- Blaming women for outcomes
- Played out publicly

Failures of compassion and listening
- Examples in almost every account we heard
- Dismissive and uncaring attitudes
- Not listening – labour, fetal movements
- Led directly to poor outcomes
- Left a permanent legacy

Failures after safety incidents

- Similar attitudes and behaviours
  - lack of compassion
  - blame shifting
  - defensiveness
- Denial, deflection and dishonesty
- Failure to learn

The individual and collective behaviours of those providing the services were visible to senior managers and the Trust Board in a series of reports right through the period from 2009 to 2020 and lay at the root of the pattern of recurring harm. The Board were advised that at any time during this period, the problems identified could have been acknowledged and tackled effectively. Eight clear separate opportunities were identified where this should have happened.

It was explained that had care been given to the nationally recognised standards, the outcome could have been different in 97 of the 202 cases assessed by the Panel and the outcome could have been different in 45 of the 65 baby deaths.

The Panel has not been able to detect any apparent improvement in outcomes or suboptimal care, as evidenced by the cases assessed over the period from 2009 – 2020.

Four broad areas for action were identified;

1. Maternity Signalling System – monitoring safe performance
   There is plenty of data being collected, but this is often analysed poorly, and not meaningful or timely. There are vast benefits to the effective monitoring of outcomes. Speak to staff and patients, the signals were there including a high turnover of chief executives and an under-reporting culture.

2. Standards of clinical behaviour
   Caring for patients in any setting requires not only technical skills but also kindness and compassion. Unprofessional conduct is disrespectful to colleagues and endangers and effective and safe working; it undermines the trust of women. Effective clinical leadership is crucial.

3. Flawed teamworking
   The Panel found that there was dysfunctional teamworking both within and across professional groups. The lack of trust and respect between midwives and obstetric staff, and between paediatric and obstetric staff, posed a significant threat to the safety of mothers and their babies. There is a need for the

establishment of common purpose, objectives and training from the outset.

4. Organisational behaviour
   There was denial, deflection, concealment and aggressive responses to challenge within the trust. A recommendation was made that the Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.

The Board noted that discussions have taken place with NHS England following the investigation and a conversation with the Health Minister has been scheduled; it is hopeful a formal response will be made from the Government.

The Board discussed the use of effective data and feedback from families and highlighted that the Family and Friends Test and staff surveys can be useful tools providing invaluable information. Also looking at social media activity, complaints and concerns raised could provide insight.

The Board noted the presentation and acknowledged the distressing content and how important and insightful, specifically the personal testimonies and experiences from families and staff.

RESOLVED:
The Board **THANKED** Dr Bill Kirkup for the presentation

B/2023/85 Questions from the Public on Items on the Agenda

None.

B/2023/86 Any other business

There were no other items of business.

The meeting closed at 13:30

Item: 5

Board (public)

NHS
North East and North Cumbria

Log updated: 08 March 2023

No:	Date of meeting	Minute reference	Agenda Item	Action Point	Lead	Timescale	Comments	Current status
1	7/1/2022	B/2022/08	Establishment of Board Committee Structure	The proposed committee membership to be circulated to all Board members for information	C Riley	November 2022		Closed
2	7/1/2022	B/2022/10	Adoption of key policies	All policies to be reviewed within the first six months following the establishment of the ICB to ensure they reflect an ICB perspective	All Executive Directors	February 2023	Rolling programme to update all policies. Long list currently being worked through.	Ongoing
3	11/29/2022	B/2022/49	Learning Disabilities and Autism: Building the Right Support	The Board to receive quarterly updates on the transforming care key performance indicators and progress on delivery of the ambitions of building the right support	D Purdue	January 2023	Added to cycle of business to look at more indepth at a future Board meeting	Closed
4	11/29/2022	B/2022/49	Learning Disabilities and Autism: Building the Right Support	Contact details of the Lawnmowers Independent Theatre Company to be shared with the Executive Director of Place (North and North Cumbria)	D Purdue	December 2022		Closed
5	11/29/2022	B/2022/52	Integrated Delivery Report	An indepth review into the work of the discharge funding to be presented at the next board meeting.	D Purdue	January 2023	Presentation at January Board	Closed
6	11/29/2022	B/2022/56	NHS England Commissioning Delegations - Primary care and Specialised Commissioning	A further update to be brought to the Board in March on the delegation of POD services prior to the proposed delegation on 1 April 2023 and on progress for the proposed delegation of specialised services to the ICB.	D Gallagher / J Myers	March 2023	Update to be included in Chief Executive's Report for March Board meeting	Closed
7	1/31/2023	B/2023/74	Integrated Delivery Report	A further update to be brought to a future Board meeting with regards to County Durham and Darlington NHS Foundation Trust tier 2 escalation.	J Myers	March 2023	Update to be included in March report	Ongoing
8	1/31/2023	B/2023/76	Integrated Care Strategy	The Healthier and Fairer Advisory Group update to be presented at Board in March.	N O'Brien	March 2023	On agenda 28 March 2023	Closed
9	1/31/2023	B/2023/77	The use and development of information systems for the work of the ICB	Executive Chief Digitial and Information Officer to present at the Intragted Care Partnership (ICP) meeting.	G Evans	June 2023	On agenda for next ICP meeting on 21 June 2023	Closed

Item: 6.1

NHS
North East and North Cumbria

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

BOARD 28 March 2023	
Report Title:	The use and development of information systems for the work of the Integrated Care Board (ICB) – Follow up report.

Purpose of report

The purpose of this paper is to provide a further update in relation to the NHS North East and North Cumbria (NENC) ICB Board of Directors meeting of 31 January 2023.

Key points

- The paper presents a further update to the series of questions being used to determine the current data provision capabilities. Appendix 1 - includes the most recent data sets and associated infographics. This paper compliments the previous report and associated presentation by the ICB Executive Chief Digital and Information Officer.
- At the point of reporting, there are still some data and reporting gaps, as data is not available or able to be collected. There will be more work undertaken to close these remaining gaps.

Risks and issues

- There is an increasing dependency on data and analytics services to support the ICB's strategic and operational needs, as well as broader insight to inform and transform population health and associated care services.
- The ICB's data, analytics and insight strategic approach, requires all parts of the integrated care system to provide, high quality timely and accurate data.
- Subject matter/domain experts will need to work in partnership with data and analytics experts to contextualize data and develop appropriate actionable insights.
- It is evident that not all data items are currently available in order to fully respond to all questions being asked.

Assurances

- The ICB's data and analytics service development has the full commitment and support of the ICB board and Executive team and is recognised as a critical service.

Recommendation/action required

The challenge questions set have illustrated the availability and interpretation of data is broadly available within the digital and data services supporting the Integrated Care Board and wider Integrated Care System. From the source data available within this revised report, there is a general conclusion that it is broadly:

a) relevant, meaningful, accurate and up to date.
b) capable of enabling valid judgements based on comparisons of service performance over time and between similar services delivered in different localities.
c) accepted and valued by clinicians and other staff;
d) can and will be used and relied on by system and organisational leaders and managers;
e) trusted by patients, service users and the public.

There are some remaining data gaps that continue to be addressed in order fully complete the challenge requirements.

Acronyms and abbreviations explained

All acronyms/abbreviations used have been explained within the body of the report.

Sponsor/approving director	Professor Sir Liam Donaldson
Report author	John Fitzsimmons/Professor Graham Evans

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

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

Relevant legal/statutory issues

N/A

Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	**X**	**N/A**	

If yes, please specify

Item: 6.1

Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	**X**
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	**X**

Key implications	
Are additional resources required?	No
Has there been/does there need to be appropriate clinical involvement?	N/A
Has there been/does there need to be any patient and public involvement?	N/A
Has there been/does there need to be partner and/or other stakeholder engagement?	No

Item: 6.1

NHS
North East and
North Cumbria

CHAIRMAN'S CHALLENGE: WHAT IS THE CAPABILITY OF CURRENT INFORMATION SYSTEMS TO ANSWER KEY PERFORMANCE QUESTIONS ABOUT THE INTEGRATED CARE SYSTEM?

Purpose

The purpose of this paper is to provide a further update in relation to the NHS North East and North Cumbria (NENC) ICB Board of Directors meeting of 31 January 2023 and further contribute to the Board level exploration of the capability of existing sources information underpinning the delivery of these responsibilities and generate a common understanding across the Integrated Care System (ICS).

This report provides a progress update of the data readily available as well as illustrating the remaining data gaps – the report compliments the data provided in Appendix 1.

Illustrative questions

The following section of the report builds on the original report and now includes responses by each of the 10 challenge questions.

As a reminder, the questions were not intended to systematically and comprehensively cover the ICB's work. Nor is the list of data 'requests' intended to be exhaustive, simply to enable a free-ranging discussion amongst board members.

1. ***Are people with diabetes receiving a standard of care that gives the lowest possible level of avoidable complications of their disease?***

Rationale*: Diabetes is a common non-communicable disease that affects large numbers of people. If it is well-managed, known adverse outcomes can be eliminated or their onset delayed. These include premature death or disability (e.g. from heart disease or stroke), blindness, skin ulceration (sometimes leading to limb amputation), kidney disease, nerve damage, obesity (with its attendant risks).*

Availability of information*: What information is routinely available to describe where people with diabetes are living within the ICS area? How well is diabetes being controlled amongst residents in different ICS Places? What level of known complications is occurring amongst residents in different ICS Places?*

Response

213,000 patients are registered as diabetic in the NENC region as at January 2023 (6.7% of all patients), prevalence strongly linked to age and sex as well as deprivation.

More than 3,200 admissions for diabetes (primary diagnosis) October 2021 – September 2022, including 950 for diabetic complications.

There are strong links to deprivation and co-morbidities (particularly learning disabilities and mental health disorders).

28% of adult diabetic patients have had all 9 care processes recorded in past year (57% at least 8). This is lower in more deprived areas. 17% of adult diabetic patients have 5 or fewer of the key care processes recorded – higher in more deprived areas.

The most commonly 'missed' care processes are recording foot checks, retinal screening and albumin levels. Recorded albumin levels very low in Tees and Sunderland, and recorded foot checks very low in Tees, Sunderland, and South Tyneside - but this may be due to recording.

Glycaemic control worse, on average, in more deprived areas.

Patients with learning disabilities and mental health disorders, compared with NENC's general diabetic population consistently have:

- Lower uptake of Key Care Processes
- Poorer glycaemic control
- Higher rates of hospital admission for diabetes and its complications

2. ***How early is bowel cancer being detected and treated?***

Rationale*: Colo-rectal cancer is the fourth commonest cancer in the UK and the second biggest killer. Of those diagnosed in the earliest cancer stage, 90% survive for five years or more whilst for those cancers recognised at the latest stage, survival is 10%.*

Availability of information*: What is the incidence of colo-rectal cancer amongst residents in each ICS place? What is its incidence in the under-50 age groups? What is the distribution of stages of cancer at diagnosis amongst residents in each ICS Place? What are the rates of five- and 10-year survival for different stages of cancer at diagnosis amongst residents of different ICS Places? What are the rates of five- and 10-year survival for different stages of cancer at diagnosis according to which hospital the patients were treated at?*

Response

In 2020, NENC has a higher incidence rate of colorectal cancer (68.8 per 100,000) than the national rate (63.3 per 100,000). All areas within NENC are above the national incidence rate for colorectal cancer. The rate varies from Sunderland at the highest with a rate of 77.4 and County Durham at the lowest of 63.4.

When looking at incidence of colorectal cancer in under 50s, the NENC rate (6.2) per 100,000 population continued to be higher than the national average (5.9). South Tyneside had the highest proportion of colorectal cancers being diagnosed at stage 1 within the NENC region.

NENC is below the national average survival rate for colorectal cancer when comparing across 1, 5 and 10 years. In the NENC region, the 1-year survival rate ranges from 81.3% in Newcastle Gateshead to 79.0% in County Durham

3. ***What is the health and health care experience of the most deprived areas?***

***Rationale**: The population served by the ICS contains some of the highest levels of economic and social deprivation in the country. These conditions are powerful determinants of poor health and well-being and have proved to be intractable over time.*

***Availability of information**: Taking the smallest population areas as the unit of analysis, which are the 50 such areas in the ICS that score worst on deprivation indices? Using five markers (expectation of life at birth, expectation of life at 65 years, death from cardiovascular disease, infant mortality, suicide rate) compare the 50 small areas collectively with all other areas combined.*

Response
Middle Layer Super Output Areas (MSOA's) are used as the area for small populations. There are 380 MSOAs in NENC meaning that the top 50 most deprived are the top 13% deprived of areas. Middlesbrough has the highest number of the top 50 deprived MSOAs (8), including the most deprived: North Ormesby & Brambles farm.

Hartlepool has the highest proportion of it's MSOAs in the top 50 with 6 out of 12 (50%) ranked.

Deprived areas have a lower life expectancy at birth (F 78.4 / M 73.4) than other MSOAs (F 82.4 / M 78.6). The other 330 MSOAs still have a lower life expectancy than England overall (F 83.2 / M 79.5)

Death from cardiovascular disease is shown in a standardised mortality rate with England being 100.0, the top 50 most deprived areas have an average of 147.2, while other areas still have a higher value than national (106.2).

Data on expectation of life at 65 years, infant mortality, and suicide rate are not available at small population areas.

4. ***How good is population uptake and coverage for preventive health interventions?***

***Rationale**: A number of preventive health services organised NHS-wide reduce disease incidence and mortality, but their effectiveness depends on achieving high uptake.*

***Availability of information:** For the following four preventive services- bowel cancer screening, breast cancer screening, childhood immunisation, proportion of over-65s with high blood pressure being successfully controlled- what is the percentage coverage of the eligible population in each of the ICS areas? For the same four measures in small areas, across the whole ICS, what are the five best and five worst performers?*

Response
In 2021-22, the North East and Cumbria local authorities perform better than the national average for vaccine uptake in children in most cases, with the below exceptions:
Middlesbrough LA is below national average for uptake on every vaccination statistic, for 1, 2- and 5-year-olds.
Newcastle upon Tyne LA are lower than national average for DTaP-IPV-Hib-HepB (2 year olds), MenB (1 & 2 year olds) and Hib/MenC (5 year olds).

The North East region is the highest performing region in England across all vaccine uptake metrics, with South Tyneside, Sunderland and County Durham LAs being the highest of all local authorities in the country for vaccine uptake in 1- and 2-year-olds.

The prevalence of controlled hypertension in NENC is significantly higher than the latest published national figure for those aged 65-74 (North East 27.5%, England 24.5%) and 75+ (North East 39.1%, England 29.8%).

The highest prevalence within NENC is in County Durham and Newcastle upon Tyne LA's, which are 12% and 9% higher than the national figure for those aged 75+.

Prevalence is higher in males generally, however in those aged 75+, the difference in prevalence in the North East compared to England is higher in females (+9.8%).

The bowel cancer screening up take was higher in NENC (72.7%) than the national average (70.3%). The uptake rate in NENC ranged from 77.3% in Northumberland to 66.3% in Middlesbrough. All but two areas within NENC had a rate higher than the national uptake.

The breast cancer screening up take was higher in NENC (67.8%) than the national average (64.9%). The uptake rate in NENC ranged from 73.3% in North Cumbria to 56.8% in North Tyneside. All but three areas within NENC had a rate higher than the national uptake.

5. ***What is known about levels of incapacity and frailty of older people living at home?***

Rationale*: Three-quarters of people aged 75 years and older have more than one long-term condition. People of this age and older living at home are at greatly increased risk of attending an accident and emergency department, being acutely admitted to hospital or needing to be in a residential care facility.*

These risks are dependent on the nature of their illness, but also the extent of their physical and mental capacity and the presence of frailty.

Availability of information: *What are the numbers of men and women aged over 65 years with moderate and severe levels of frailty living within the ICS area? What age groups are they in? How many live alone? What are the same data for each of the ICS Places?*

Response
The identification of frailty is key to support people pro-actively and reduce the risk of avoidable healthcare events such as unplanned hospital admissions.

Ageing Well workstreams are working with clinical leads and NECS analysts to develop new tools that reflect the wide range of risks that can cause frailty. This new approach is being rolled out across the NENC Primary Care Community through engagement and shared learning.

6. ***What is the level and causal nature of avoidable harm generated by care providers and in care settings?***

***Rationale**: Studies of patient safety and review of data arising from incident reporting systems carried out nationally and internationally have shown that the level of avoidable harm associated with care is higher than it is generally perceived to be. Action to reduce it and sustain improvement have been of limited success.*

***Availability of information:** What numbers of serious patient safety incidents have occurred in the past five years (2018-2022) in each of the providers of care within the ICB's jurisdiction? What types of incidents were they? Acknowledging that there will be overlap between serious incident and Never Events, what numbers and types of Never Events have occurred in each of the providers of care within the last five years?*

Response
In the past 5 years (2018 to 2022), there have been some 4,655 serious incidents together with 140 never events recorded and reported regionally. Never Events (NE's) are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Main causes of recorded incidents for Mental Health related services include, Apparent/ Actual/Suspected Self Harm being the most common recorded in the last 5 years (2018-2022). Acute secondary care providers are the biggest contributors to the rest of the top 10 most common incident types including Slips/Trips/Falls through to Medication Incidents.

The reported NE's are predominantly related to Surgical invasive procedures, followed by medication incidents, other reported problems relate mainly to screening and medical equipment events.

7. ***What are the risks to patients of acquiring an infection during their care?***

Rationale: In hospitals providing acute care in high-income countries like the United Kingdom, the World Health Organisation has estimated that, out of every 100 patients, seven will acquire at least one health care-associated infection during their hospital stay. The COVID-19 pandemic has clearly shown how central infection prevention and control is to maintain vital services and ensuring patient and staff safety.

Health care-associated infections and the spread of antimicrobial resistance in health care settings are a consequence of poorly organised and delivered infection prevention and control programmes.

Key failures include low compliance with hand hygiene and aseptic practices, contaminated medical equipment and supplies, inadequate environmental cleaning, insufficient training in infection prevention and control policies and practices, very high bed occupancy, understaffing and suboptimal infrastructure for patient isolation, weak leadership and adverse cultures.

Availability of information: For each provider of acute care show the number of healthcare-associated infection in the following categories: i) surgical site infections ii) catheter associated urinary tract infections iii) central line associated blood stream infections iv) Methicillin-resistant staphylococcus aureus (MRSA) bacteraemia v) Clostridium difficile for each year 2017-2022. For each provider of acute care show the number of cases of

COVID-19 acquired in hospital by patients and staff for the years 2020-2022. For each provider of acute care show the rate of hand hygiene compliance in clinical areas in the most recent available time period.

Response
In progress – further update expected week ending 17th March 2023

8. ***What do patients think of the care that they receive and what information about services is available to them?***

Rationale: *Looked at from first principles the kind of questions a user or potential user of a service might ask about their care could include: How quickly will I be first seen; how quickly will I get a diagnosis and how quickly will I receive definitive treatment? If my condition is potentially life-threatening, will the local service give me the best odds of survival, or could I do better elsewhere?*

Will the staff treating me be competent and up to date in their practice? Does the service have a low level of complications for treatment like mine compared to other services? Does the service have good quality assurance and quality improvement systems in place? What is the safety record of the service concerned?

How good are the amenities and environment of the hospital or health centre where I will be treated?

Is the medical equipment for diagnosing and treating patients like me, state of the art? Have patients treated by this service in the recent past rated it highly on dignity, respect, information-giving? How does the service compare to others around the country and elsewhere in the world? Many of these practical and common-sense questions that patients and families might have are not readily available to them.

Availability of information: *What information is produced by each provider of care within the ICS about patients' views and experience of care? What range of information about quality of services (particularly comparative and benchmarking data) is available for patients and families? How extensively are Patient Reported Outcome Measures (PROMS) used by providers of care and what are the main findings of analysis of these data?*

Response
In progress – further update expected week ending 17th March 2023

9. ***Children and young people's mental health***

Rationale: *In 2022, in England, 18% of children aged 7 to 16 years and 22% of young people aged 17 to 24 years had a probable mental disorder. In children aged 7 to 16 years, rates rose from 1 in 9 (12.1%) in 2017 to 1 in 6 (16.7%) in 2020. Rates of probable mental disorder then remained stable between 2020, 2021 and 2022. In young people aged 17 to 19 years, rates of a probable mental disorder rose from 1 in 10 (10.1%) in 2017 to 1 in 6 (17.7%) in 2020. Rates were stable between 2020 and 2021, but then increased from 1 in 6 (17.4%) in 2021 to 1 in 4 (25.7%) in 2022. The numbers of suicides amongst the 15–19-year-olds in England rose by 35% between 2020 and 2021 and is the highest for 30 years.*

Availability of information: *How many referrals to children and adolescent mental health services were made from each of the ICS's Places each year from 2018 to 2022? Which are the small areas with the highest number of such referrals? How many suicides were there amongst young people aged 15 to 19 years for each of the years 2018 to 2022 and where did they live?*

Response
A recovery action plan is in place to deliver services by 2023/24 for increased number of children and young people receiving at least one mental health contact. All waiting times are beginning to be monitored. Neurodevelopmental conditions and eating disorders are challenging. There are some concerns in relation to difficulties in recruiting and retain appropriate staff.

10. ***What progress is being made in controlling tobacco-related disease?***

Rationale: *Smoking remains the leading cause of preventable death in the ICS region. Although smoking rates are still higher than the national average, the region has achieved the largest reduction in smoking prevalence in the country (15.3% in 2019 vs 29% in 2005). Tobacco is a major causal contributor to health inequalities.*

Availability of information: *What is the prevalence of smoking in each of the ICS Places? Which are the small areas that collectively contain 80% of the ICS's current smokers? Which are the ten small areas with the highest smoking prevalence?*

How many people attending smoking cessation services in each of the ICS Places in the years 2018-2022? What were the quit rates achieved by each of these services in the same time periods?

Response
In 2021, 14.8% of the 16+ population in the region were identified as smokers, this compares with 21.3% in 2011. Highest prevalence is Middlesbrough (17.9%) and the lowest is Darlington (10.6%). The region has a smoking reduction target of 5.0% by 2030. There are several smoking cessation initiatives regionally, as of March 2022, there were 3,794/100k adults (16+) setting a quit date, this compares to 6,256/10k in March 2018.

Most "places have smoking cessation initiatives in operation, except Hartlepool, who have not had a service sine 2018-19. North Cumbria, service users have been declining since the Covid-19 pandemic, a reinvestment plan is scheduled for Q4 2022-23. Self-reporting successful quitters are being validated/confirmed using Carbon Monoxide meter readings.

Conclusions

Item: 6.1

As previously reported, information on the performance of services is needed for at least four main purposes: accountability, quality improvement, choice, and management.

From the source data available, within this revised report, there is a general conclusion that it is broadly :

f) relevant, meaningful, accurate and up-to-date.
g) capable of enabling valid judgements based on comparisons of service performance over time and between similar services delivered in different localities;
h) accepted and valued by clinicians and other staff;
i) can and will be used and relied on by system and organisational leaders and managers; e) trusted by patients, service users and the public.

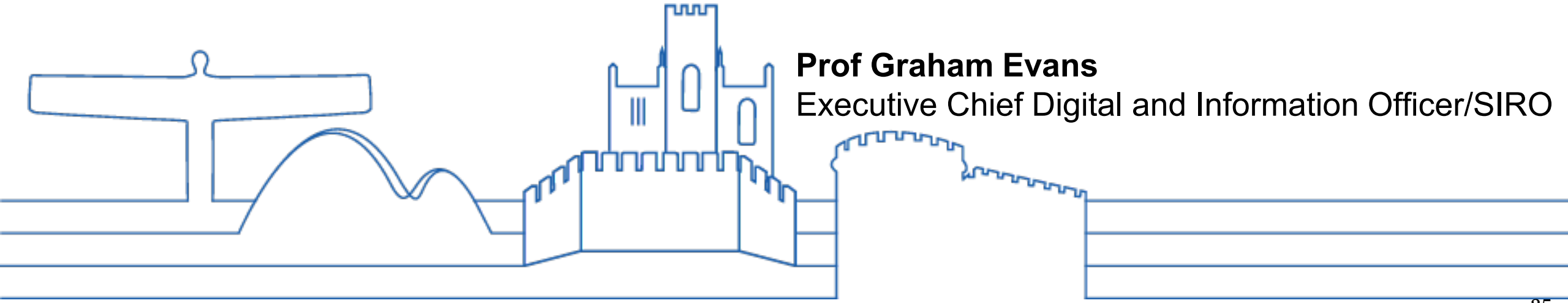
There are some remaining data gaps that continue to be addressed in order fully complete the challenge requirements.

Professor Graham Evans
14 March 2023

NHS
North East and North Cumbria

Integrated Care Board : ICB Chair data challenge questions (NENC 10)

Summary at 10/03/23



Prof Graham Evans
Executive Chief Digital and Information Officer/SIRO

The use and development of information systems for the work of the Integrated Care Board (ICB) - recap.

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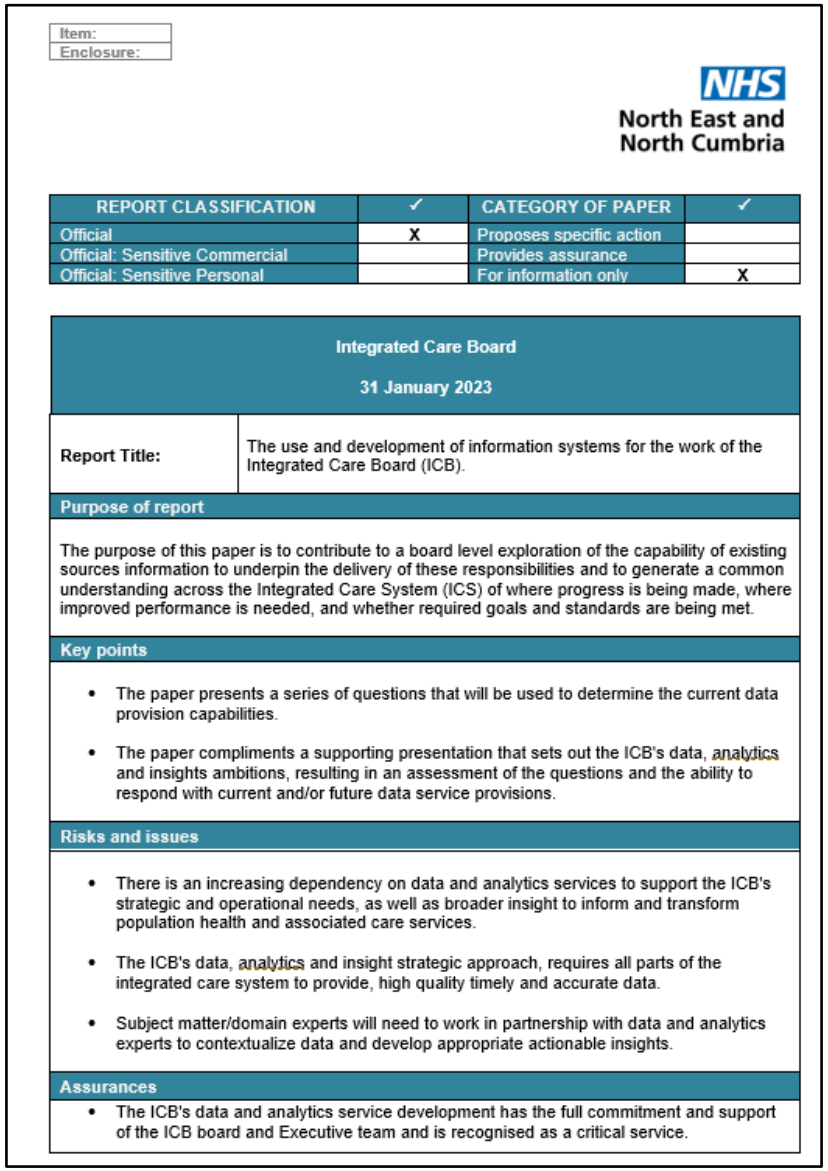

Item:
Enclosure:

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

Integrated Care Board

31 January 2023

Report Title:	The use and development of information systems for the work of the Integrated Care Board (ICB).

Purpose of report

The purpose of this paper is to contribute to a board level exploration of the capability of existing sources information to underpin the delivery of these responsibilities and to generate a common understanding across the Integrated Care System (ICS) of where progress is being made, where improved performance is needed, and whether required goals and standards are being met.

Key points

- The paper presents a series of questions that will be used to determine the current data provision capabilities.
- The paper compliments a supporting presentation that sets out the ICB's data, analytics and insights ambitions, resulting in an assessment of the questions and the ability to respond with current and/or future data service provisions.

Risks and issues

- There is an increasing dependency on data and analytics services to support the ICB's strategic and operational needs, as well as broader insight to inform and transform population health and associated care services.
- The ICB's data, analytics and insight strategic approach, requires all parts of the integrated care system to provide, high quality timely and accurate data.
- Subject matter/domain experts will need to work in partnership with data and analytics experts to contextualize data and develop appropriate actionable insights.

Assurances

- The ICB's data and analytics service development has the full commitment and support of the ICB board and Executive team and is recognised as a critical service.

Ten questions about the health and wellbeing of

the North East & North Cumbria population

The NENC 10 – ICB data availability overview

NHS
North East and North Cumbria

Question	Status	Summary	
1. Are people with diabetes receiving a standard of care that gives the lowest possible level of avoidable complications of their disease?	Complete	Feedback from Prevention and PHM team to be reviewed and actioned.	
2. How early is bowel cancer being detected and treated?	Partial	"What are the rates of five and 10 year survival for different stages of cancer at diagnosis according to which hospital the patients were treated at?" - Still investigating	
3. What is the health and health care experience of the most deprived areas?	Partial	Data not available at small population areas for 3 of the 5 markers. Expectation of life at 65 years – would need to initiate project to calculate Infant mortality & Suicide rate - unavailable	
4. How good is population uptake and coverage for preventive health interventions?	Partial	Further update w/e 17/03	
5. What is known about levels of incapacity and frailty of older people living at home?	Complete		

The NENC 10 – ICB data availability overview

NHS North East and North Cumbria

Question	Status	Summary	
6. What is the level and causal nature of avoidable harm generated by care providers and in care settings?	Complete		
7. What are the risks to patients of acquiring an infection during their care?	In Progress	Further update w/e 17/03	
8. What do patients think of the care that they receive and what information about services is available to them?	In Progress	Further update w/e 17/03	
9. Children and young people's mental health?	Complete		
10. What progress is being made in controlling tobacco-related disease?	Partial	Which are the small areas that collectively contain 80% of the ICS's current smokers? Which are the ten small areas with the highest smoking prevalence? A small area data set is not currently reliable enough to use in order to undertake this analysis. This is the current focus of the treating Tobacco Dependence Taskforce.	

The NENC 10 – Q1 to Q5

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North Cumbria

Are people with **diabetes** receiving a **standard of care** that gives the lowest possible level of **avoidable complications** of their disease?

How early is **bowel cancer** being **detected and treated**?

What is the **health** and health care **experience** of the most **deprived areas**?

How good is **population uptake** and coverage for **preventive health** interventions?

What is known about levels of **incapacity and frailty** of older people **living at home**?

The NENC 10 – Q6 to Q10

NHS
North East and
North Cumbria

What is the level and causal nature of **avoidable harm** generated by care providers and **in care settings**?

What are the **risks** to patients of acquiring an **infection during their care**?

What do **patients think of the care** that they receive and what **information** about services is available to them?

Children and young people's **mental health**?

What **progress** is being made in controlling **tobacco-related disease**?

NHS
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North Cumbria

Q1.
Are people with **diabetes** receiving a **standard of care** that gives the lowest possible level of **avoidable complications** of their disease?

- What information is routinely available to describe **where people with diabetes are** living within the ICS area?
- How well is diabetes being **controlled** amongst residents **in different ICS Places**?
- What level of **known complications** is occurring amongst residents **in different ICS Places**?

Are people with diabetes receiving a standard of care that gives the lowest possible level of avoidable complications of their disease?

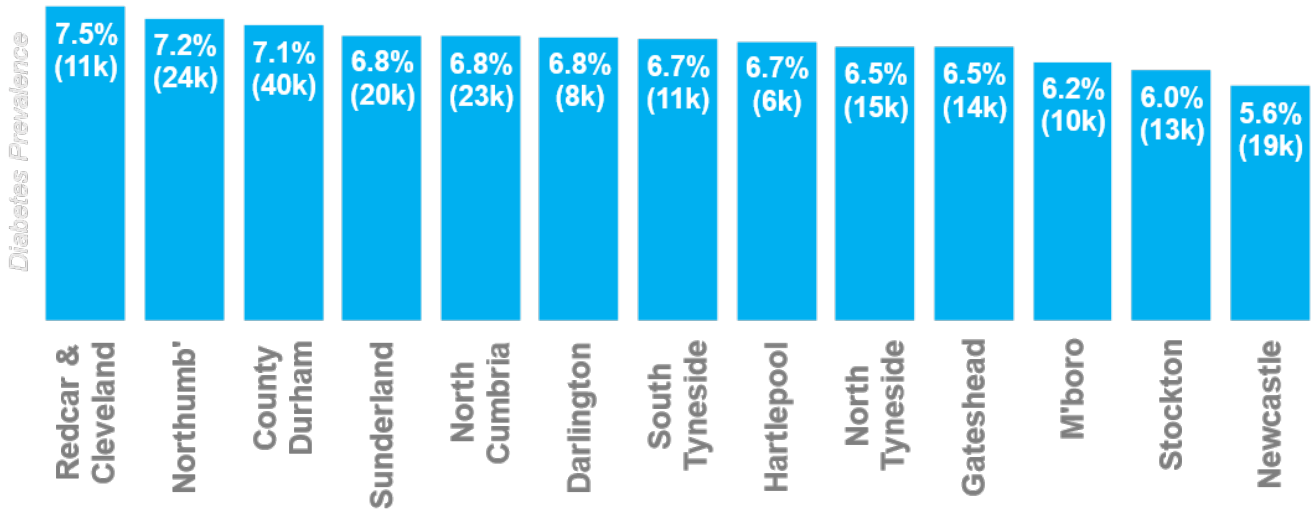
NHS
North East and North Cumbria

213,000
diabetics (Jan '23)

~7% of all people

Prevalence strongly linked to:

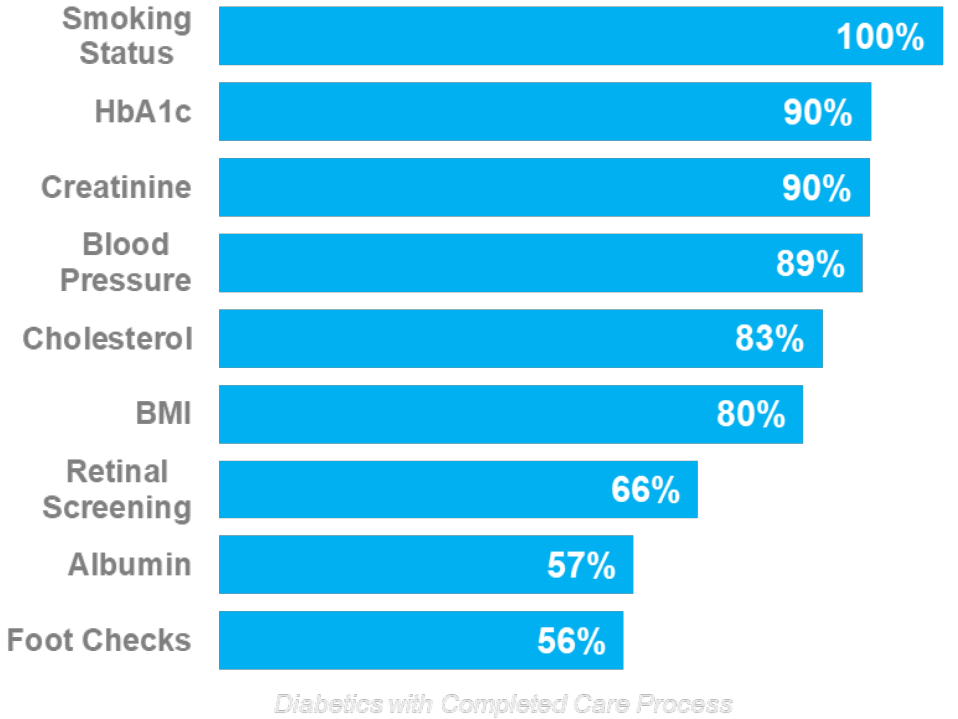
- **Age**
- **Sex**
- **Deprivation**



most deprived 20% of LSOAs **7.3%** *vs* **5.7%** **least deprived** 20% of LSOAs
Diabetic prevalence

There are **9 Key Care Processes** for diabetics

28% of adult diabetics had **all 9** in the past year (57% at had least 8)



Population Data: GP Practice Data January 2022
RAIDR primary care data based on coverage of 93% across NENC GP practices
Admissions data via SUS Oct '21 – Sep '22

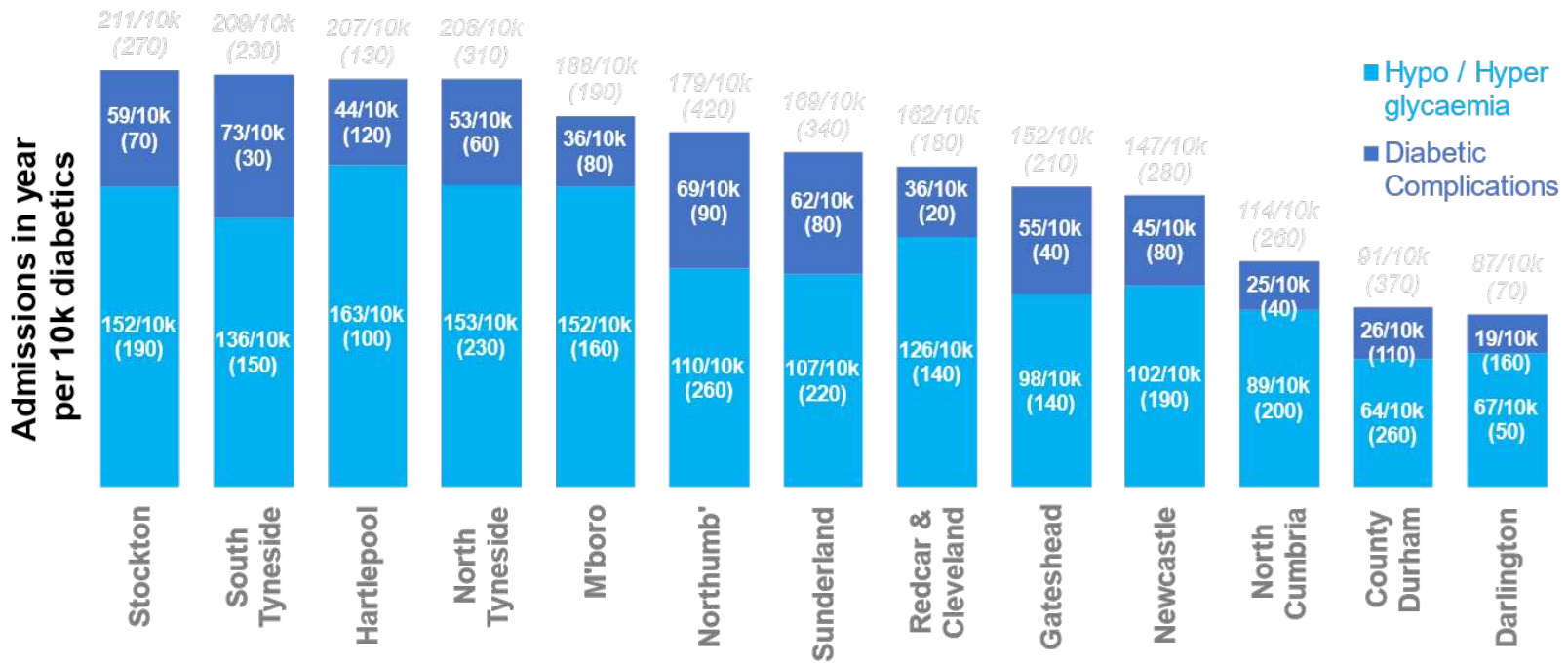
Are people with diabetes receiving a standard of care that gives the lowest possible level of avoidable complications of their disease?

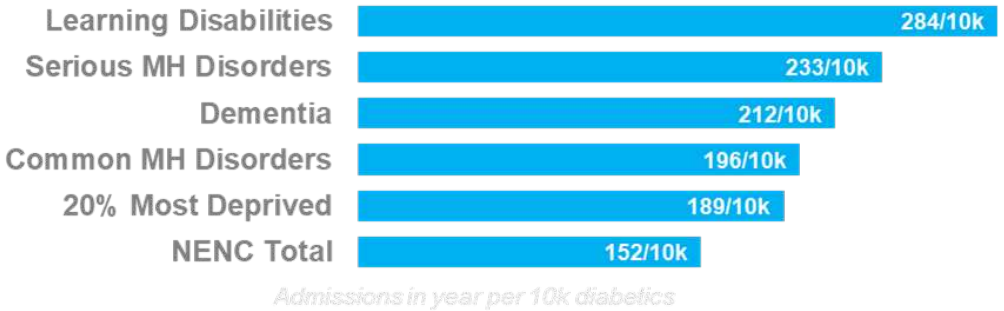
NHS North East and North Cumbria

3,200+ Admissions with a primary diagnosis of diabetes (Oct '21 – Sep '22) including

950 diabetic complications

Admission strongly linked to
- **Deprivation**
- **Co-morbidities**
- **Learning Disabilities**
- **Mental Health**





In NENC that is an **admission rate** of

152 *per 10k diabetics*

107 *per 10k diabetics* for hypo / hyper glycaemia

45 *per 10k diabetics* for diabetic complications

Population Data: GP Practice Data January 2022
RAIDR primary care data based on coverage of 93% across NENC GP practices
Admissions data via SUS Oct '21 – Sep '22

NHS
North East and North Cumbria

Q1.
Are people with **diabetes** receiving a **standard of care** that gives the lowest possible level of **avoidable complications** of their disease?

- 213,000 patients registered as diabetic in NENC as at Jan 2023 (6.7% of all patients)
  - Prevalence strongly linked to age and sex
  - Prevalence linked to deprivation
- More than 3,200 admissions for diabetes (primary diagnosis) Oct 21 – Sep 22 including 950 for diabetic complications.
  - Strong links to deprivation and co-morbidities (particularly learning disabilities and mental health disorders)
- 28% of adult diabetic patients have had all 9 care processes recorded in past year (57% at least 8). This is lower in more deprived areas.
- 17% of adult diabetic patients have 5 or fewer of the key care processes recorded – higher in more deprived areas.
- Most commonly 'missed' care processes are recording foot checks, retinal screening and albumin levels. Recorded albumin levels very low in Tees and Sunderland, and recorded foot checks very low in Tees, Sunderland and South Tyneside - but this may be due to recording.
- Glycaemic control worse, on average, in more deprived areas.
- Patients with learning disabilities and mental health disorders, compared with NENC's general diabetic population consistently have:
  - Lower uptake of Key Care Processes
  - Poorer glycaemic control
  - Higher rates of hospital admission for diabetes and its complications

NHS
North East and
North Cumbria

Q2.
How early is **bowel cancer** being **detected and treated**?

- What is the **incidence** of colorectal cancer amongst residents **in each ICS place**?
- What is its **incidence** in the **under-50** age groups?
- What is the **distribution of stages** of cancer at diagnosis amongst residents **in each ICS Place**?
- What are the rates of **five and 10 year survival for different stages** of cancer at diagnosis amongst residents of **different ICS Places**?
- What are the rates of **five and 10 year survival for different stages** of cancer at diagnosis according to which **hospital the patients were treated at**?

How early is bowel cancer being detected and treated?

NHS
North East and North Cumbria

Colorectal Cancer **Incidence*** Rate (2020) **68.8** *per 100k people*

Compared to the **national** incidence rate **63.3** *per 100k people*

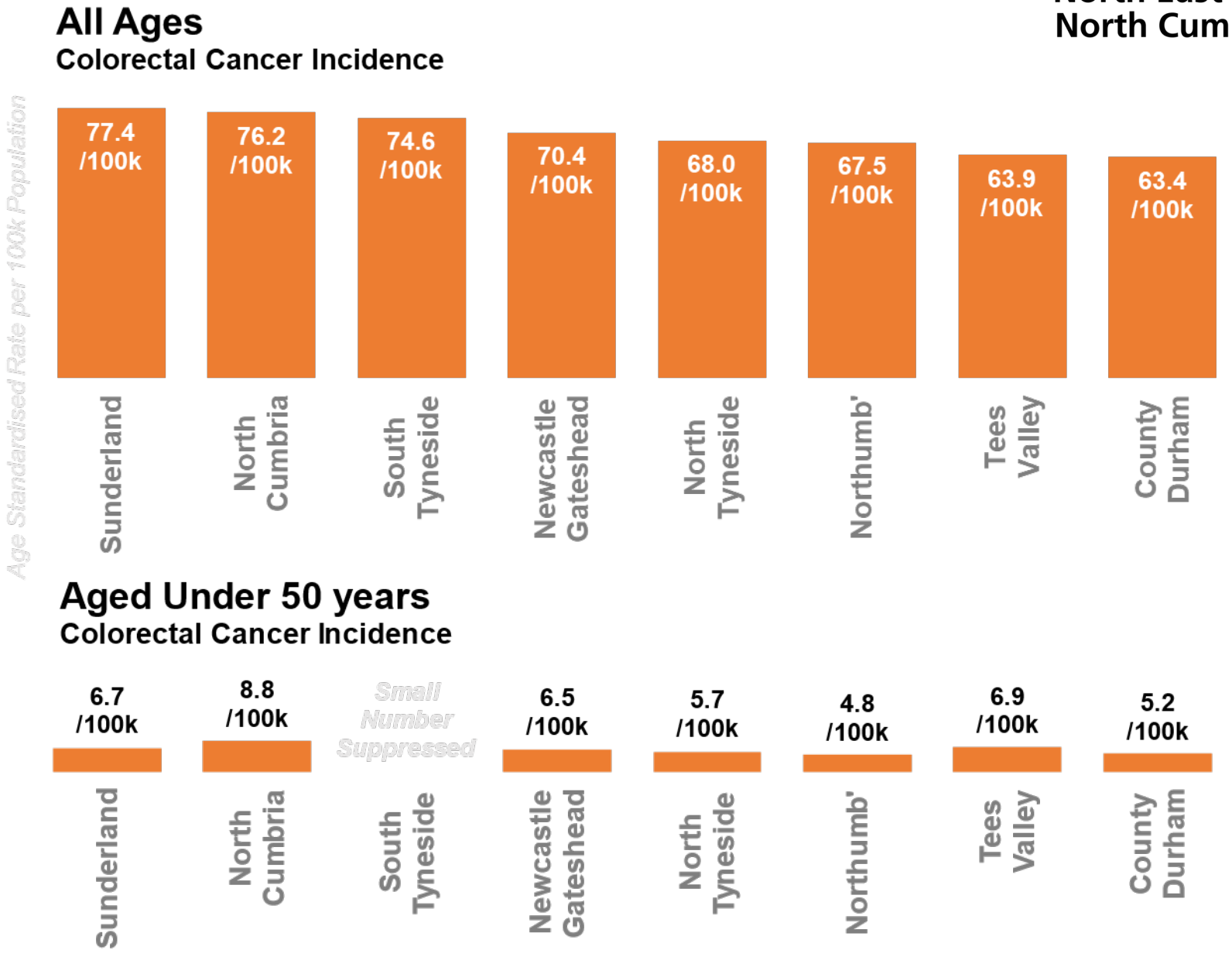
* ***Incident cases*** *of cancer are counted for* ***each separate primary tumour****.*

One person *may be diagnosed with* ***more than one tumour****, and would then appear twice in the incidence statistics.*

Recurrences *of a previous cancer are* ***not counted*** *as new incident cases.*

In people **aged under 50** the incidence rate is **6.2** *per 100k people*

while the **national** rate is **5.9** *per 100k people*



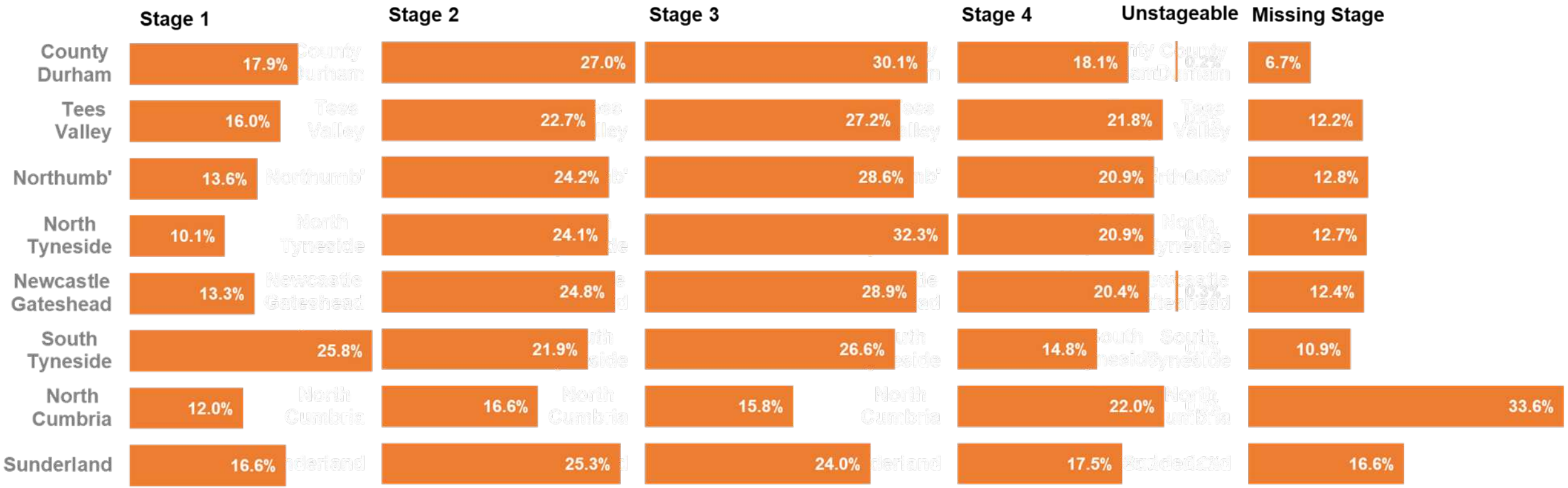
https://www.cancerdata.nhs.uk/

How early is bowel cancer being detected and treated?

NHS
North East and North Cumbria

Stage at Diagnosis (2019)

for Colon & Rectum and Rectosigmoid Junction Cancers



the cancer is small and hasn't spread elsewhere

the cancer has grown, but hasn't spread

the cancer is larger and may have spread to the surrounding tissues and/or the lymph nodes

the cancer has spread to at least one other organ (secondary or metastatic cancer)

the data is incomplete

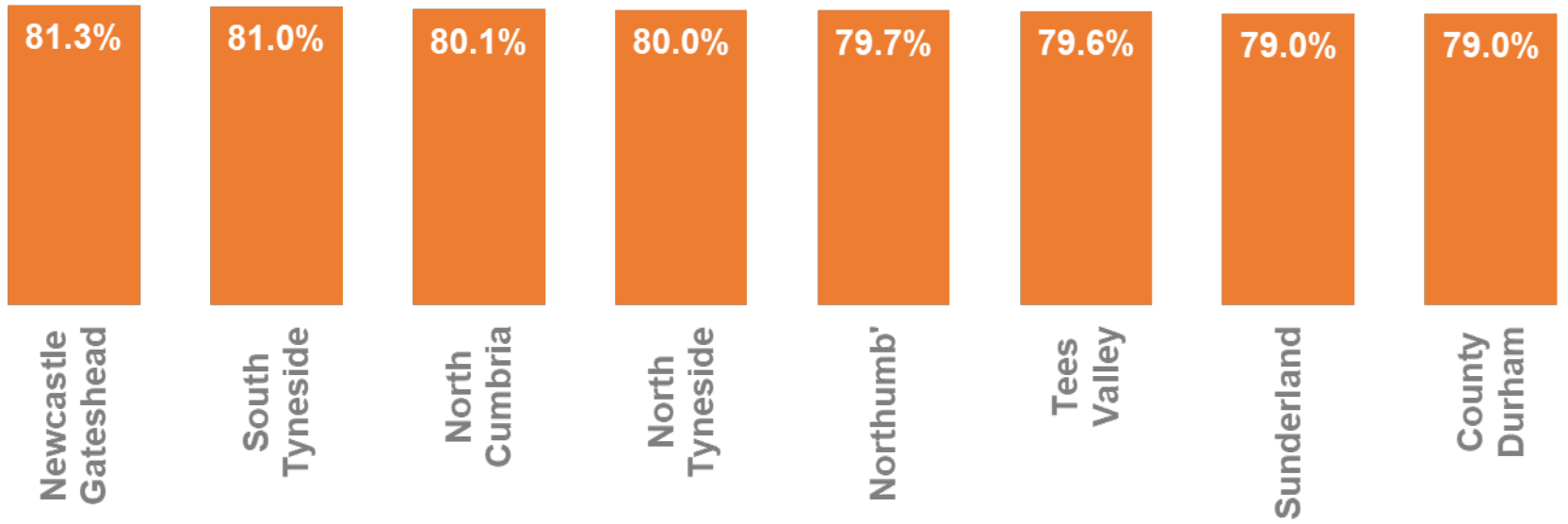
https://www.cancerdata.nhs.uk/

How early is bowel cancer being detected and treated?

NHS
North East and North Cumbria

Colorectal Cancer **Survival** Rate	(from 2019 to 2020) **1** year	(from 2015 to 2020) **5** year	(from 2010 to 2020) **10** year
Northern Cancer Alliance	80.1%	60.7%	54.0%
England	80.9%	61.7%	54.7%

1 Year Survival
for Colorectal Cancer



5 & 10 year survival rates are **unavailable** at **place** (CCG) level

https://www.cancerdata.nhs.uk/

NHS
North East and
North Cumbria

Q2.
How early is **bowel cancer** being **detected and treated**?

- In 2020, NENC has a **higher incidence** rate of colorectal cancer (68.8 per 100,000) **than the national rate** (63.3 per 100,000).
- **All areas within NENC are above the national** incidence rate for colorectal cancer. The rate varies from **Sunderland at the highest** with a rate of 77.4 and **County Durham at the lowest** of 63.4.
- When looking at incidence of colorectal cancer in **under 50s**, the NENC rate (6.2) per 100,000 population continued to be **higher than the national average** (5.9).
- **South Tyneside** had the **highest proportion** of colorectal cancers being **diagnosed at stage 1** within the NENC region.
- NENC is **below the national average survival rate** for colorectal cancer when comparing across 1, 5 and 10 years.
- In the NENC region, the 1-year survival rate ranges from **81.3% in Newcastle Gateshead** to **79.0% in County Durham**

NHS
North East and North Cumbria

Q3.
What is the **health** and health care **experience** of the most **deprived areas**?

- Taking the **smallest population areas** as the unit of analysis, which are the **50** such areas in the ICS that score **worst** on **deprivation indices**?

- Using **five markers compare the 50** small areas collectively **with all other areas** combined.
  1. **expectation** of life at **birth**
  2. **expectation** of life at **65 years***
  3. **death** from **cardiovascular** disease
  4. **infant mortality***
  5. **suicide** rate*

**metrics not available at small population areas*

What is the health and health care experience of the most deprived areas?

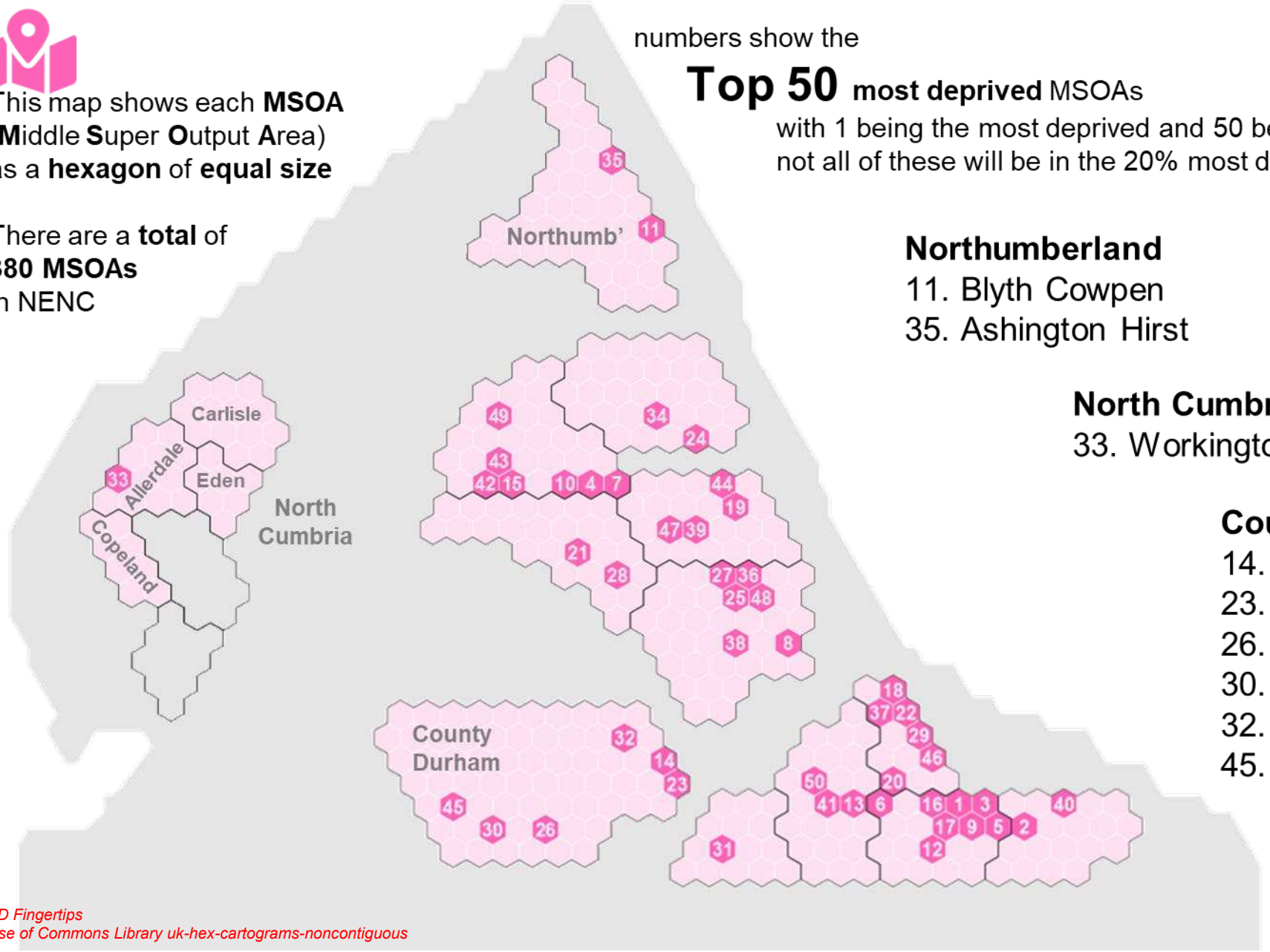
NHS
North East and North Cumbria

This map shows each **MSOA** (**M**iddle **S**uper **O**utput **A**rea) as a **hexagon** of **equal size**

There are a **total** of **380 MSOAs** in NENC

numbers show the

Top 50 most deprived MSOAs
with 1 being the most deprived and 50 being the least
not all of these will be in the 20% most deprived areas nationally



Northumberland
11. Blyth Cowpen
35. Ashington Hirst

North Cumbria
33. Workington West

County Durham
14. Peterlee East
23. Horden
26. Newton Aycliffe West
30. Bishop Auckland South
32. Murton North & Parkside
45. Coundon North

OHID Fingertips
House of Commons Library uk-hex-cartograms-noncontiguous

What is the health and health care experience of the most deprived areas?

NHS
North East and North Cumbria

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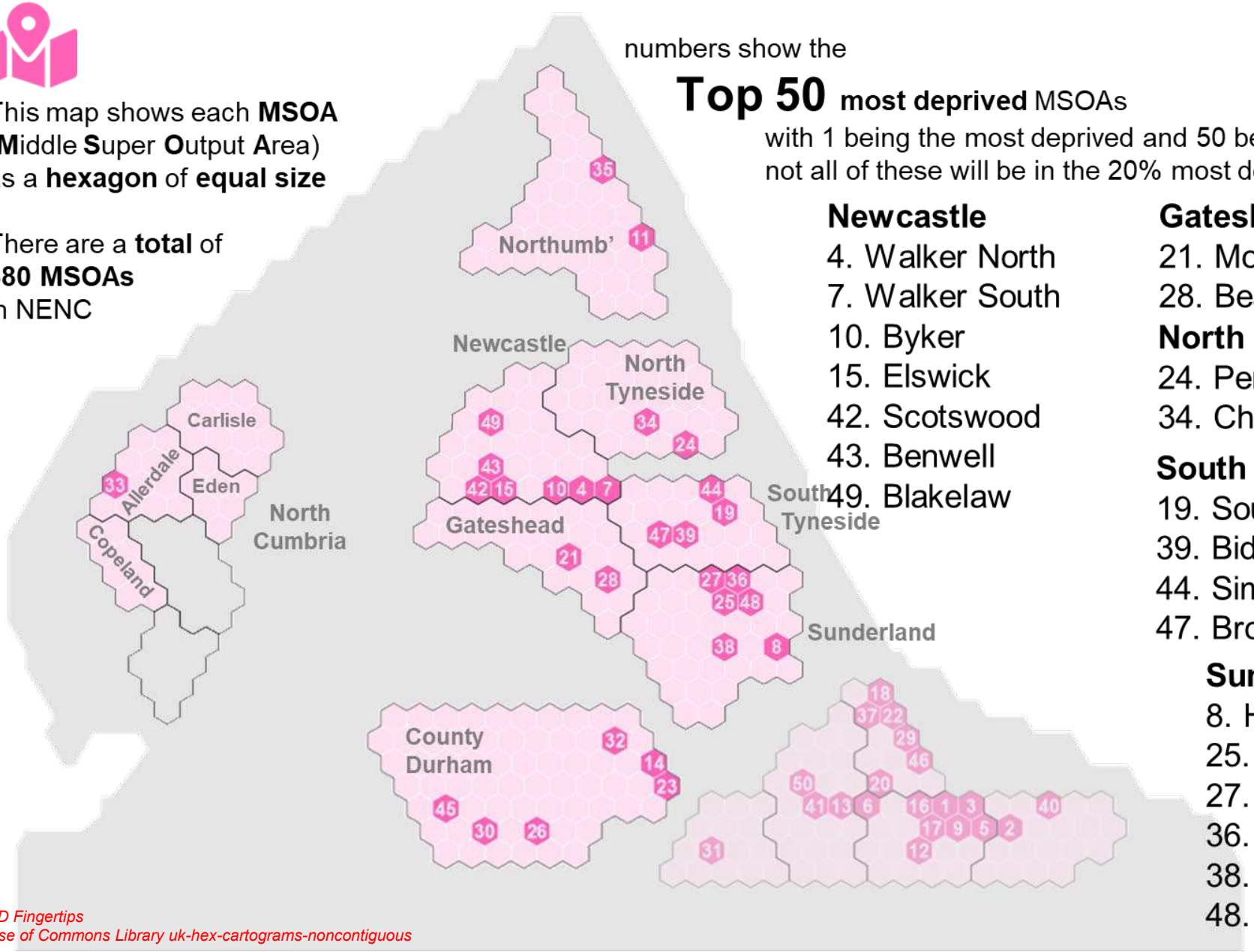


numbers show the

Top 50 **most deprived** MSOAs

with 1 being the most deprived and 50 being the least
not all of these will be in the 20% most deprived areas nationally

Newcastle
4. Walker North
7. Walker South
10. Byker
15. Elswick
42. Scotswood
43. Benwell
49. Blakelaw

Gateshead
21. Mount Pleasant & Deckham East
28. Beacon Lough & Wrekenton

North Tyneside
24. Percy Main
34. Chirton

South Tyneside
19. South Shields West
39. Biddick Hill
44. Simonside
47. Brockley Whins

Sunderland
8. Hendon & Docks
25. Pallion North
27. Town End Farm
36. Hylton Red House & Marley Pots
38. Thorney Close & Plains Farm
48. Southwick

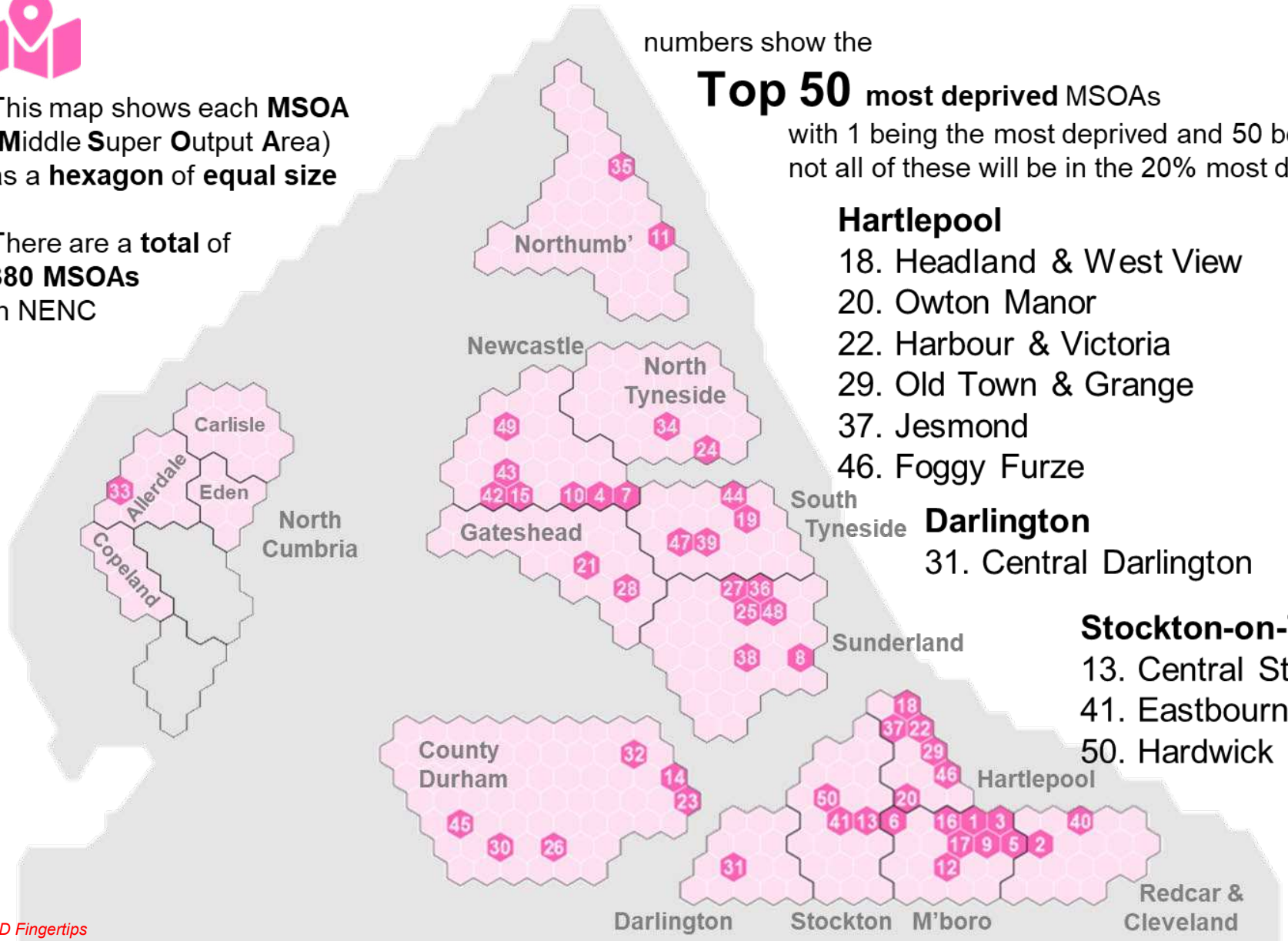
OHID Fingertips
House of Commons Library uk-hex-cartograms-noncontiguous

What is the health and health care experience of the most deprived areas?

NHS
North East and North Cumbria

This map shows each **MSOA** (**M**iddle **S**uper **O**utput **A**rea) as a **hexagon** of **equal size**

There are a **total** of **380 MSOAs** in NENC



numbers show the

Top 50 **most deprived** MSOAs

with 1 being the most deprived and 50 being the least

not all of these will be in the 20% most deprived areas nationally

Hartlepool

18. Headland & West View
20. Owton Manor
22. Harbour & Victoria
29. Old Town & Grange
37. Jesmond
46. Foggy Furze

Darlington

31. Central Darlington

Middlesbrough

1. North Ormesby & Brambles
3. Thorntree
5. Park End
6. Ayresome
9. Berwick Hills
12. Beechwood & James Cook
16. Middlesbrough Central
17. Park Vale

Stockton-on-Tees

13. Central Stockton, Portrack & Low Hartburn
41. Eastbourne & Newham Grange
50. Hardwick & Salters Lane

Redcar and Cleveland

2. Grangetown
40. Redcar Town & Coatham

OHID Fingertips
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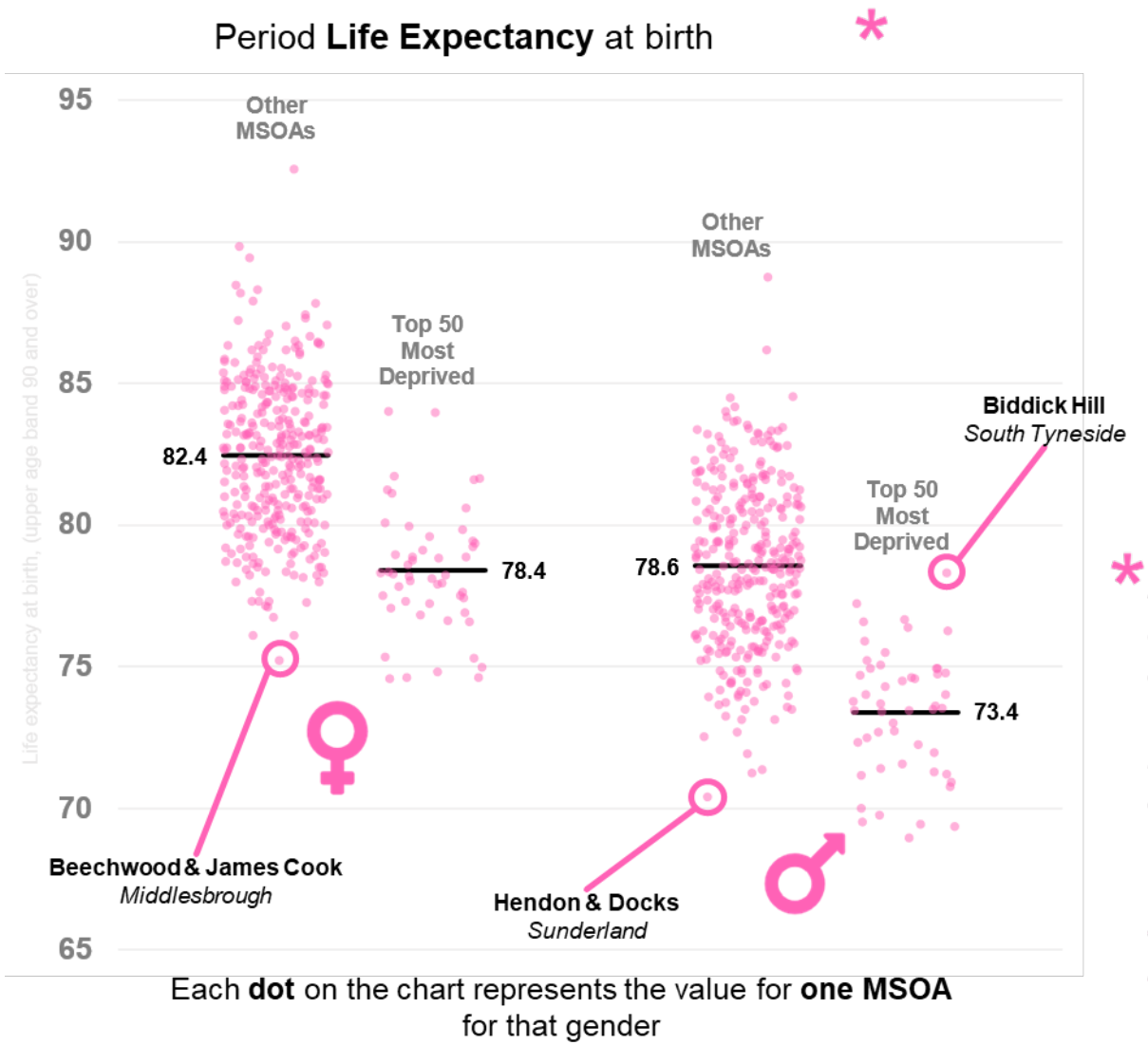
What is the health and health care experience of the most deprived areas?

NHS
North East and North Cumbria



Each **dot** on the chart represents the value for **one MSOA** for that gender

	Women	Men
Top 50 most **deprived** MSOAs average **life expectancy** at birth (2016-2020)	**78.4**	**73.4**
other MSOAs average	**82.4**	**78.6**
England overall	83.2	79.5

* *Estimate of the **average** number of **years** a new-born baby would survive if they experienced the **contemporary age-specific mortality** rates for that area and time period throughout their life*

*Reflects mortality among **those living in an area**, rather than mortality among those born in the area*

*The figures are **NOT the number of years** a **baby born in the area could actually expect to live**, both because the mortality rates of the area are likely to **change in the future** and because many of those born in the area will **live elsewhere** for at least some part of their lives.*

What is the health and health care experience of the most deprived areas?

NHS
North East and North Cumbria

Top 50 most **deprived** MSOA average **Circulatory** Disease Standardised **Mortality Ratio** (2016-2020) **147.2** *per 100*

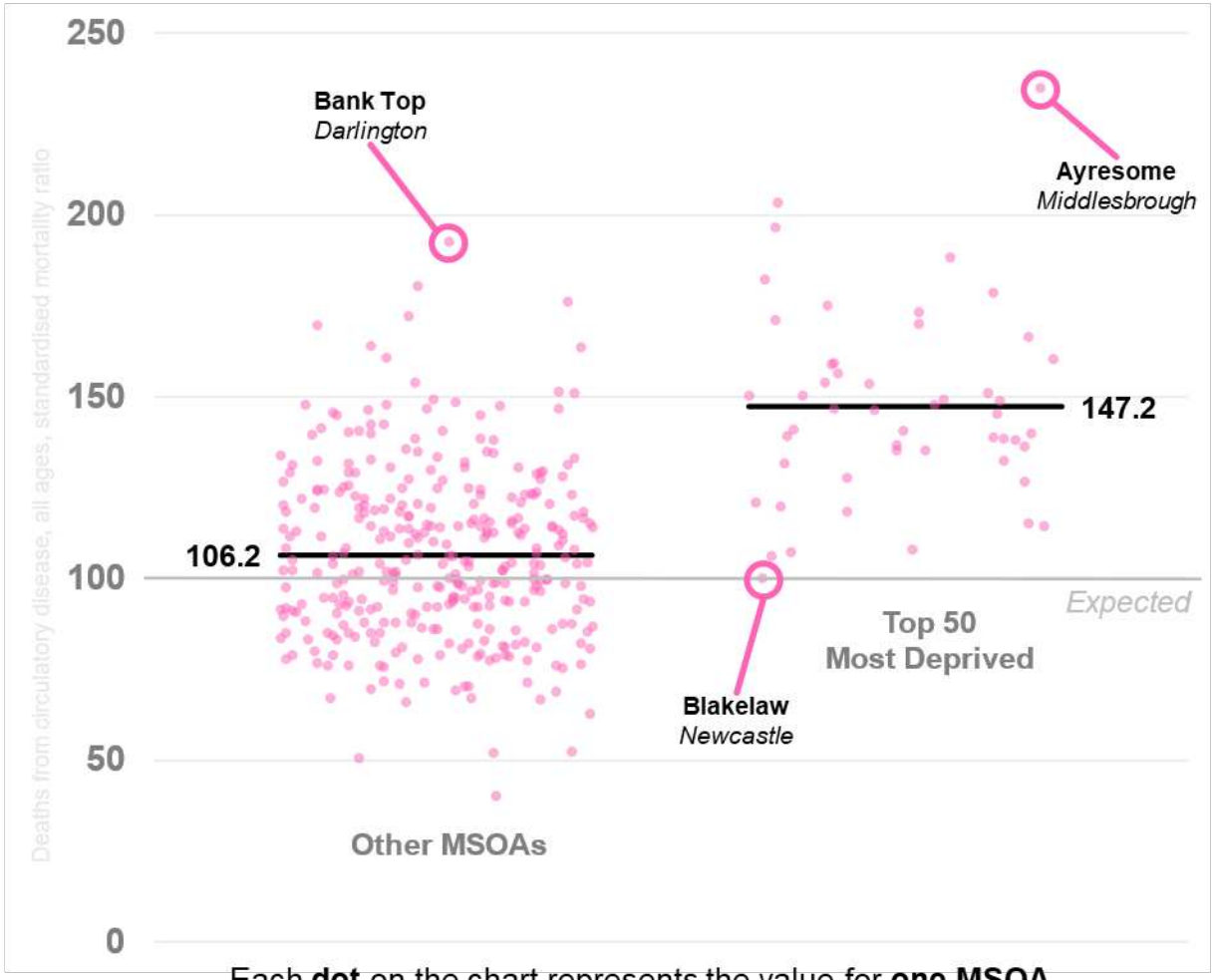
compared to the **other MSOAs** average **106.2** *per 100*

***Numerator** is the total **number of deaths from circulatory disease** among persons of all ages in the area* *

Denominator** is the **expected number of deaths** from circulatory disease, if the area experienced the **same** age-specific (aggregated into five year age bands 0-4, 5-9 through to 90+) **mortality rates as for England

The value for **England** overall is **100.0** *per 100* as this is the **expected** value

Circulatory Disease Standardised **Mortality Ratio** *



Each **dot** on the chart represents the value for **one MSOA**

NHS
North East and North Cumbria

Q3.
What is the **health** and health care **experience** of the most **deprived areas**?

- MSOAs are used as the area for small populations. There are **380 MSOAs in NENC** meaning that the **top 50** most deprived are the **top 13%** deprived of areas
- **Middlesbrough** has the **highest number** of the top 50 deprived MSOAs (8), including the **most deprived: North Ormesby & Brambles**
- **Hartlepool** has the **highest proportion** of it's MSOAs in the top 50 with 6 out of 12 (50%) ranked
- Deprived areas have a **lower life expectancy** at birth (F 78.4 / M 73.4) than other MSOAs (F 82.4 / M 78.6). The **other 330 MSOAs** still have a **lower life expectancy than England** overall (F 83.2 / M 79.5)
- **Death from cardiovascular disease** is shown in a standardised mortality rate with **England being 100.0**, the **top 50 most deprived** areas have an average of **147.2**, while other areas still have a higher value than national (106.2)
- Data on expectation of **life at 65 years**, **infant mortality**, and **suicide** rate are **not available at small population areas**.

NHS
North East and North Cumbria

Q4.
How good is **population uptake** and coverage for **preventive health** interventions?

- For the following four **preventive services** what is the **percentage coverage** of the eligible population in each of the **ICS areas**?
  1. **Bowel cancer** screening
  2. **Breast cancer** screening
  3. **Childhood immunisation**
  4. Proportion of **over-65s** with **high blood pressure** being **successfully controlled**

- Across the whole ICS, what are the **five best** and **five worst** performers?
  1. **Bowel cancer** screening*
  2. **Breast cancer** screening*
  3. **Childhood immunisation***
  4. Proportion of over-65s with **high blood pressure** being **successfully controlled**

**metrics not available at small population areas*

How good is population uptake and coverage for preventive health interventions?

North East and North Cumbria

~30,000

Children (2021-22)

aged 2 years

in the North East and Cumbria

96.0% had the vaccines **DTaP-IPV-Hib-HepB**

- **D**iphtheria, **T**etanus **a**nd **P**ertussis
- Polio (**IPV**)
- **H**aemophilus **i**nfluenzae type **b**
- **Hep**atitis **B**

the **national uptake** is only **93.0%**

1

Children (2021-22)

aged 5 years

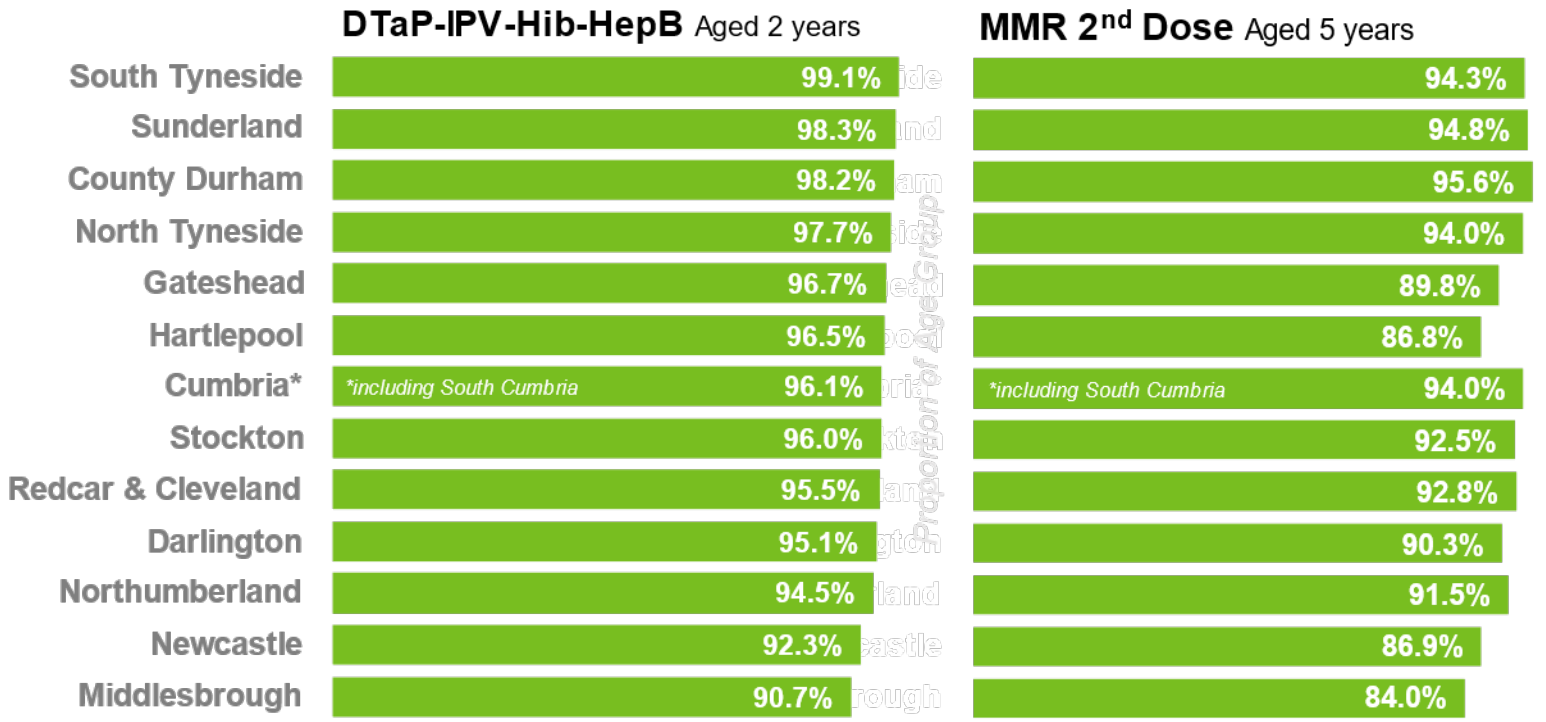
~35,000

in the North East and Cumbria

96.4% had a first dose measles, mumps, & rubella (MMR) jab

92.1% had both **MMR** doses

These are better than the **national uptake** of **93.5% first** dose and **85.7% second** dose



Childhood Vaccination Coverage Statistics- England, 2021-22 - NDRS (digital.nhs.uk)

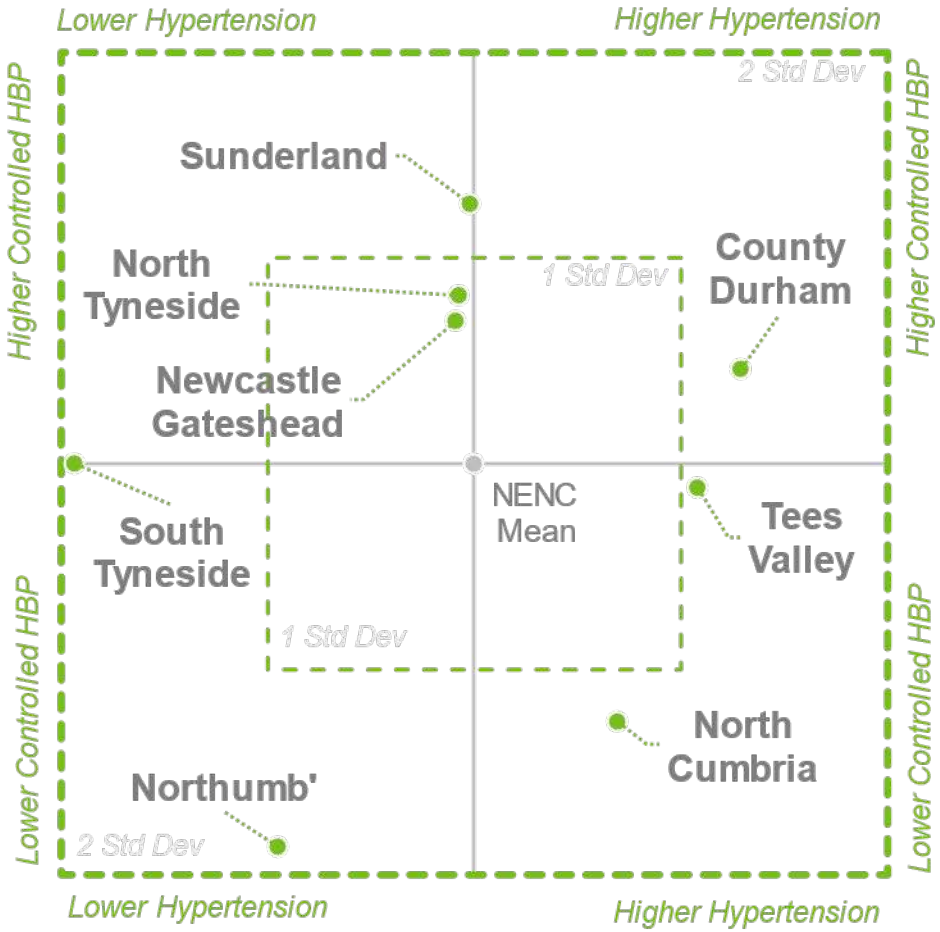
How good is population uptake and coverage for preventive health interventions?

NHS
North East and North Cumbria

It is expected that a place with a **larger hypertension population** would have **more people** who need to **control high blood pressure**

Differences in population mean that different places have **different rates of hypertension**

North Cumbria and **Tees Valley** both have a **higher** than average **hypertension** incidence and a **lower** than average rate of **controlled high blood pressure**

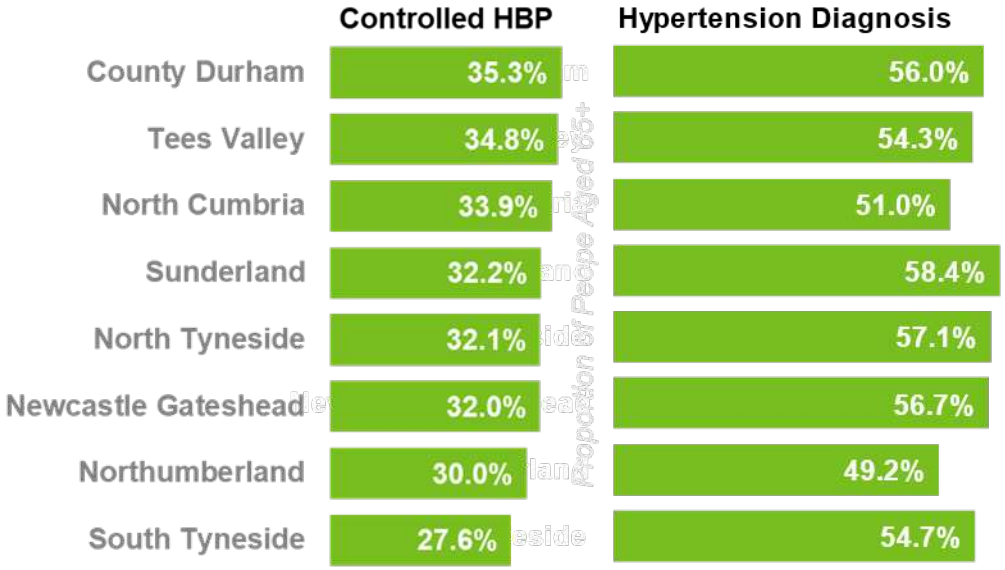


The **above** chart shows:

- on the **horizontal** the difference in rates of **hypertension** in people aged 65+ from the NENC mean place value
- on the **vertical** the difference in rates of **Controlled HBP** (**H**igh **B**lood **P**ressure) in people aged 65+ from the NENC mean place value

~203,000

People **aged 65+** (Oct '22) with **Controlled High Blood Pressure** (HBP)



Definition of controlled HBP:

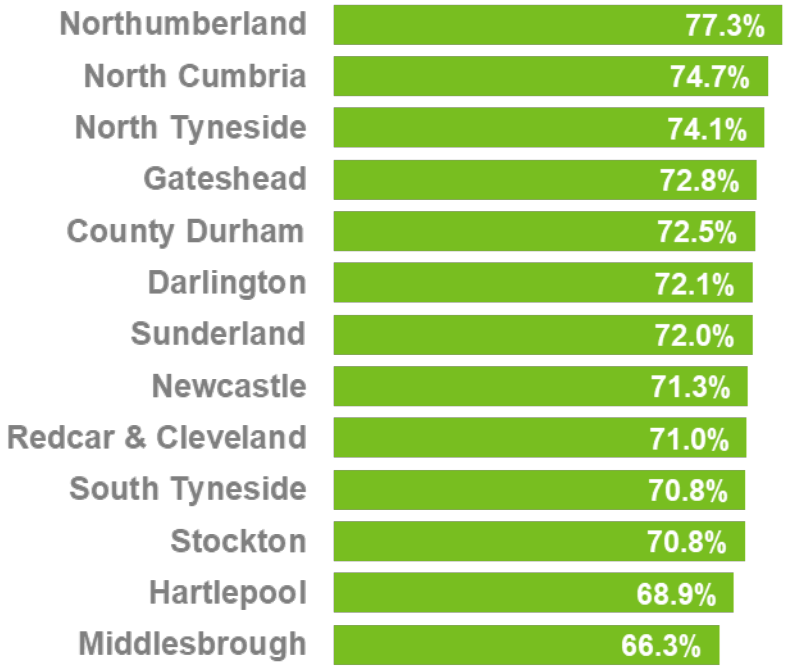
- **Systolic** blood pressure **below 140** mmHg
- **Diastolic** blood pressure **below 90** mmHg
- Currently taking **medication** for blood pressure
- Blood pressure **reading** within the **last 12 months**

2

How good is population uptake and coverage for preventive health interventions?

NHS
North East and North Cumbria

Bowel Cancer Screening Uptake



- Eligible people
- Aged **60-74**
- **Resident** in the area
- **g**uaiac **F**ecal **O**ccult **B**lood **T**est (**gFOBT**) screening result in the **past 30 months**
- **Excluding opt outs** and those whose **recall has ceased** for clinical reasons (e.g. no functioning colon)

72.7%

Bowel Cancer

people aged 60-74 Screening Uptake (Oct '22)

England uptake **70.3%**

3

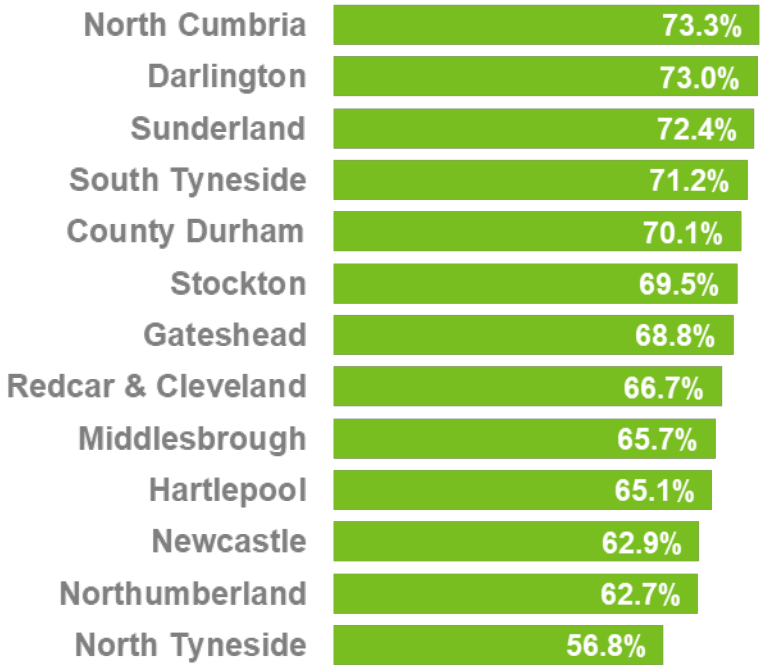
4

67.8%

Breast Cancer

women aged 53-70 Screening Uptake (Oct '22)

England uptake **64.9%**



- Eligible women
- Aged **53-70**
- **Resident** in the area
- **Registered** with a GP
- Screening test result in the **past 36 months**
- **Excluding** those whose **recall has ceased** for clinical reasons (e.g. due to bilateral mastectomy)

Breast Cancer Screening Uptake

Childhood Vaccination Coverage Statistics- England, 2021-22 - NDRS (digital.nhs.uk)

NHS
North East and North Cumbria

Q4. How good is **population uptake** and coverage for **preventive health** interventions?

Part A

- In 2021-22, the North East and Cumbria local authorities perform better than the national average for vaccine uptake in children in most cases, with the below exceptions:
  - Middlesbrough LA is below national average for uptake on every vaccination statistic, for 1,2 and 5 year olds.
  - Newcastle upon Tyne LA are lower than national average for DTaP-IPV-Hib-HepB (2yo), MenB (1&2yo) and Hib/MenC (5yo).
- The North East region is the highest performing region in England across all vaccine uptake metrics, with South Tyneside, Sunderland and County Durham LAs being the highest of all local authorities in the country for vaccine uptake in 1 and 2 year olds.
- The prevalence of controlled hypertension in NENC is significantly higher than the latest published national figure for those aged 65-74 (North East 27.5%, England 24.5%) and 75+ (North East 39.1%, England 29.8%).
- The highest prevalence within NENC is in County Durham and Newcastle upon Tyne LAs, which are 12% and 9% higher than the national figure for those aged 75+.

NHS
North East and North Cumbria

Q4. How good is **population uptake** and coverage for **preventive health** interventions?

Part - B

- Prevalence is higher in males generally, however in those aged 75+, the difference in prevalence in the North East compared to England is higher in females (+9.8%)
- The bowel cancer screening up take was higher in NENC (72.7%) than the national average (70.3%). The uptake rate in NENC ranged from 77.3% in Northumberland to 66.3% in Middlesbrough. All but two areas within NENC had a rate higher than the national uptake.
- The breast cancer screening up take was higher in NENC (67.8%) than the national average (64.9%). The uptake rate in NENC ranged from 73.3% in North Cumbria to 56.8% in North Tyneside. All but three areas within NENC had a rate higher than the national uptake.

NHS
North East and
North Cumbria

Q5.
What is known about levels of **incapacity and frailty** of older people **living at home**?

- What are the **numbers** of men and women aged **over 65** years with **moderate** and **severe** levels of frailty living within the ICS area, **by area**?
- What **age groups** are they in?
- How many **live alone**?

What is known about levels of incapacity and frailty of older people living at home?

NHS
North East and North Cumbria

9% of men aged 65+

67,000 People aged 65+ are **moderately** or **severely** frail (Dec '22)

~10% of people aged 65+

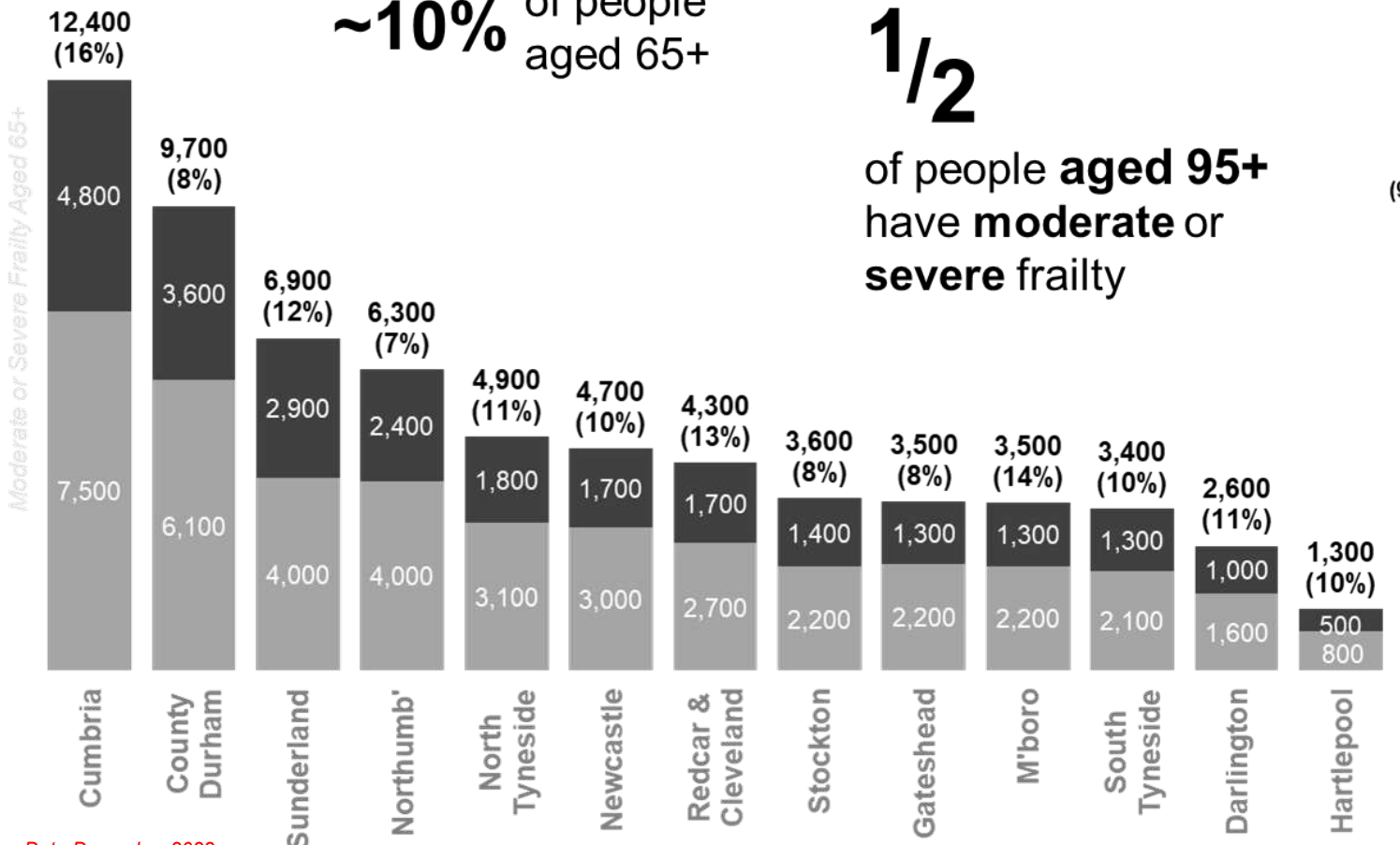
1/2 of people **aged 95+** have **moderate** or **severe** frailty

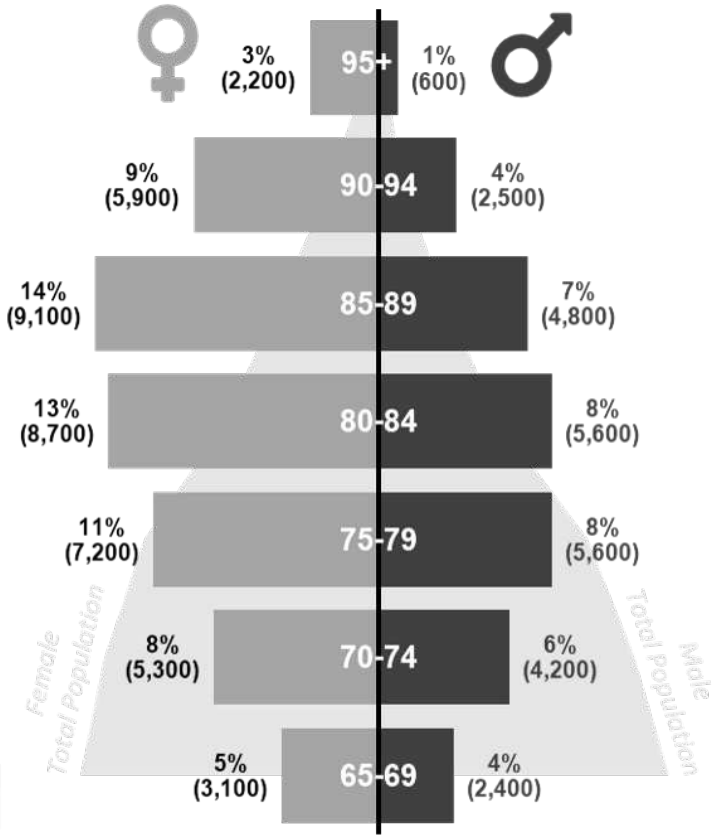
25,700

41,400

of women aged 65+

12%



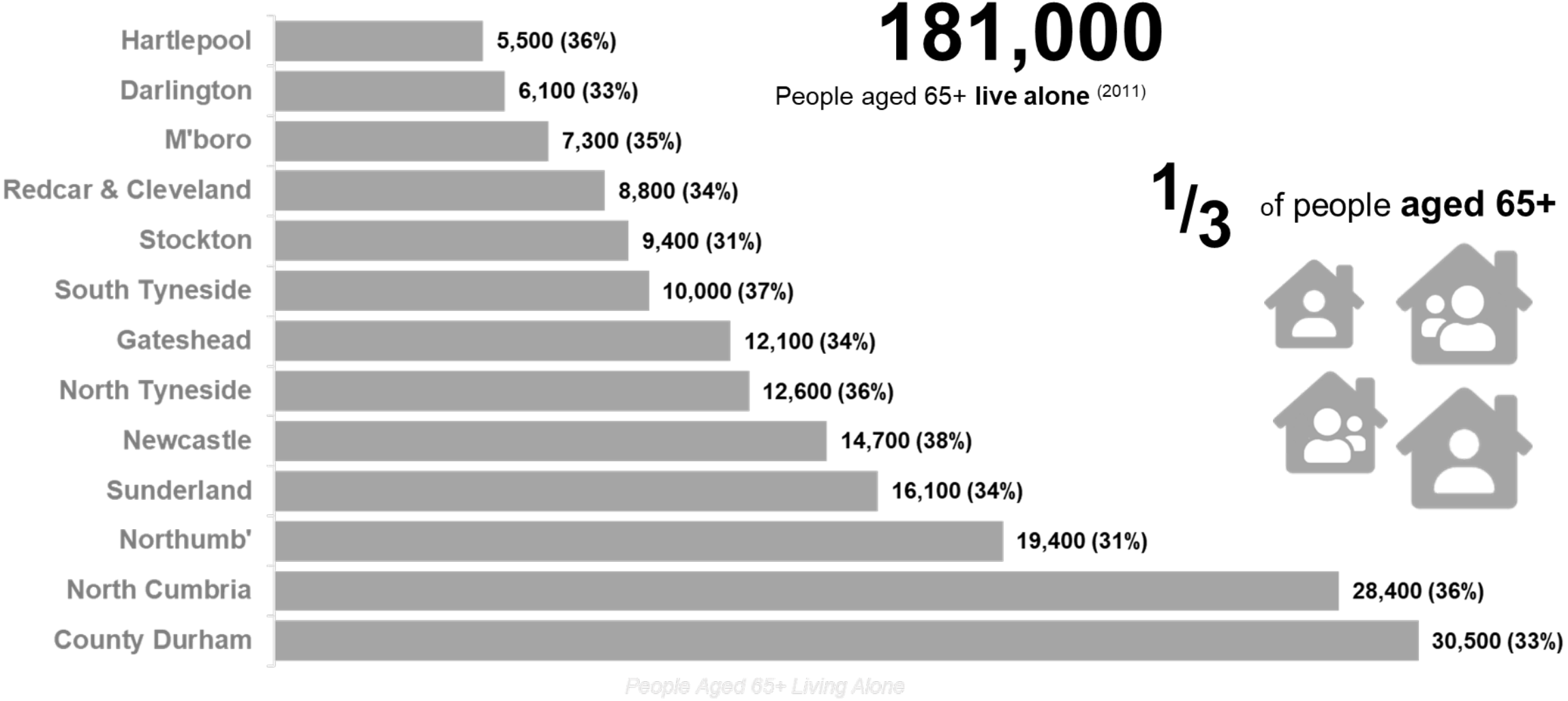


Proportion of Age & Gender in 65+ Mod/Severe Frail Population

Population Data: GP Practice Data December 2022
RAIDR primary care data based on coverage of 93% across NENC GP practices

What is known about levels of incapacity and frailty of older people living at home?

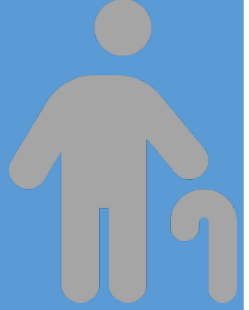
NHS
North East and North Cumbria



181,000

People aged 65+ **live alone** (2011)

1/3 of people **aged 65+**



NHS
North East and North Cumbria

Q5. What is known about levels of **incapacity and frailty** of older people **living at home**?

- The **identification of frailty is key** to support people pro-actively and reduce the risk of avoidable healthcare events; such as unplanned hospital admissions
- **Ageing Well workstreams** are working with clinical leads and NECS analysts to develop **new tools** that reflect the **wide range of risks** that can cause frailty
- This new approach is being rolled out across the **NENC Primary Care Community** through engagement and shared learning

NHS
North East and North Cumbria

Q6.
What is the level and causal nature of **avoidable harm** generated by care providers and **in care settings**?

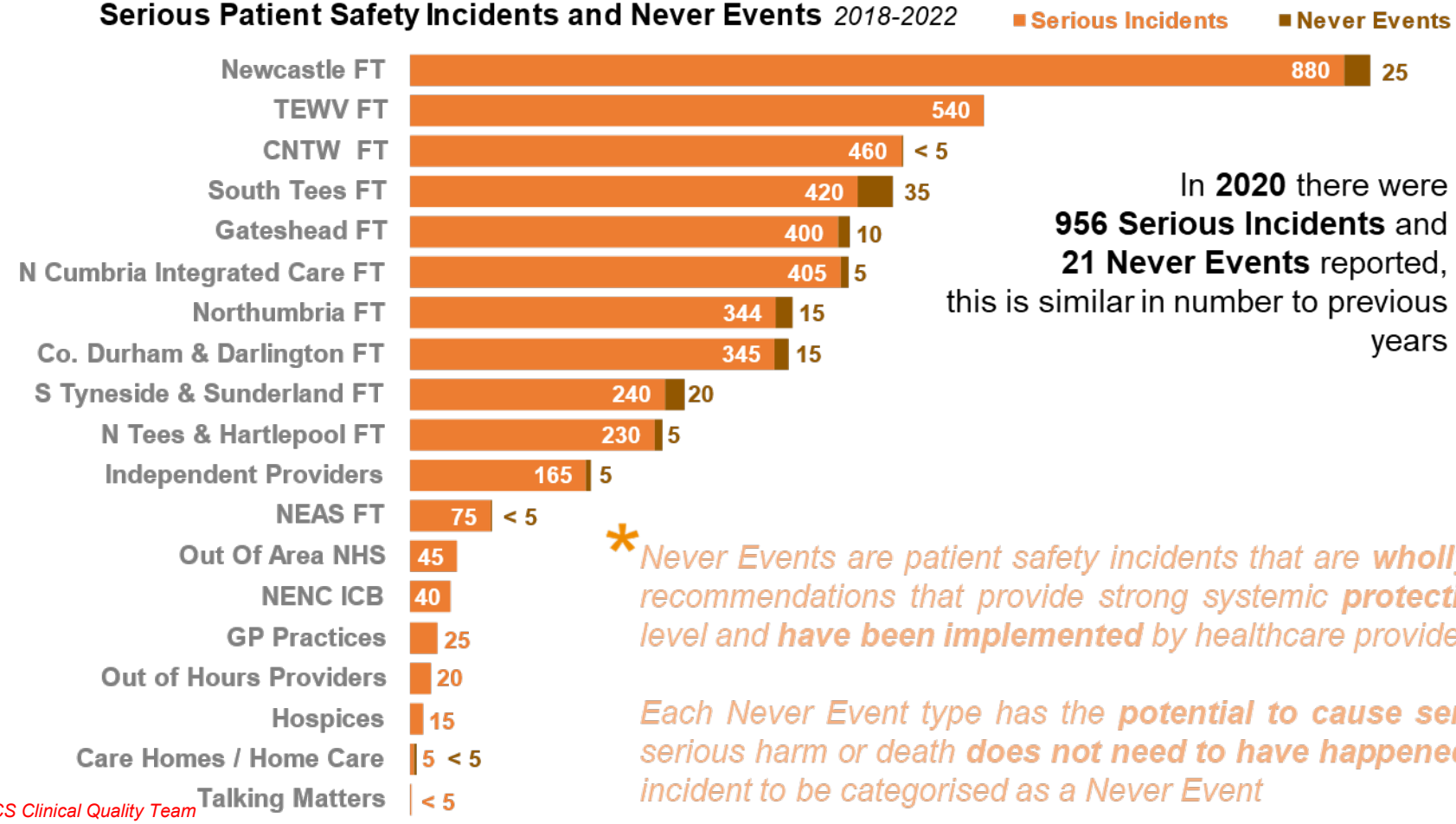
- What numbers of **serious patient safety incidents** have occurred in the **past five years** (2018-2022) in each of the **providers of care** within the ICB's jurisdiction?
- **Types** of incidents?
- Acknowledging that there will be overlap between serious incident and Never Events, what numbers and types of **Never Events** have occurred in each of the **providers of care** within the **last five years**?

What is the level and causal nature of avoidable harm generated by care providers and in care settings?

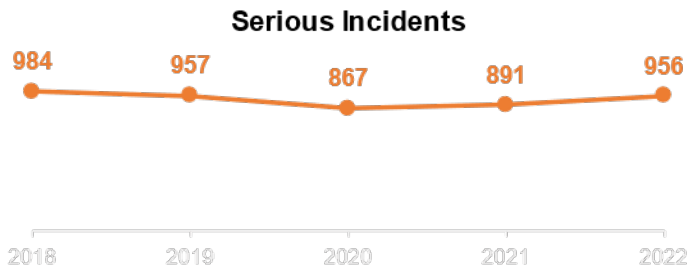
NHS
North East and North Cumbria

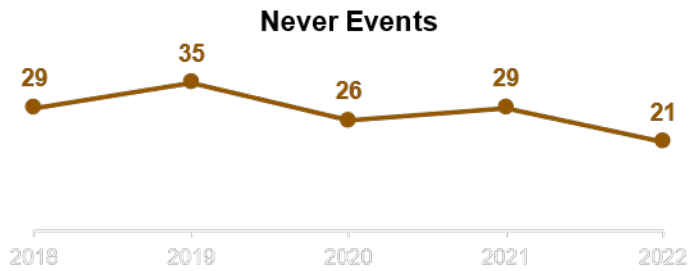
Serious Patient Safety Incidents recorded in the last 5 years (2018-22)

4,655 + 140 **Never Events***



In **2020** there were **956 Serious Incidents** and **21 Never Events** reported, this is similar in number to previous years





*Never Events are patient safety incidents that are **wholly preventable** where guidance or safety recommendations that provide strong systemic **protective barriers are available** at a national level and **have been implemented** by healthcare providers.*

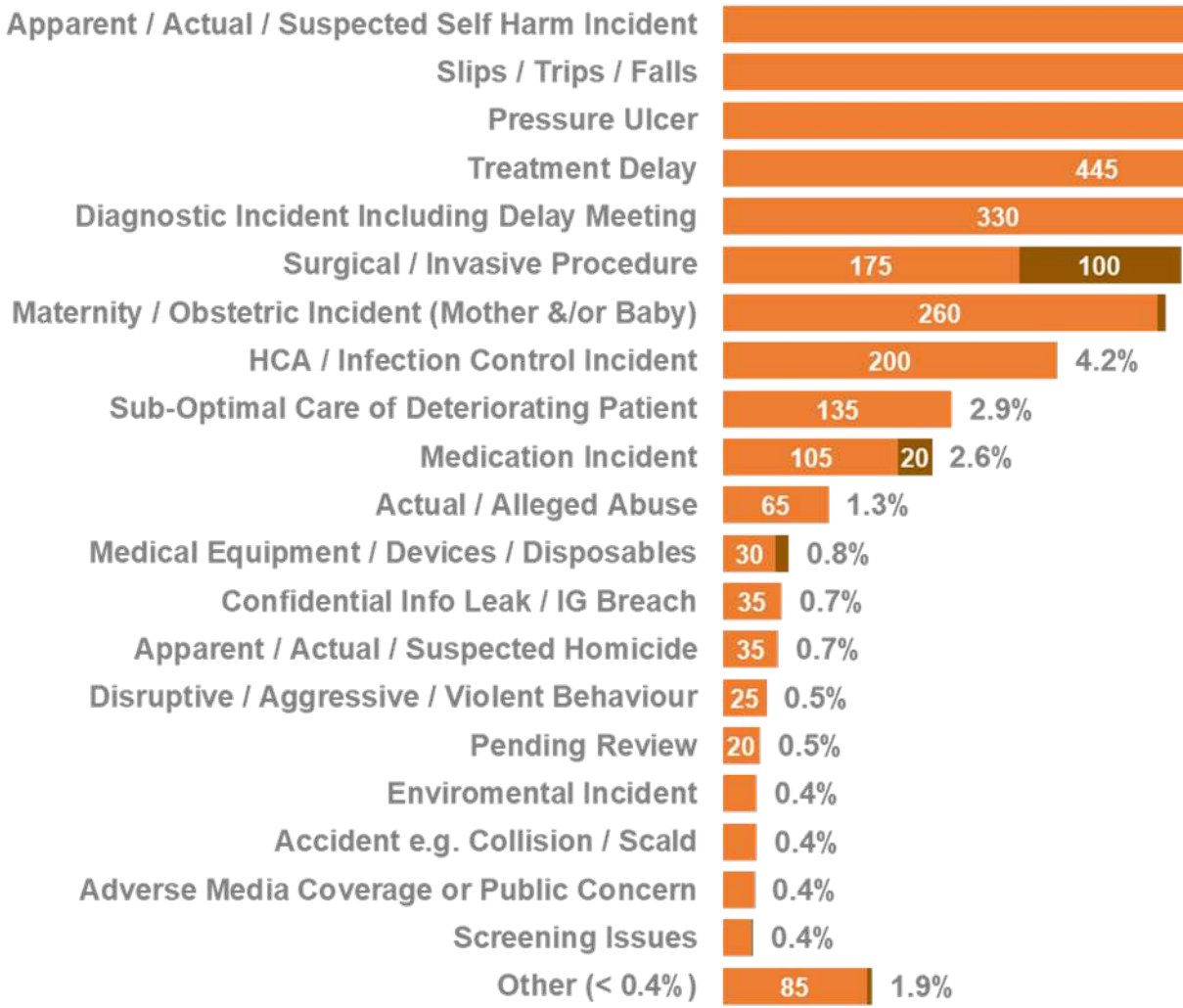
*Each Never Event type has the **potential to cause serious patient harm or death**. However, serious harm or death **does not need to have happened** as a result of a specific incident for that incident to be categorised as a Never Event*

NECS Clinical Quality Team
NHSE Revised Never Events policy and framework

What is the level and causal nature of avoidable harm generated by care providers and in care settings?

NHS
North East and North Cumbria

Serious Patient Safety Incidents and Never Events *2018-2022*



Apparent / Actual / Suspected Self Harm is the **most common** type of incident recorded in the last 5 years (2018-22)

recorded at the two main **mental health** providers:

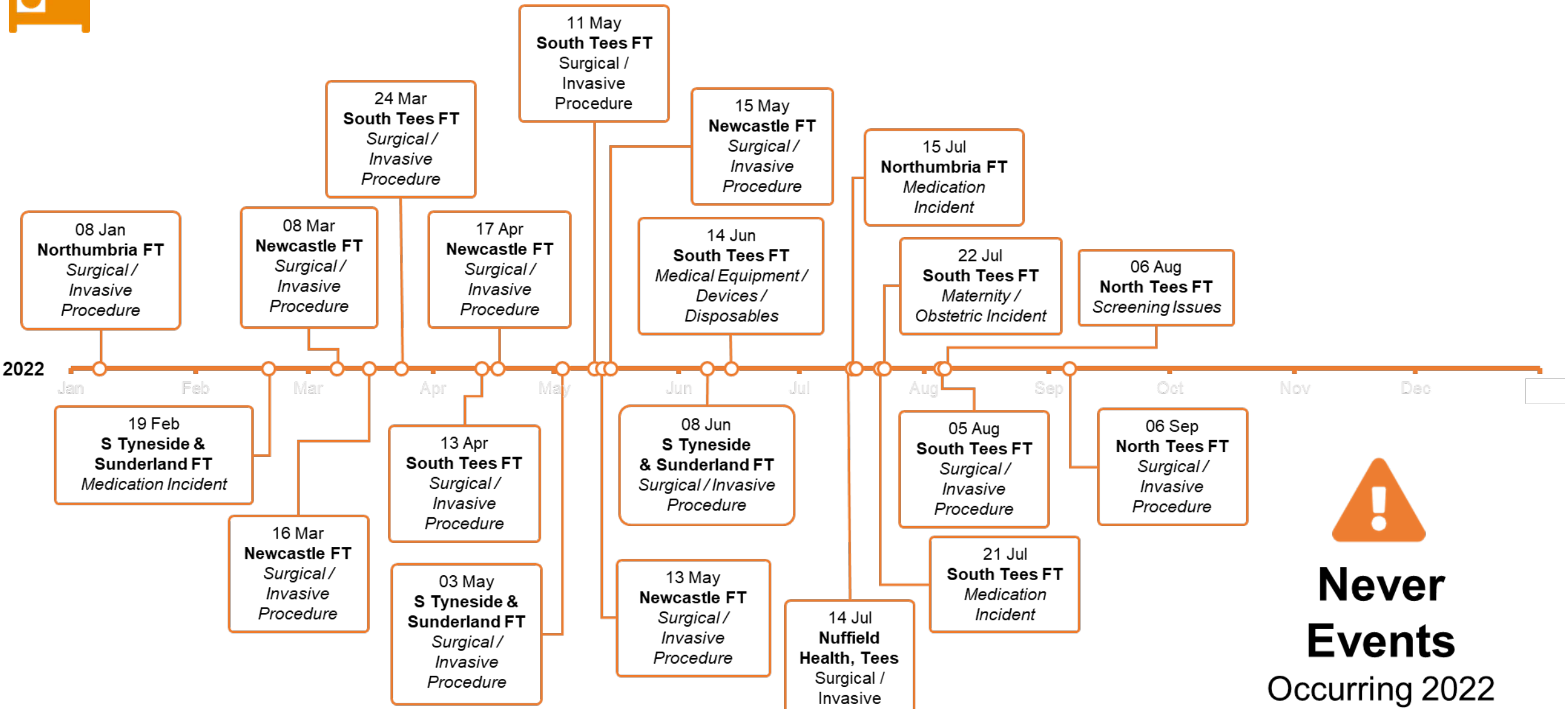
90% **Tees, Esk & Wear Valleys FT**
Cumbria, Northumberland, Tyne & Wear FT

Secondary care providers are the biggest contributors to the **rest of the top 10** most common incident types (*Slips/Trips/Falls* through *Medication Incidents*)

NECS Clinical Quality Team
NHSE Revised Never Events policy and framework

What is the level and causal nature of avoidable harm generated by care providers and in care settings?

NHS
North East and North Cumbria



Never Events
Occurring 2022

NHS
North East and North Cumbria

Q6.
What is the level and causal nature of **avoidable harm** generated by care providers and **in care settings**?

- In the past 5 years (2018 to 2022), there have been some 4,655 serious incidents together with 140 never events recorded and reported regionally.
- Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.
- Main causes of recorded incidents for Mental Health related services include; Apparent / Actual / Suspected Self Harm being the most common recorded in the last 5 years (2018-2022).
- Acute secondary care providers are the biggest contributors to the rest of the top 10 most common incident types (Slips/Trips/Falls through Medication Incidents)
- Never events are predominantly related to Surgical invasive procedures, followed by medication incidents, other reported problems relate mainly to screening and medical equipment events.

NHS
North East and
North Cumbria

Q7.
What are the risks to patients of acquiring an infection during their care?

- In progress – further update expected week ending 17th March 2023.

NHS
North East and
North Cumbria

Q8.
What do patients think of the care that they receive and what information about services is available to them?

- In progress – further update expected week ending 17th March 2023.

NHS
North East and
North Cumbria

Q9.
Children and young people's **mental health**?

- How many **referrals** to **children and adolescent mental health services** were made from each of the **ICS's Places** each year from **2018 to 2022**?
- Which are the **small areas** with the **highest number** of such referrals?
- How many **suicides** were there amongst young people **aged 15 to 19** years for each of the years **2018 to 2022** and **where did they live**?

Children and young people's mental health?

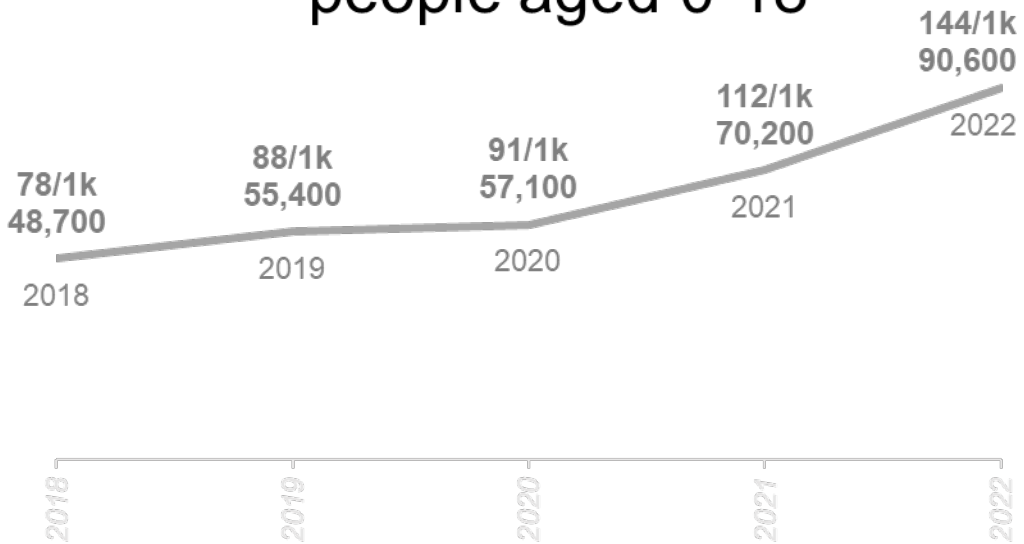
NHS
North East and North Cumbria

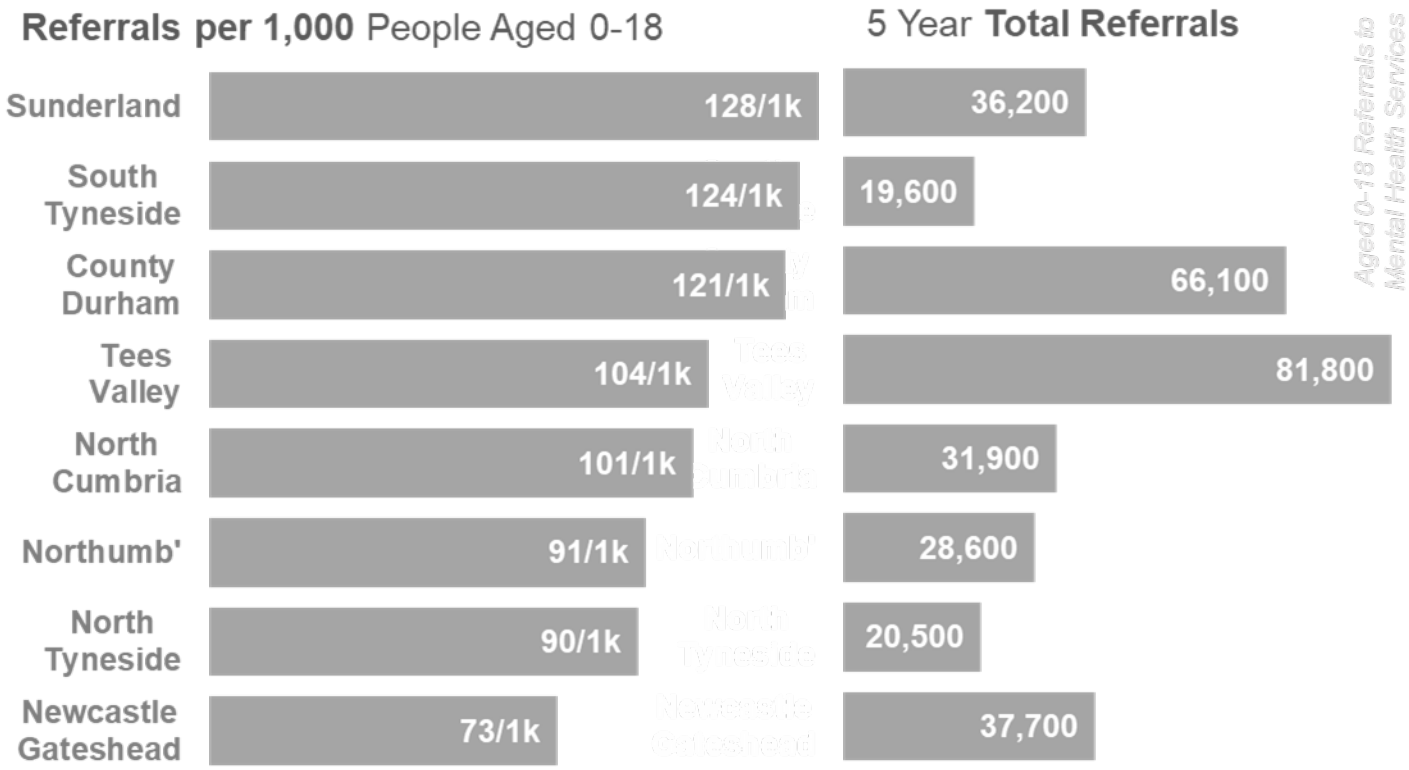
In the **past 5 years** (2018-2022) there were

322,000 referrals to **Mental Health Services** for people under **aged 0-18 years**

~117,000 distinct **patients**

~1 referral* per 10 people aged 0-18





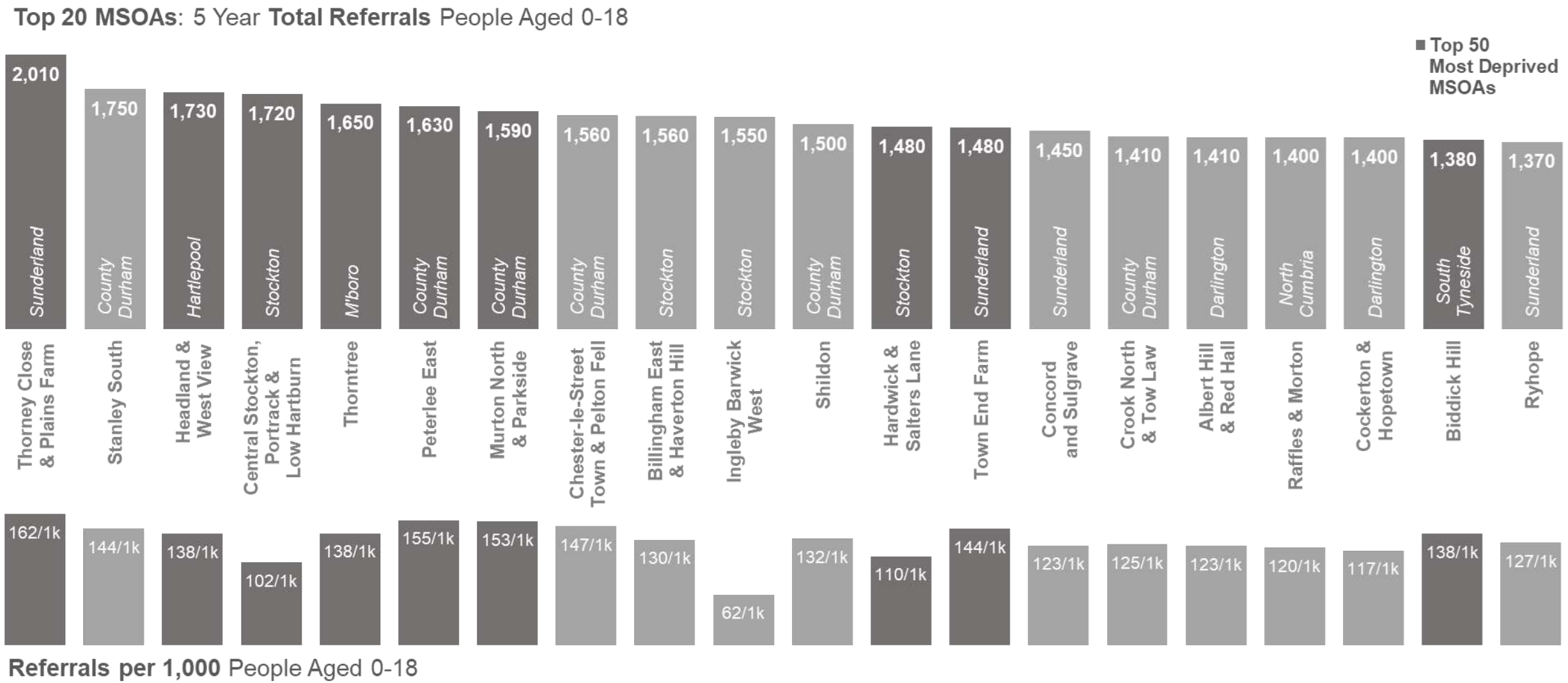
*Number of referrals made to **NHS funded mental health services** for patients aged 0-18 made in the years **2018 to 2022***

Referrals include mental health, eating disorders, learning disability, and autism & other neurodevelopmental conditions.

Mental Health Services Dataset (MHSDS) Commissioning extract
ONS mid-year population extracts (latest available year 2020 used for subsequent years)
NHS England GP registration data (using each year's June file)

Children and young people's mental health?

NHS
North East and North Cumbria



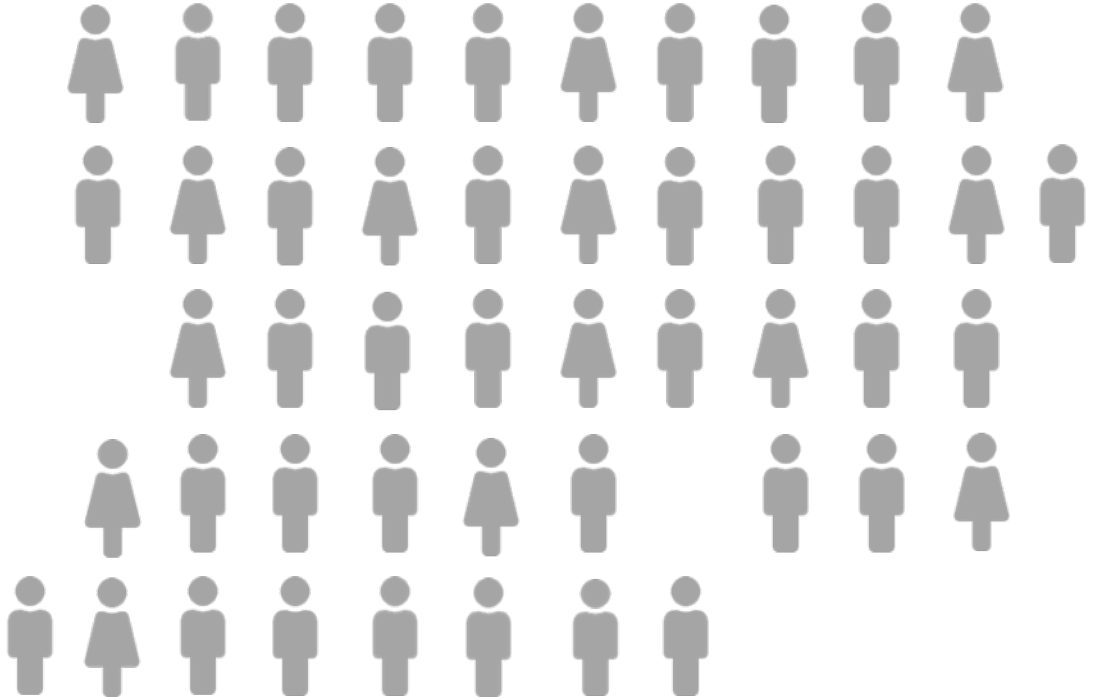
Mental Health Services Dataset (MHSDS) Commissioning extract
ONS mid-year population extracts (latest available year 2020 used for subsequent years)
NHS England GP registration data (using each year's June file)

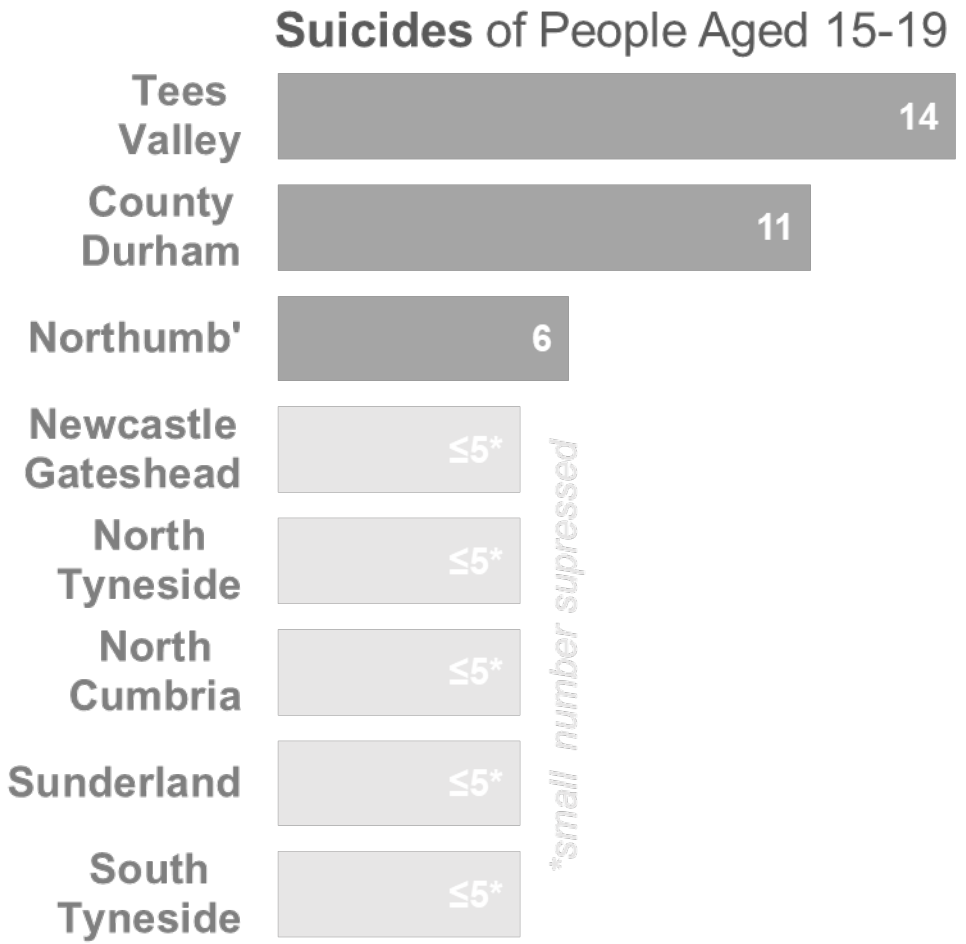
Children and young people's mental health?

NHS
North East and North Cumbria

47 deaths by **suicide** were recorded for people aged **15 to 19 years** old in NENC 2018 and 2022

Data likely to be incomplete for 2022 for cases awaiting coroner's verdict



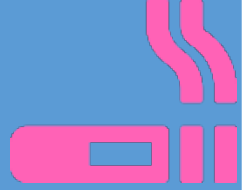


Deaths registration dataset

NHS
North East and
North Cumbria

Q9.
Children and young people's **mental health**?

- **Recovery Action Plan is in place** to deliver services by 2023/24 for increased number of children and young people receiving at least one mental health contact.
- **Waiting times** beginning to be **monitored**
- **Neurodevelopmental** conditions and **eating disorders** are challenging
- Difficult to **recruit and retain** staff



NHS
North East and
North Cumbria

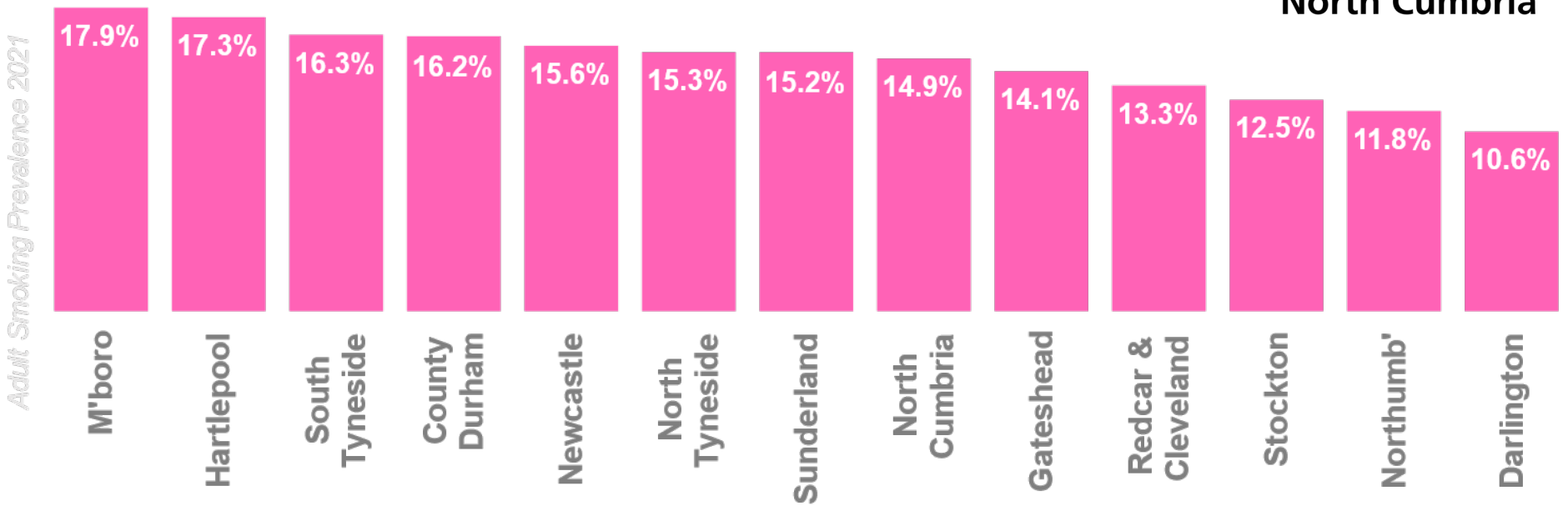
Q10.
What **progress** is being made in controlling **tobacco-related disease**?

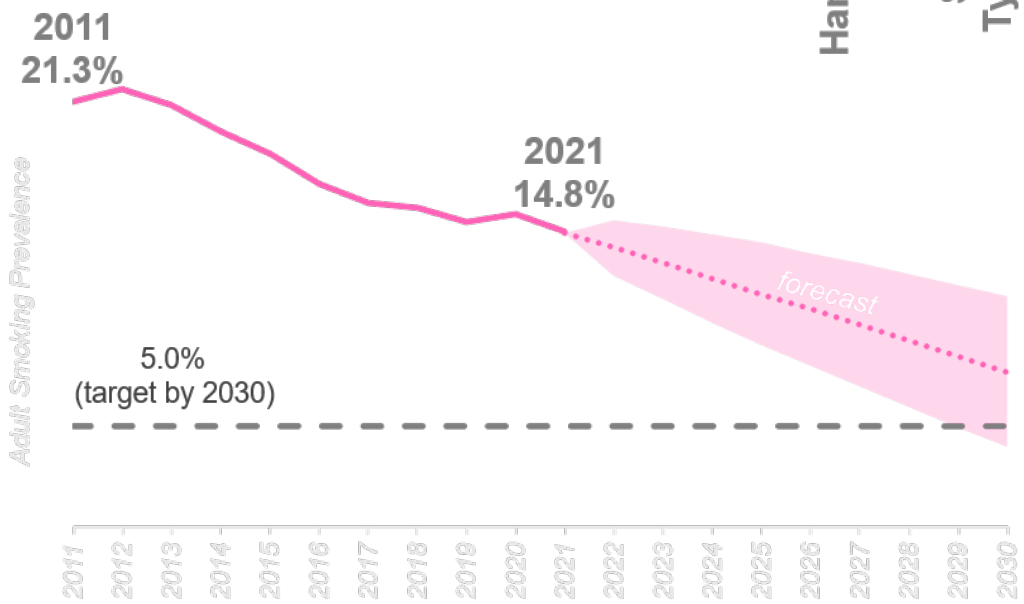
- What is the **prevalence of smoking** in each of the ICS **Places**?
- Which are the **small areas** that collectively contain **80% of the ICS's current smokers**?
- Which are the **ten small areas** with the **highest** smoking prevalence?
- How many people **attending smoking cessation** services in each of the ICS **Places** in the years **2018-2022**?
- What were the **quit rates** achieved by each of these services in the same time periods?

What progress is being made in controlling tobacco-related disease?

NHS
North East and North Cumbria

14.8%
of people aged 16+ are
smokers (APS 2021)





Smoking prevalence has a **target** of **5.0%** by **2030**

These figures are from survey data, but current **primary care data** shows:

- **Little variability** over time, prevalence being ~18% to ~20% for 3 years
- **Covid-19 impact** on the recording of recent (prev. 12 to 15 months) smoking status
- **Variation in recording** in different places

Improving this data is a current focus for **Treating Tobacco Dependence Taskforce** and would enable small area focus

Annual Population Survey data via ONS 2011-2021
NHS Stop Smoking Service reporting to Q4 `17-18 to Q4 `21-22

What progress is being made in controlling tobacco-related disease?

North East and North Cumbria

March 2022 rate of adults (16+) setting a **Quit Date** with a

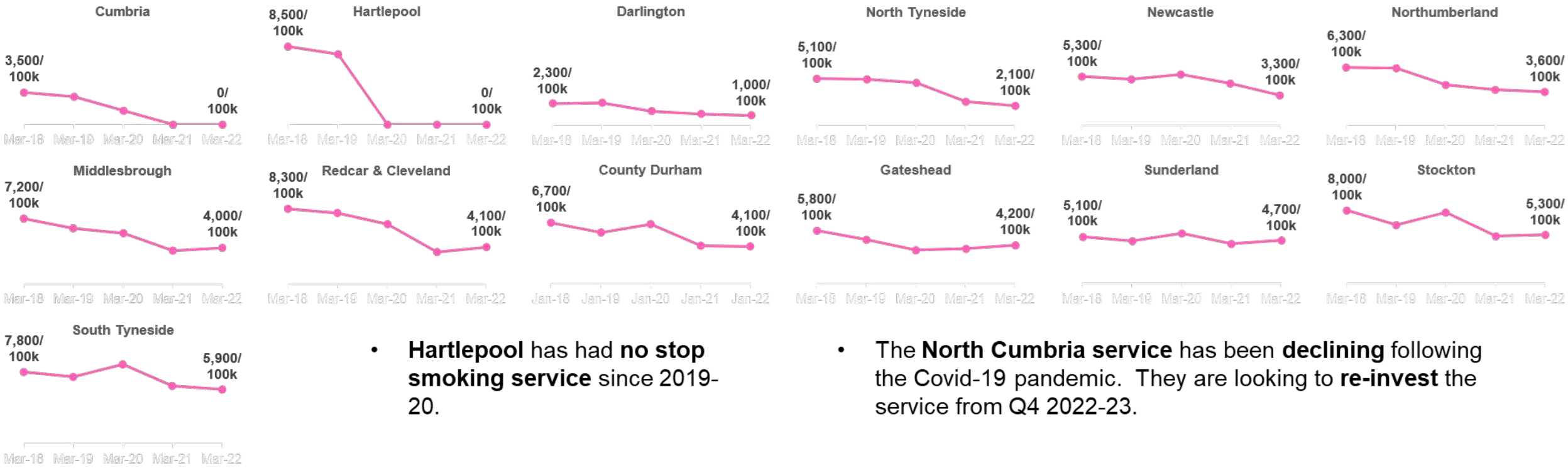
Stop Smoking Service

3,794 *per 100k aged 16+*

But in **March 2018** the rate was **higher** at **6,256** *per 100k aged 16+*

Setting a Quit Date 2018-2022

rate per 100,000 people aged 16+



- **Hartlepool** has had **no stop smoking service** since 2019-20.
- The **North Cumbria service** has been **declining** following the Covid-19 pandemic. They are looking to **re-invest** the service from Q4 2022-23.

Annual Population Survey data via ONS 2011-2021
NHS Stop Smoking Service reporting to Q4 `17-18 to Q4 `21-22

What progress is being made in controlling tobacco-related disease?

NHS
North East and North Cumbria

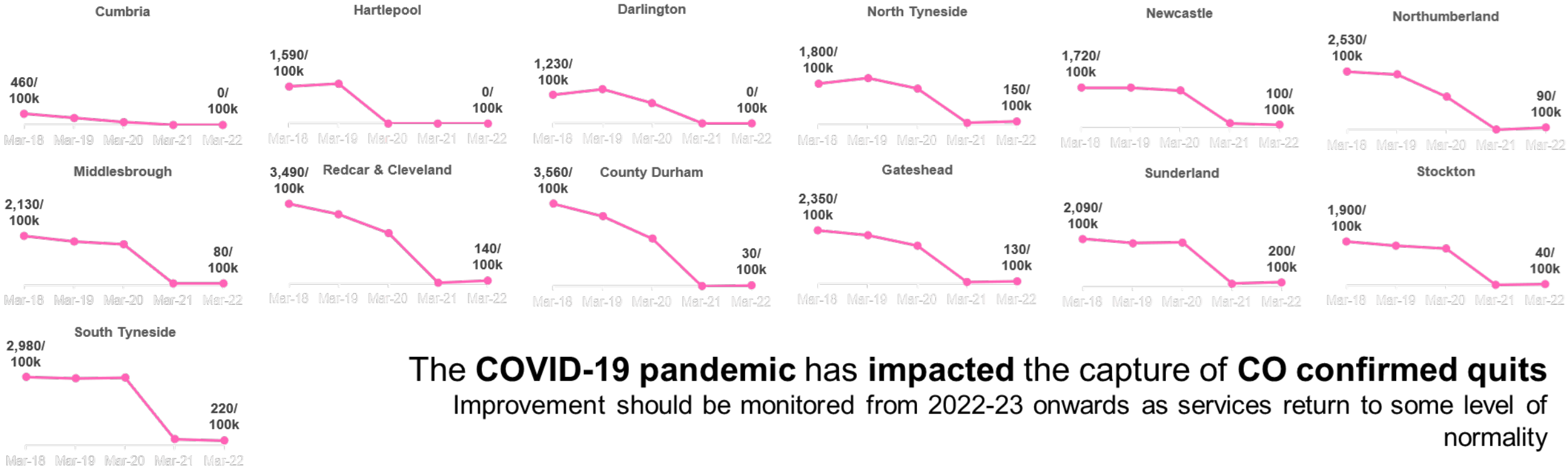
March 2022 rate of adults (16+) self reported as **Successful Quitters** then validated with a **Carbon Monoxide** (CO) monitor reading

97 *per 100k aged 16+*

But in **March 2018** the rate was **higher** at

2,408 *per 100k aged 16+*

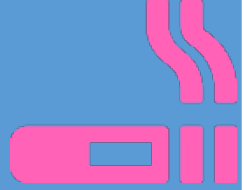
Successful quitters 2018-2022
self-reported with CO validation
rate per 100,000 people aged 16+



The **COVID-19 pandemic** has **impacted** the capture of **CO confirmed quits**

Improvement should be monitored from 2022-23 onwards as services return to some level of normality

Annual Population Survey data via ONS 2011-2021
NHS Stop Smoking Service reporting to Q4 `17-18 to Q4 `21-22



NHS
North East and
North Cumbria

Q10.
What **progress** is being made in controlling **tobacco-related disease**?

- In 2021, 14.8% of the 16+ population in the region were identified as smokers, this compares with 21.3% in 2011.
- Highest prevalence is Middlesbrough (17.9%) and the lowest is Darlington (10.6%).
- The region has a smoking reduction target of 5.0% by 2030.
- There are several smoking cessation initiatives regionally, as of March 2022, there were 3,794/100k adults (16+) setting a quit date, this compares to 6,256/100k in March 2018.
- Most “places have smoking cessation initiatives in operation, except Hartlepool, who have not had a service sine 2018-19. North Cumbria, service users have been declining sine the Covid-19 pandemic, a reinvestment plan is scheduled for Q4 2022-23.
- Self-reporting successful quitters are being validated/confirmed using Carbon Monoxide meter readings.

Data Sources (1/2)

NHS North East and North Cumbria

Diabetes

- Population Data: GP Practice Data January 2022
- RAIDR primary care data based on coverage of 93% across NENC GP practices
- Admissions data via SUS Oct '21 to Sep '22

Bowel Cancer

- National Cancer Registration and Analysis Service (NCRAS) CancerData

Frailty

- Population Data: GP Practice Data December 2022
- RAIDR primary care data based on coverage of 93% across NENC GP practices
- OHID Fingertips

Deprivation

- OHID Fingertips
- House of Commons Library uk-hex-cartograms-non-contiguous

Avoidable Harm

- NECS Clinical Quality Team
- NHSE Revised Never Events policy and framework

Data Sources (2/2)

NHS
North East and North Cumbria

Prevention

- RAIDR primary care data based on coverage of 93% across NENC GP practices
- National Cancer Registration and Analysis Service (NCRAS) CancerData
- BSA Primary Prescribed Medicines to Oct '22

Children & Young People's Mental Health

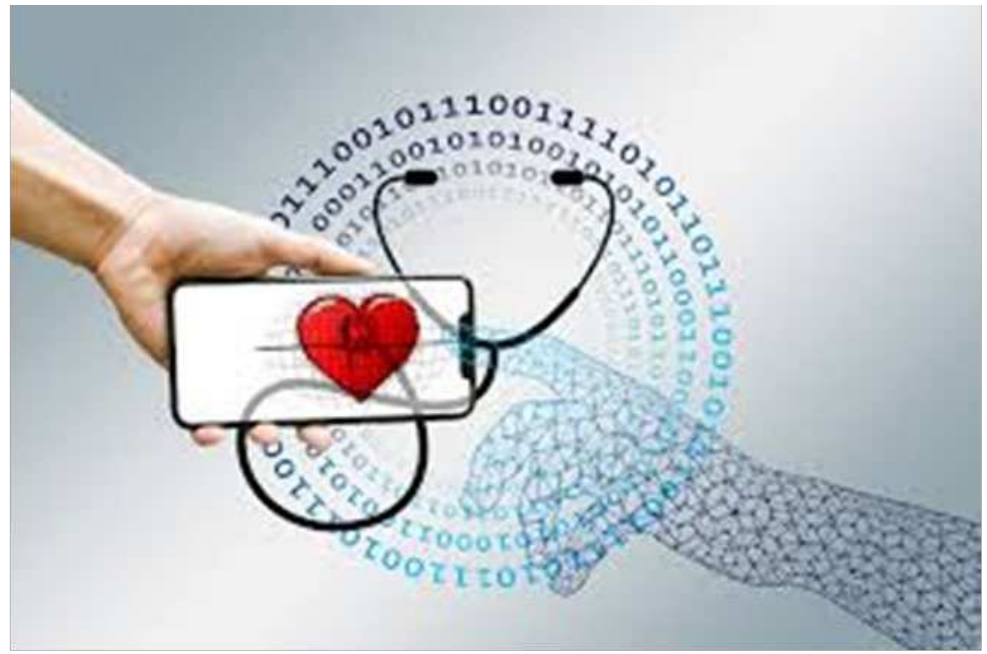
- Mental Health Services Dataset (MHSDS) Commissioning extract

- Deaths registration dataset
- ONS mid-year population extracts (latest available year 2020 used for subsequent years)
- NHS England GP registration data (using each year's June file)

Smoking

- Annual Population Survey data via ONS 2011-2021
- NHS Stop Smoking Service reporting to Q4 `17-18 to Q4 `21-22

NHS
North East and
North Cumbria



#DataSavesLives

Item: 7.1
Enclosure:

North East and North Cumbria

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

NORTH EAST & NORTH CUMBRIA ICB BOARD MEETING

28 March 2023

Report Title:	**Chief Executive Report**

Purpose of report

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

Key points

The report includes items on:

- An update on the Integrated Care Partnership Development and Place Based Working.
- The requirement to reduce the running costs of the Integrated Care Board.
- New national primary care contract.
- An update on the Hewitt Review.
- A meeting with the Department of Health and Social Care on discharge.
- Learning disability and the transforming care programme.
- The planned delegation from NHS England for specialised commissioning and pharmacy, optometry and dentistry.
- An update on the Hospice Collaboration for the North East and North Cumbria.
- The Shuri Network and International Women's Day.
- A letter received from the Equality and Human Rights Commission about the public sector equality duties.
- How we are working with Foundation Trusts on the Workforce Race and Equality Standards

Risks and issues

- To note the interim arrangements established for people with a learning disability established to ensure the effective oversight of people's placements
- To note the risk linked to the delegation of commissioning responsibilities from NHS England

Item: 7.1
Enclosure:

Assurances

The report provides an overview for the board on key national and local areas of interest and highlights any new risks.

Recommendation/action required

The Board is asked to:

- Receive the report and ask any questions of the Chief Executive.
- Note the current arrangements for learning disabilities oversight have been reviewed and action taken by the Chief Nurse
- Note the risks linked to the specialist commissioning, pharmacy, optometry and dentistry delegation, mitigation for these and approve the planned delegation of commissioning to the ICB.

Acronyms and abbreviations explained

ICB – Integrated Care Board
ICS – Integrated Care System
JMEG - Joint Management Executive Group
MOU - Memorandum of Understanding
NENC – North East and North Cumbria
NCTR - No Criteria to Reside
POD - Pharmacy, Optometry and Dentistry
PCN - Primary Care Networks
RCA – Running Cost Allowance
SDC – Safe Delegation Checklist
WRES – Workforce Race Equality Standard

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

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

Relevant legal/statutory issues

Note any relevant Acts, regulations, national guidelines etc

Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**	✓	**N/A**	

Item: 7.1
Enclosure:

If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓
Key implications						
Are additional resources required?	None noted.					
Has there been/does there need to be appropriate clinical involvement?	Not applicable – for information and assurance only.					
Has there been/does there need to be any patient and public involvement?	Not applicable – for information and assurance only.					
Has there been/does there need to be partner and/or other stakeholder engagement?	Engagement has taken place throughout the assurance process with NHS England and provider organisations.					

Item: 7.1
Enclosure:

North East and North Cumbria

Chief Executive Report

1. Introduction

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

2. National

2.1 Running Costs

NHS England (NHSE) have confirmed the expected 30% cut to the Running Cost Allowance (RCA) for the ICB for the next three years.

Baseline allowances for ICBs have already been held flat in cash terms in 2023/24. The RCA will then be subject to a 30% real terms reduction per ICB by 2025/26, with at least 20% to be delivered in 2024/25, as shown in the table below:

ICB Running Cost Allowance	2023/24 £'000	2024/25 £'000	2025/26 £'000
NHS North East and North Cumbria ICB	**57,406**	**46,785**	**43,227**
Cumulative % reduction (cash terms)		*-19%*	*-25%*
Cumulative % reduction (real terms estimate)	*-3%*	*-22%*	*-30%*

I have established a working group to develop the approach we will take to deliver this national requirement. Whilst this will be challenging it does present us with an opportunity to ensure the ICB is operating efficiently and effectively to deliver our core aims.

2.2 Primary Care 2023/2024 Changes to GP Contract

On 06 March NHSE announced changes to the 2023/24 GP Contract. The key changes are a response to patient feedback on access. From 2025 all GP practice analogue telephone systems must be replaced by a cloud-based telephony. NHSE have produced a Better Purchase Framework for General Practice and capital funding will be available. The ICB will support practices with the transition and implementation.

Patients will also be offered an assessment of need or signposted to an appropriate service upon making initial contact with a practice. Patients will no longer be asked to ring back the next morning and try again. Patients are also to have online access to their medical records for new health information by 31 October 2023.

Further updates linked to workforce are expected given the shortfall in General Practitioners. The additional roles reimbursement scheme will be given a number of new flexibilities around Nurse Practitioners and Mental Health Practitioners.

The impact and investment fund will have targets reduced from 33 to 5. These indicators will concentrate on flu vaccinations, learning disability health checks, early cancer diagnosis and the 2-week general practice access indicator. The funding will become a monthly payment to primary care networks (PCNs) via the capacity and access support payment, which no doubt should ease some of the workforce and financial challenges for general practice.

Flexibilities have been introduced for immunisations and vaccinations to promote coverage for routine childhood programmes. There is also the introduction of a new personalised care adjustment, which will enable the vaccination of patients who have registered too late, removing the penalty to the Practice. The well-established quality and outcomes framework has some indicator changes, including the quality improvement modules which will focus on workforce wellbeing and optimising demand and capacity in general practice.

2.3 Hewitt Review

The publication of the report has been delayed slightly and is now expected to be published at the end of March 2023.

3. **North East and North Cumbria**

3.1 Integrated Care Partnership Development

When the Strategic Integrated Care Partnership (ICP) met in December it was agreed to seek nominations to chair each of the four Area ICPs. It was also recommended that these chairs should be elected members – typically either current Health Wellbeing Board chairs or local authority cabinet members with a relevant portfolio, such as Adults Services or Public Health. Nominations were then put forward from each area which were then considered by a joint ICB and Local Authority appointments panel which met last week and was chaired by Sir Liam as acting chair of the Strategic ICP.

We are pleased to confirm that we have now appointed four highly experienced and knowledgeable elected members to chair our Area ICPs: Councillor Lynne Caffrey from Gateshead will chair the North Area ICP, Councillor Bob Cook, leader of Stockton-on-Tees Borough Council will chair the Tees Valley Area ICP, Councillor Kelly Chequer, from Sunderland will chair the Central Area ICP and Councillor Mark Fryer, who is the leader of the new Cumberland Council, will chair the North Cumbria Area ICP.

We are delighted to now have these chairs in post, and they will serve for two years. They will lead and give direction to area ICP members in the delivery of the integrated care strategy 'better health and wellbeing for all'.

They will also lead on the needs assessment process for our Integrated Care Strategy, building up a picture of need from each of the places within their Areas, and feeding this into the biannual meetings of our Strategic ICP which covers North East and North Cumbria. The next meeting of the Strategic ICP will take place on 21 June.

3.2 Place-Based Working

How we work with our partners in each of our fourteen local authority 'places' has been a key consideration for us since before the ICB was established. Through the work of the Joint Management Executive Group (JMEG), comprising senior executives from the ICB, NHS foundation trusts and local authorities, we formally recognised the importance of minimising disruption for the 'Place-Based Partnerships' that already exist between the NHS and local authorities in each of our places. A key consideration has been thinking through how to safely delegate ICB functions and resources to those places, while retaining clear accountability to the ICB for how those functions are discharged and money is spent locally.

At the most recent meeting of JMEG we identified a pragmatic way forward which will utilise our existing Place-Based Partnerships as the key delivery vehicle for integrated services in each of our places – working alongside their respective Health and Wellbeing Boards who will retain their duty to lead the Joint Strategic Needs Assessment process locally and the setting of local priorities through a Joint Local Health Wellbeing Strategy.

JMEG agreed with our proposal to adapt these existing Place Based Partnerships so that as well as providing an important consultative body and forum for integrated working they can also oversee the functions and resources delegated to place from the ICB, as well as providing a vehicle for the important joint governance work we need to carry out with local authority partners on the Better Care Fund and our Section 75 agreements (which allows the ICB and local authorities to contribute to a common fund which can be used to commission health or social care related services). Put simply, we will establish a governance model in each of our places based around one partnership meeting in three parts.

Our approach here will be one of learning by doing, and we are keen to test these proposed place governance arrangements and associated financial delegations in 2023/24 to identify any operational challenges and mutually agreed solutions. It was agreed Durham will be a test bed for these. Further work is now being led by our Corporate Governance, Communications and Involvement team to align these governance arrangements, so that we can both empower our Place-based Partnerships whilst ensuring accountability to the ICB. Formal proposals setting out these governance arrangements in more detail will need to come to a future meeting of the ICB for formal approval.

3.3 Department of Health and Social Care Discharge

The ICB discharge lead and Local Authority ICB Board representative met with representatives from DHSC and the NHSE Hospital Discharge teams to share our joint approach to improving discharge across the ICS.

The meeting focused on the following four questions:

1. Why do you believe that North East and North Cumbria ICS's no criteria to reside (NCTR) numbers have reduced since October?
2. Are there any specific activities that you think have been effective in reducing NCTRs?
3. Do you think there is anything preventing NCTRs reducing at a faster rate?
4. Is there anything else specific to your local context that you think we should be aware of in relation to NCTR numbers or the impact of the Winter Discharge Fund and NHS step-down care funding?

The ICB were acknowledged for being one of a small number of ICBs who have seen a reduction in the number of people with NCTR in hospital. We shared our approach to discharge, the value of having a joint plan, collective accountability at place, having measurable outcomes and system leadership. In terms of reducing at a faster rate, we discussed the challenge with the lateness and non-recurrent funding of schemes and workforce.

For the final question we discussed the complexity of the ICB especially with 13 Local Authorities, 8 Acute and 2 Mental Health providers and how this caused variation in the numbers of people not meeting the criteria to reside but how we have taken collective responsibility at our places to deliver improvements. The ICS were praised for their leadership of the discharge processes.

3.4 Learning Disability Transforming Care

The current arrangements for the oversight of people with a Learning Disability who require complex packages of care in the community have been reviewed. The outcome identified areas for improvement and the Chief Nurse is taking action to improve the oversight and monitoring of people in placements.

3.5 Specialised Commissioning

Specialised commissioning is due to be delegated to ICBs from April 2024 with an overarching aim of enabling more joined up commissioning across patient pathways.

From April 2023, there will be a transition year where ICBs will increase their understanding and influence on specialised commissioning. The ICB Board received a report in November 2022 which included an overview of the timeline for a phased implementation of specialised commissioning delegation, the pre-delegation assessment framework submission and risks and issues associated with the delegation of specialised commissioning. Importantly, the report set out NENC ICB's intention to work jointly with NHSE to begin influencing specialised commissioning decisions during 2023/24 and to conduct due diligence and prepare for full delegation in April 2024.

The ICB's greater involvement from April 2023 will be via a Joint Committee with NHSE which will support NHSE specialised service commissioning. The Joint Committee will not be a formal part of the ICB governance though it is proposed that updates will be provided to the Executive Committee during 2023/24, via the Chief Strategy and Operations Director who will be a voting member of the Joint Committee.

The Joint Committee will have a support structure of sub-committees and task and finish groups which will enable ICB officers to conduct due diligence on finance, service and quality risks and design the future commissioning model to be established for April 2024. The Joint Committee will be underpinned by a joint working agreement which sets out how the ICB and NHSE will work together. The ICB will take on no risk, financial or otherwise, during the transition year but will gain influence on specialised commissioning with involvement in NHSE decision making.

The Executive Committee reviewed and approved the proposed joint working agreement in March 2023 and the I, the Chief Executive, will sign the final version. Once the Joint Committee, sub-committee and task and finish groups are up and running, ICB officers will focus on two main things over the coming months:

- Increasing understanding of, and involvement in, specialised commissioning functions via the Joint Committee.
- Undertaking due diligence, preparing a delivery model and meeting NHSE pre-delegation assessment framework requirements for full delegation from April 2024.

The delivery model for delegated specialised commissioning within the ICB will be particularly important and will need to align and be incorporated within ICB structures and governance to ensure the desired integration is delivered.

3.6 Pharmacy, Optometry and Pharmacy Delegation

The ICB continues to work closely with colleagues in NHSE on the planned delegation of pharmacy, optometry and dental services.

3.7 Hospice Collaboration

I am delighted the Hospices across the North East and North Cumbria have formed a Collaborative. Given the challenging financial climate, which is proving particularly difficult for organisations reliant on donations, it was good to learn more about their collaborative working when I met with them. I have ensured they are connected with the work of the ICS and together we have identified areas where we have some opportunities, such as digital, and their role in palliative and end of life care plans.

3.8 The Shuri Network

The Shuri Network was established 2019 and was set up to; celebrate difference and diversity in digital health, challenging the system to take action and supporting women of colour to succeed in their careers. There are currently around 2400 members and 300 allies in the network nationally.

As a region, we have taken the opportunity to become part of the Shuri Network and help create a greater level of diversity and inclusion in digital health roles through the Digital fellowship programme. The objectives of the programme are to support women from minority ethnic groups who work within digital health to progress into senior positions and decrease the current disparity in representation at senior levels.

This will also help NHS organisations to upskill staff, implement digital change and build a pipeline of inclusive digital leadership.

This is a tremendous opportunity for our people in our ICS and our digital data and technology agenda and is clearly an example of "*being the best at getting better*".

3.9 EHRC Letter

Each ICB Chief Executives has received a letter from the Equality and Human Rights Commission relating to our responsibilities under the Public Sector Equality Duties. This is an area we take very seriously, and I will bring a detailed update to the Board later this year on the actions we are taken to meet these.

3.10 Workforce Race Equality Standard

The Workforce Race Equality Standard results have been published for all NHS Trusts. There is much opportunity for improvement across all organisations, as well as sharing good practice. Our Director of Health Equity and Inclusion is working with each of our NHS Trusts to develop an improvement approach. The outcome of this and approach taken will be shared at a future meeting.

4. Recommendations

The Board is asked to:

- Receive the report and ask any questions of the Chief Executive.
- Note the current arrangements for learning disabilities oversight have been reviewed and action taken by the Chief Nurse
- Note the risks linked to the specialist commissioning, pharmacy, optometry and dentistry delegation, mitigation for these and approve the planned delegation of commissioning to the ICB.

Name of Author: Samantha Allen

Name of Sponsoring Director: Sir Liam Donaldson

Date: 15 March 2023

Item: 8.1

NHS
North East and North Cumbria

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

BOARD 28 March 2023	
Report Title:	**North East and North Cumbria (NENC) ICB: Integrated Delivery report – February 2023**

Purpose of report

The NENC Integrated Delivery Report provides an ICS overview of quality, performance and finance, highlighting any significant changes, areas of risk and mitigating actions. The report encompasses key elements of the 2022/23 planning priorities, NHS Oversight Framework (NHS OF) metrics, some NHS Long Term Plan (LTP) and NHS People Plan commitments. The performance and finance elements of the report are discussed in detail at the Finance Performance and Investment Committee, and the Quality elements at the Quality and Safety Committee. The report is also received by the ICB Executive Committee and the NENC ICB Board.

The report uses published performance and quality data covering December 2022 for most metrics and January 2023 for others, unless otherwise specified. The finance update is at January 2023.

Key points

Quality - key changes from previous report

CQC Inspection and updates

North Cumbria Integrated Care NHS Foundation Trust (NCICFT) – the CQC has classed the Trust as high risk particularly in relation to the medical wards. Concerns include repeated incidents with similar themes and concerns about sharing lessons to reduce reoccurrence.

South Tyneside and Sunderland NHS Foundation Trust (STSFT) received an overall rating of *'requires improvement'* from the CQC. The report published on 3 February 2023 showed the Trust was rated as requires improvement across the domains of Safe, Effective,

	Responsive and Well-led. Caring continued to be rated as good. The Trust's response and action plan will be shared with the ICB via the Quality Review Group (QRG) arrangements. North East Ambulance Service (NEAS) received an overall rating of *'requires improvement'* from the CQC. The report published on 1 February 2023 showed the Trust was rated as requires improvement across the domains of Safe and Effective, Well-led was rated as inadequate and Caring and Responsive were rated as good. The Trust's response and action plan will be shared with the ICB via the QRG arrangements. BPAS Middlesborough CQC Inspection Report: The provider has undertaken an extensive improvement programme and completed the required actions outlined in the CQC report. The conditions imposed on the registration have now been removed and the associated Contract & Performance Notice has been lifted.
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Independent Provider	An independent mental health provider notified the ICB of a serious incident involving a locum consultant undertaking attention deficit hyperactivity disorder (ADHD) assessments, who was found to be working below acceptable standards. A full investigation is underway, and a number of interim measures have been introduced.

Quality – other areas of note/risk

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	outcome of the recent CQC inspection will also be known at that point.
NEAS	A Board to Board meeting with NHSE took place on 2 February 2023 to discuss CQC recommendations and it was confirmed that the trust would move to segment 3.
Workforce and capacity in health and social care	Significant issues in relation to workforce are impacting on capacity to source placements in the community (packages of care).
System flow	Significant pressures across health and social care system resulting in pressures on emergency departments and ambulance waits.
CHC	Financial risks in relation to CHC fee rates in Northumberland which are being managed centrally in the ICB, some capacity risks relating to a mixed model of CHC service delivery in the North relating to capacity. CHC Fragility in Domiciliary Care market: Continued concerns in North Cumbria with multiple domiciliary providers.
SEND	Special Educational Needs and Disability (SEND) health funding and Inspection Framework: Publication of the revised SEND inspection framework is fuelling activity in preparation for an anticipated round of inspections commencing Spring 2023. Revised guidance on locality authority (LA) high needs budgets is presenting a financial risk to the ICB in Newcastle Gateshead regarding funding to meet health needs in Special Schools. This issue has potential ICB wide implications.
LeDeR	Learning from Death Reviews(LeDeR): Risks remain around the availability of reviewers. NECS were commissioned to undertake a number of reviews late last year and these are progressing well. It is anticipated however that NECs may take on further cases due to continual increases in caseload. NENC ICB is currently reviewing the long term plan for LeDeR workforce.

Quality and Safety Committee – comments/actions

The Quality and Safety Committee met on 16 February and received the January Integrated Delivery report and updates from the 4 Area Directors of Nursing. Committee members noted the key changes and key risks, particularly in relation to CQC ratings. It was confirmed that the detailed surveillance and discussions around quality takes place in the 4 area quality and safety sub committees with reporting by exception to the ICB Quality and Safety Committee to highlight areas of good practice, progress, risk, learning and any areas where support is needed. The risks that were highlighted by the area quality assurance activity are noted in this report.

Committee members noted the continuing performance challenges in relation to long waits for elective care and pressures in urgent and emergency care pathways, it was requested going forward that the report draws out the quality impact of relevant performance metrics.

The Committee received a separate report on the Clinical Negligence Scheme for Trusts (CNST), a scheme which incentivises ten maternity safety actions. The ICB has the responsibility to confirm the self-declaration of the eight maternity providers. Four trusts in NENC are currently declaring full compliance and 4 are declaring non-compliance. The Trusts that have declared elements of non-compliance have submitted action plans and will provide a quarterly report on progress to the NENC LMNS. NENC ICB held a session with all providers using local intelligence and data to provide the assurance that all declared positions were accurate.

Performance - Key Changes from Previous Report

Handover delays	Following a rapid process improvement workshop (RPIW) in November 2022, a new approach whereby NEAS crews will leave patients in the care of ED staff at 59 minutes has gone live from February 2023. Handover performance has significantly improved w/e 18 February 2023 with an average of 20 hours lost per day. In addition, 88.7% of handovers were under 30 minutes compared to a 95% standard, and 92.2% under 60 minutes (expected standard of zero >60 mins). These compare favourably to previously reported levels as at w/e 15 January of 76.3% and 86.2% respectively.
12 hour delays in A&E from decision to admit	Patients waiting in A&E more than 12 hours following decision to treat has decreased significantly in January to 1583 following a significant increase to 2347 in December across NENC.
Ambulance Response times	Ambulance response times were extremely challenging through December 2022 but have shown improvements in January 2023. Category 2 mean performance has since improved from 1:36:22 in December to 32:24 in January 2023.
78+ week waiters	Although 78+ waiters have plateaued in December 2022 compared to November levels, unvalidated weekly data shows a decrease in recent weeks across NENC to 990 (w/e 29 Jan), with a particular reduction at South Tees. The majority of the long waiters which remain are at NUTH and CDDFT.
Reducing Reliance on IP for people with Learning Disabilities	Reducing Reliance on inpatient care (IP) care trajectories is off track overall as at 13/2/23, with a total of 168 patients in IP care, working towards no more than 71 adults in NENC by 2023/24. There is a significant risk to achievement of the end of year trajectory in NENC with an expected outcome of +10 above trajectory.

Diagnostics waiting times >6 weeks	The number of patients waiting greater than 6 weeks for one of the 15 key diagnostic tests has deteriorated across NENC in December and continues below the requirement of 1%, with 20.3% patients waiting over 6 weeks for a diagnostic test compared to 16.1% in November 2022. There was a comparable deterioration in the England average.

Performance – other areas of note/risk

Children and Young People (CYP) Mental Health Waiting times	Waiting times for children and young people entering treatment for mental health problems have shown an increase in NENC. This pressure has exacerbated since the pandemic, due to the increased demand and the shortage of qualified mental health staff in the region. The ICB is working hard to improve the pathway for our patients, as well as investing in extra support to help children who have additional emotional, mental health and wellbeing needs. The ICB is making progress in improving services, with further work underway to address any variation within the region.
NHSE Escalation	NENC ICB has 3 trusts which remain in Tier 2 escalation: • NUTH – elective and cancer • CDDFT – elective • NCIC – cancer

Finance - key changes from previous report

The ICB is forecasting surplus of £2.7m after expected retrospective central funding of £8.9m relating to the Primary Care Additional Roles Reimbursement Scheme (ARRS). The financial plan of the ICB required an overall efficiency target of £48.4m and the ICB is on track to deliver this.

Finance – other areas of note/risk

Mitigations have been identified to manage the majority of risks, and in month 10 there is no unmitigated risk within the ICB. A number of potential risks to the wider ICS financial position have also been identified for NHS provider trusts, with unmitigated financial risk assessed at £7m.

Finance, Performance and Investment Committee – key updates, actions and learning

The Finance, Performance and Investment Committee met on 2 March and received the February Integrated Delivery report.

Committee members noted that a schedule of oversight meetings with providers is underway and advance provision of data packs by Trust had led to quality and value

added discussions and an increased level of assurance. Transparency was recognised as a critical success factor to the oversight process.

Key changes in CQC ratings were highlighted and a description given of the recent memorandum of understanding between Northumbria Healthcare Foundation Trust and North East Ambulance Service to develop governance and organisational development approach.

The Committee acknowledged positive improvement in ambulance handover delays, ambulance response times and 12 hour delays from decision to admit.

The Committee discussed the significant risk to achievement of the end of year reducing reliance on inpatient care trajectory due to an increase in admissions of people with learning disabilities. Related work of the Mental Health, Learning Difficulties and Autism transformation team to develop a strategy framework to create suitable packages of care, which include support with additional case managers, complex management case hubs, was felt to be important.

Risks and issues

- Please see above

Assurances

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

Recommendation/action required

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

Acronyms and abbreviations explained

- **AMR** - Antimicrobial resistance
- **CAS** – Central Alerting System
- **C. Difficile** – Clostridium Difficile
- **CDDFT** – County Durham and Darlington NHS Foundation Trust
- **CNST** – Clinical Negligence Scheme for Trusts
- **CNTWFT** – Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- **CQC** – Care Quality Commission – independent regulator of health and social care in England
- **CYPS** – Children and Young People Service
- **E.Coli** – Escherichia coli
- **FFT** - Friends and Family Test
- **FT** - Foundation Trust
- **GHFT** - Gateshead Health NHS Foundation Trust
- **GNBSI** – Gram-Negative bloodstream Infections

- **GP** - General Practitioner
- **HCAI** – Healthcare Associated Infections
- **IAPT** – Improving Access to psychological Therapies – NHS service designed to offer short term psychological therapies to people suffering from anxiety, depression and stress.
- **IPC** - Infection Prevention and Control
- **MRSA** – Methicillin-resistant Staphylococcus aureus
- **MSSA** – Methicillin-sensitive Staphylococcus aureus
- **NCICFT** – North Cumbria Integrated Care Foundation Trust
- **NEAS** – North East Ambulance Service Foundation Trust
- **NENC** - North East and North Cumbria
- **NHCFT** – Northumbria Healthcare NHS Foundation Trust
- **NHS LTP** – Long Term Plan – the plan sets out a number of priorities for healthcare over the next 10 years, published in 2019.
- **NHS OF** – NHS Oversight Framework which outlines NHSE`s approach to NHS Oversight and is aligned with the ambitions set in the NHS Long Term Plan
- **NTHFT** – North Tees and Hartlepool NHS Foundation Trust
- **NuTHFT** – Newcastle upon Tyne Hospitals NHS FT
- **SPC** – Statistical Process Control – An analytical technique which plots data over time, it helps us understand variation and in doing so guides us to take the most appropriate action.
- **STSFT** South Tyneside and Sunderland NHS FT
- **STHFT** – South Tees Hospitals NHS FT
- **TEWVFT** – Tees, Esk and Wear Valleys NHS FT
- **QIPP** – Quality, Innovation, Productivity and prevention – Large scale programme introduced across the NHS to ensure the NHS delivers more for the same funding
- **QRG** – Quality Review Groups
- **RCA** – Root Cause Analysis
- **SI** – Serious Incident
- **SIRMS** – Safeguard Incident Risk Management System
- **UEC** – Urgent and Emergency Care
- **YTD** – Year to date

Executive Committee Approval	14 March 2023
Sponsor/approving executive director	Jacqueline Myers – Executive Chief of Strategy and Operations Lucy Topping - Director of Performance and Improvement
Report author	Claire Dovell, Performance and Planning Manager

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

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

Item: 8.1

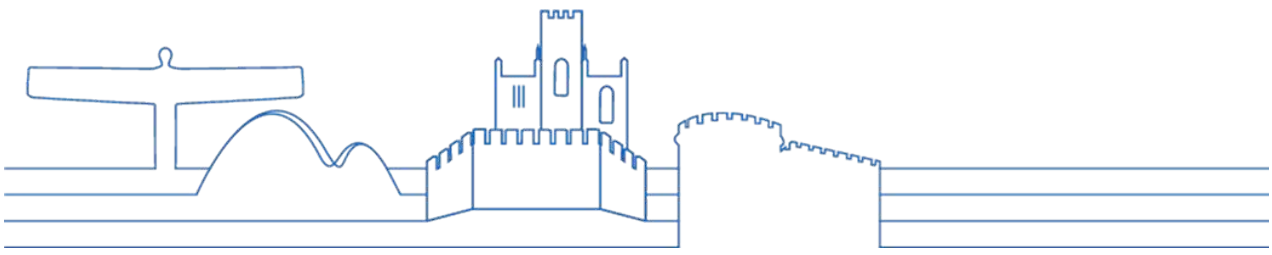
Any potential/actual conflicts of interest associated with the paper? (please tick)	**Yes**		**No**		**N/A**	✓
If yes, please specify						
Equality analysis completed (please tick)	**Yes**		**No**		**N/A**	✓
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken? (please tick)	**Yes**		**No**		**N/A**	✓
Key implications						
Are additional resources required?	N/A					
Has there been/does there need to be appropriate clinical involvement?	N/A					
Has there been/does there need to be any patient and public involvement?	N/A					
Has there been/does there need to be partner and/or other stakeholder engagement?	N/A					

Item 8.1

NHS
North East and
North Cumbria

Integrated Delivery Report

February 2023



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12 hour delays in A&E from decision to admit	Patients waiting in A&E more than 12 hours following decision to treat has decreased significantly in January to 1583 following a significant increase to 2347 in December across NENC.
Ambulance Response times	Ambulance response times were extremely challenging through December 2022 but have shown improvements in January 2023. Category 2 mean performance has since improved from 1:36:22 in December to 32:24 in January 2023.
78+ week waiters	Although 78+ waiters have plateaued in December 2022 compared to November levels, unvalidated weekly data shows a decrease in recent weeks across NENC to 990 (w/e 29 Jan), with a particular reduction at South Tees. The majority of the long waiters which remain are at NUTH and CDDFT.
Reducing Reliance on IP for people with Learning Disabilities	Reducing Reliance on inpatient care (IP) care trajectories is off track overall as at 13/1/23, with a total of 168 patients in IP care, working towards no more than 71 adults in NENC by 2023/24. There is a significant risk to achievement of the end of year trajectory in NENC with an expected outcome of +10 above trajectory.
Diagnostics waiting times >6 weeks	The number of patients waiting greater than 6 weeks for one of the 15 key diagnostic tests has deteriorated across NENC in December and continues below the requirement of 1%, with 20.3% patients waiting over 6 weeks for a diagnostic test compared to 16.1% in November 2022. There was a comparable deterioration in the England average.

Performance – other areas of note/risk

Children and Young People (CYP) Mental Health Waiting times	Waiting times for children and young people entering treatment for mental health problems have shown an increase in NENC. This pressure has exacerbated since the pandemic, due to the increased demand and the shortage of qualified mental health staff in the region. The ICB is working hard to improve the pathway for our patients, as well as investing in extra support to help children who have additional emotional, mental health and wellbeing needs. The ICB is making progress in improving services, with further work underway to address any variation within the region.

NHSE Escalation	NENC ICB has 3 trusts which remain in Tier 2 escalation: • NUTH – elective and cancer • CDDFT – elective • NCIC - cancer

Finance – key changes from previous report

The ICB is forecasting surplus of £2.7m after expected retrospective central funding of £8.9m relating to the Primary Care Additional Roles Reimbursement Scheme (ARRS).

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

Finance – other areas of note/risk

Mitigations have been identified to manage the majority of risks, in month 10 there is no unmitigated risk within the ICB. A number of potential risks to the wider ICS financial position have also been identified for NHS provider trusts, with unmitigated financial risk assessed at £7m.

NENC Quality, Access & Outcomes

OPERATIONAL PERFORMANCE

= Standard met
= Standard partially met
= Standard not met

Indicator (and target)		Actual
A&E 4hr wait (95%) January 23		**75.1%**
Ambulance handovers		
< 30+ mins delays (95%) Feb 23		**90.4%**
% Patients not meeting criteria to reside (Oct) (9.2%)		**9.2%**
Ambulance response	NEAS	
C1 Mean (7 mins) Jan 23		**7:07**
C2 Mean (18 mins) Jan 23		**32:24**
Bed occupancy (85%) (Jan 23)		**91.8%**
104+ waiters (0 March 23; 37 end Jan plan)		29 (w/e- 29 Jan)
78+ waiters (0 by April 2023; 492 Jan plan)		**990** (w/e 29 Jan)
52+ waiters (0 by 2025; 4231 Jan plan)		**8701** (w/e 29 Jan)
Diagnostics 6 week wait (1%) Dec		**20.3%**
Cancer FDS (75%) December 22		**77.7%**
Cancer 62 Days backlog (Feb 23 plan 1078)		**1222** (w/e 5/2/23)

PRIMARY CARE ACTIVITY

Indicator (and target)		Actual
GP appointments (December 22) Operational plan target 1.49m		**1.45m**
GP attendances (December 22)	Increasing	1.37m
DNA rate (Dec 22) 5.1% (national 5.2%)		5.1%
Face to Face appointment rate 72.1% (national level 67.3% Dec 22)		72.1%

MENTAL HEALTH

= Standard met
= Standard partially met
= Standard not met

Indicator (and target)		Actual
IAPT Access		
Patients accessing treatment within 6 weeks (75%)		**96.4%**
Patients accessing treatment within 18 weeks (95%)		**99.3%**
IAPT Moving to recovery (50%)		**50.6%**
Proportion of patients waiting for treatment from first to second treatment >90 days (10%) Sept 22		**33.3%**
SMI Health checks (16,260 Mar 23 ;16325 Dec)		**14,592**
Children and Young People Eating Disorders (95%) Sept 22		
Urgent patients seen in 1 week NENC		**89.9%**
Routine patients seen in 4 weeks NENC		**74.3%**
Dementia (67%) Sept 22		**65.4%**

LEARNING DISABILITY & AUTISM

= Standard met
= Standard partially met
= Standard not met

Indicator (and target)		Actual
Learning Disability health checks (73% 22/23)		**47%** YTD
Reduction in ICS IP beds (69 beds)		**85** (Dec)
Reduction in Secure Services IP beds (36 beds)		**75** (Dec)

QUALITY

Indicator (and target)		Actual
Never events (zero tolerance)		**17** YTD
MRSA (zero tolerance)		**9** YTD
Serious incidents 2 day reporting (95% target)		2 trusts outside the target in month
C Difficile Infection		5 Trusts over trajectory

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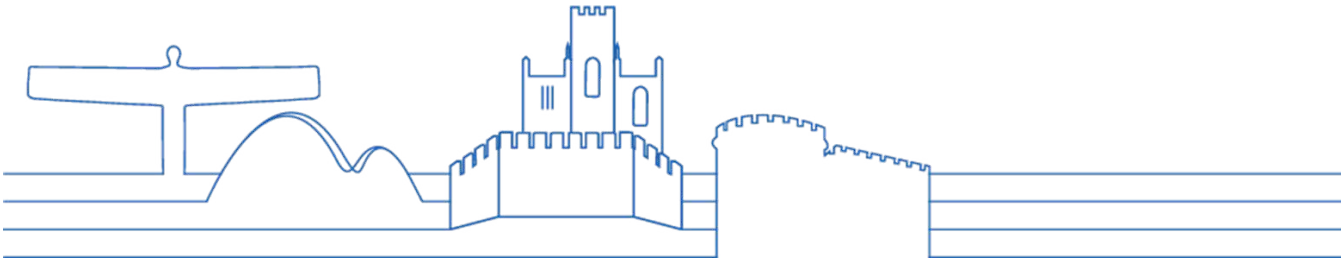
System oversight



NHS Oversight Framework (NHS OF) Summary

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

Segmentation

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

NENC ICB is in segment 2, as are most of the NHS trusts within NENC ICB, with the exception of three trusts in segment 1 (NUTHFT, CNTWFT and NHCFT) and four trusts in segment 3 (STFT, NCICFT, TEVWFT and NEASFT). Following a Board to Board meeting with NHSE on 2 February to discuss oversight segmentation NEAS was moved to segment 3. There are no trusts in segment 4.

The table below shows the trust level overview of segmentation, CQC rating and any other escalation in place.

Provider	CQC Rating	Oversight framework segment	Oversight arrangements	Tier Escalation
County Durham and Darlington NHSFT	Good (2019)	2	ICB led Oversight Meeting	Tier 2 – elective
Cumbria, Northumberland, Tyne and Wear NHSFT	Outstanding (2022)	1	ICB led Oversight Meeting	N/A
Gateshead Health NHSFT	Good (2019)	2	ICB led Oversight Meeting	None
Newcastle Upon Tyne Hospital NHSFT	Outstanding (2019)	1	ICB led Oversight Meeting	Tier 2 – Elective Tier 2 – Cancer
North Cumbria Integrated Care NHSFT	Requires Improvement (2020)	3	NHSE Quality Board	Tier 2 - Cancer
North East Ambulance Service	Requires improvement, Visit in July and inspection in September 2022	3	Quality Improvement Board in place	N/A
North Tees and Hartlepool NHSFT	Requires improvement, inspected 2022	2	ICB led Oversight Meeting	None
Northumbria Healthcare NHSFT	Outstanding (2019)	1	ICB led Oversight Meeting	None
South Tees NHSFT	Requires Improvement (2019) Well Led inspection Jan 23 report expected March 23	3	Trust in quality escalation no longer led by a Board, but supported by ICB and NHSE	None
Sunderland and South Tyneside NHSFT	Inspection June 2022 report published Feb 23 Requires Improvement	2	ICB led Oversight Meeting Quality Board to be established	None
Tees, Esk and Wear Valleys NHSFT	Requires Improvement (2021)	3	Quality Board	N/A

Recent oversight meetings

NENC ICB is currently undertaking a schedule of oversight meetings with providers. A meeting was held with CDDFT on 10 February. Areas of good practice were discussed that would be helpful to share more widely e.g., the approach to health inequalities, engagement with members and patient/carer experience work including a real time 'Call for concern' phone line. Maternity services were discussed in some detail and the ICB Executive Director of Nursing will support the trust in related improvement work.

ICB position on oversight framework metrics

Appendix 1 summarises the position against the ICB level metrics within the NHS Oversight Framework for NENC. For each indicator the dashboard shows current performance alongside the national position and the standard, where there is a specified standard. The dashboard also provides a benchmark demonstrating if the ICB is ranked in the highest quartile, interquartile or lowest quartile range for each indicator.

The high level summary in the table below outlines the distribution across the quartiles by domain and notes how many standards were met in this latest data period.

Domain (Total number of indicators)	Number of indicators in highest quartile	Number of indicators in Interquartile range	Number of indicators in lowest quartile	Number met against those with identified standard
Preventing ill health & reducing inequalities (12)	7	5	0	1 of 8
People (12)	4	6	2	1 of 3
Quality, access and outcomes (52)	11	35	6	15 of 34

Metrics within the highest and lowest performing quartile for each of the reported domains include:

Preventing ill health and reducing inequalities domain:

Highest performing quartile

- Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled (71.6% compared to 32.5% nationally)
- % of hypertension patients which are treated to target as per NICE guidance (65.9% compared to national 60.4%)
- % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins (NENC 58% compared to national value of 56.9%)
- Proportion of maternity settings offering tobacco dependence services (25% compared to 13% nationally)
- Population vaccination coverage: MMR for 2 doses (5 year olds) 91.9% compared to 84.4% nationally)
- Proportion of people over 65 receiving a seasonal flu vaccination (68.9% compared to 65.4% nationally)
- Cervical screening coverage - % females aged 25-64 attending screening within the target period 74.7% compared to 70.8% nationally)

Lowest performing quartile

- None

People domain:

Highest performing quartile

- Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age.
- Growing for the future – FTE GP per 10,000 weighted patients
- Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers
- Staff survey engagement theme score

Lowest performing quartile

- Proportion of staff in senior leadership roles who are from a BME background (MH Provider)
- Sickness absence rate

Quality, access and outcomes domain:

Highest performing quartile

Access related:

- Total elective activity undertaken compared to 19/20 baseline
- Number of general practice appointments per 10,000 weighted patients
- Rate of personised care interventions (110.18 per 100,000 compared to 75.33 per 100,000 nationally)
- Number of completed referrals to community pharmacist consultation service (CPCS) from NHS 111 per 100,000 population
- Proportion of patients meeting the faster diagnosis standard (76.9% compared to 69.7% national Nov 22)
- Adult acute length of stay over 60 days as % of total discharges (16.8% NENC compared to national 20.1% October 22)

Quality related:

- Antimicrobial resistance proportion of broad spectrum antibiotic prescribing in primary care (7.6% compared to 8.4% national)
- NHS Staff survey: raising concerns people promise element sub score

Screening, immunisation and vaccination related:

- Population vaccination coverage MMR for 2 doses (5 year olds) (91.9% compared to 84.4% nationally)
- Proportion of people over 65 receiving a seasonal flu vaccination – (68.9% compared to 65.4% nationally)
- Cervical screening coverage - % females aged 25-64 attending screening within the target (74.7% compared to 70.8% nationally)

Lowest performing quartile (assurance provided in later sections of the report)

- % of patients on the waiting list who have been waiting more than 62 days
- Access rate for IAPT services (Appendix 12)
- Inappropriate adult acute mental health placement out of area placement bed days (Appendix 13)
- MRSA infection rate – commissioner (Appendix 3)
- Antimicrobial resistance total prescribing of antibiotics in primary care commissioner
- Total patients waiting more than 104 weeks to start consultant led treatment (Appendix 9)

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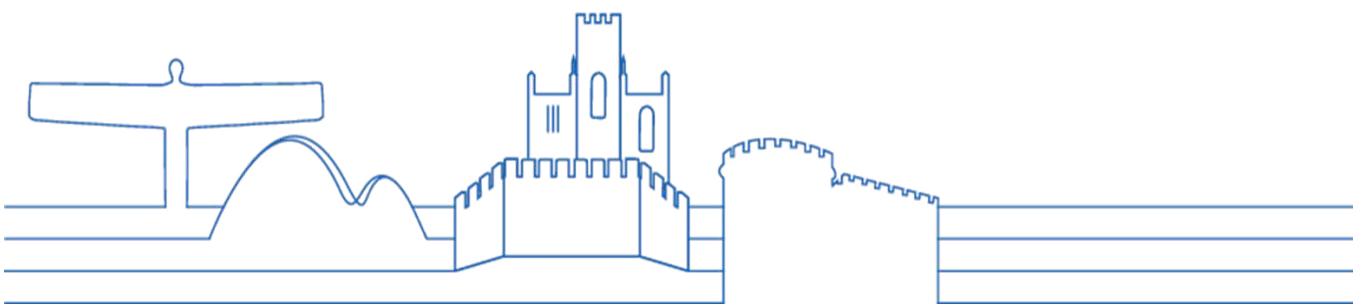
Quality



Quality Summary

Quality - key changes from previous report

CQC Inspection and updates	North Cumbria Integrated Care NHS Foundation Trust (NCICFT) – the CQC has classed the Trust as high risk particularly in relation to the medical wards. Concerns include repeated incidents with similar themes and concerns about sharing lessons to reduce reoccurrence. South Tyneside and Sunderland NHS Foundation Trust (STSFT) received an overall rating of *'requires improvement'* from the CQC. The report published on 3 February 2023 showed the Trust was rated as requires improvement across the domains of Safe, Effective, Responsive and Well-led. Caring continued to be rated as good. The Trust's response and action plan will be shared with the ICB via the Quality Review Group (QRG) arrangements. North East Ambulance Service (NEAS) received an overall rating of *'requires improvement'* from the CQC. The report published on 1 February 2023 showed the Trust was rated as requires improvement across the domains of Safe and Effective, Well-led was rated as inadequate and Caring and Responsive were rated as good. The Trust's response and action plan will be shared with the ICB via the QRG arrangements. BPAS Middlesborough CQC Inspection Report: The provider has undertaken an extensive improvement programme and completed the required actions outlined in the CQC report. The conditions imposed on the registration have now been removed and the associated Contract & Performance Notice has been lifted.
NEAS Independent Enquiry	The planned timescale for the completion of the national independent enquiry was expected by the end of 2022. However, the publication of the report has been pushed back due to ongoing external factors. This report is now expected to be published in March 2023.
Independent Provider	An independent mental health provider notified the ICB of a serious incident involving a locum consultant undertaking attention deficit hyperactivity disorder (ADHD) assessments, who was found to be working below acceptable standards. A full investigation is underway, and a number of interim measures have been introduced.

Quality – other areas of note/risk

Tees Esk and Wear Valley FT	Quality Board and support arrangements remain in place associated with CQC rating of 'Requires improvement' and NHS Oversight framework segment 3 status. Further discussions have taken place to understand if an operational group is required to discuss operational issues within the Trust. A Risk Summit has been held at the Trust in relation to 3 ligature deaths in the past 4 weeks.
North Cumbria Integrated Care FT	Quality Board and support arrangements remain in place associated with CQC rating of 'Requires improvement' and NHS Oversight framework segment 3 status.
South Tees Hospitals FT	Enhanced surveillance remains in place associated with current CQC rating of 'Requires improvement' and NHS Oversight framework segment 3 status. A Board to Board meeting with NHS E is planned in May to review the position against the segment 3 exit criteria, the outcome of the recent CQC inspection will also be known at that point.
NEAS	A Board to Board meeting with NHSE took place on 2 February 2023 to discuss CQC recommendations and it was confirmed that the trust would move to segment 3.
Workforce and capacity in health and social care	Significant issues in relation to workforce are impacting on capacity to source placements in the community (packages of care).
System flow	Significant pressures across health and social care system resulting in pressures on emergency departments and ambulance waits.
CHC	Financial risks in relation to CHC fee rates in Northumberland which are being managed centrally in the ICB, some capacity risks relating to a mixed model of CHC service delivery in the North relating to capacity. CHC Fragility in Domiciliary Care market: Continued concerns in North Cumbria with multiple domiciliary providers.
SEND	Special Educational Needs and Disability (SEND) health funding and Inspection Framework: Publication of the revised SEND inspection framework is fuelling activity in preparation for an anticipated round of inspections commencing Spring 2023. Revised guidance on locality authority (LA) high needs budgets is presenting a financial risk to the ICB in Newcastle Gateshead regarding funding to meet health needs in Special Schools. This issue has potential ICB wide implications.
LeDeR	Learning from Death Reviews(LeDeR): Risks remain around the availability of reviewers. NECS were commissioned to undertake a number of reviews late last year and these are progressing well. It is anticipated however that NECs may take on further cases due to continual increases in caseload. NENC ICB is currently reviewing the long term plan for LeDeR workforce.

Quality Exceptions and concerns including CQC visits by provider

North Cumbria

Quality Exception	Risks, Actions and Identified learning
System Flow Pressures: Significant pressures across Health and Social Care system resulting in pressures on Emergency Depts and Ambulance waits.	NCICFT is a significant outlier in relation to A&E waits with 50% of patients waiting in excess of 4hrs from a decision to admit and 21% of patients waiting in excess of 12 hrs from a decision to admit. NCICFT discharged proportionally less patients (than England average) when they no longer meet the criteria to reside, with 77% of patients remaining in hospital at the end of the day during Q2. Patient harms are appearing as a result of these treatment delays but many more are likely not meeting the threshold for moderate harm reporting.
NCICFT – CQC has classed the Trust as high risk particularly in relation to the medical wards.	Concerns include repeated incidents with similar themes and concerns about sharing lessons to reduce reoccurrence. Concerns raised about preceptorship and induction for overseas nurses, agency and locum staff. Environmental risk from patients being able to climb over balustrades at high level and concerns over fundamental standards of care.
CHC Fragility in Domiciliary Care market **–** continued concerns with multiple domiciliary providers.	Patients with one care agency had to be relocated as an emergency and the company is now in liquidation. Care had been delivered as single carers despite receiving funding for double ups and many visits had been missed. There are quality and safety concerns with another company who do not have a local CQC registration. Overall, the market is very fragile with a number of providers using their head office registration with no local oversight from the CQC.

Gateshead Health NHS Foundation Trust (GHFT)

Quality Exception	Risks, Actions and Identified learning
Pathology Laboratory incidents: A number of IT programming issues have occurred which have impacted significantly on primary care. Most recently in January 2023 a technical fault which resulted results requiring amendment and reissuing to GP practices. The issue was promptly identified and rectified.	The Trust is fully investigating this incident and some immediate steps have been taken including introducing more frequent quality control checks and asking Roche engineers to review the issue. This will be discussed at the next QRG meeting in May 2023 to seek further assurance that lessons from these incidents are being learned and embedded within the Pathology Laboratory. The regional Clinical Safety Officer is also formalising a clinical safety process that all organisations in NENC will need to follow when an informatics/digital event occurs.

County Durham and Darlington NHS Foundation Trust (CDDFT)

Quality Exception	Risks, Actions and Identified learning
Maternity Services: Due to pressures within the maternity departments the home birthing service remains suspended.	ICB colleagues are sighted on the pressures and associated rationale underpinning this decision and continue to work with the Trust and system partners in relation to the issue.

South Tyneside and Sunderland NHS Foundation Trust (STSFT)

Quality Exception	Risks, Actions and Identified learning
CQC Inspection: The CQC report was published on 3 February 2023 following an inspection of maternity services and medical wards at both Sunderland Royal and South Tyneside District Hospitals in June 2022. A further inspection of core services was undertaken in August 2022. The overall rating is 'requires improvement' which was also the rating for the domains of Safe, Effective, Responsive and Well-led. The report identifies 44 areas of improvements that STSFT must take action to improve and a further 2 areas that have been assessed as should do's.	The Trust's response and action plan will be discussed at the QRG meeting in March 2023. Following the inspection in June 2022, STSFT has kept the ICB informed of the service and quality improvements being undertaken and have participated in enhanced surveillance arrangements.

North Tees and Hartlepool NHS Foundation Trust (NTHFT)

Quality Exception	Risks, Actions and Identified learning
CQC inspection Report (published September 2022): An overall rating of 'requires improvement' was awarded. The Safe, Effective and Well-led domains were all rated 'requires improvement' and the Caring and Responsive domains were rated as 'good'.	The Trust's improvement action plan was discussed at the CQRG in December 2022 and routine engagement meetings with the CQC.

South Tees Hospitals NHS Foundation Trust (STHFT)

Quality Exception	Risks, Actions and Identified learning
Unannounced CQC inspection in November 2022 of the following clinical areas medicine, surgery, Emergency Department and ITU. The Well-led component of the inspection was undertaken in January after being delayed due to national strike action.	The Trust are awaiting feedback from the recent visit and the CQC has informed that the final report can be expected March 2023.
The Trust was stepped down from NHS England Quality Board in January 2021 however remains in escalation in relation to never events.	The provider has received substantial support from NHS England and NENC ICB Tees Valley Place team. Associated improvement work remains a priority and progress is reported via routine contract and clinical governance processes.
C Difficile performance year on year improving, although still over trajectory.	A programme of deep cleaning/de-fogging of wards has been completed at the Friarage Hospital Northallerton site and some priority areas within the James Cook site. Initial results are positive with no further cases reported on wards where this process has been completed, however, the process has been paused during January due to bed pressures.

North East Ambulance Service NHS Foundation Trust (NEAS)

Quality Exception	Risks, Actions and Identified learning
National Independent Enquiry: The Secretary of State for Health and Social Care committed to hold a full independent review into the allegations made against NEAS. The CQC Inspection Report was published on 1 February 2023 following an inspection in July and September 2022. The Trust received an overall rating of ' requires improvement', which was also the rating for the domains of Safe and Effective, the Well-led domain was rated as inadequate and Caring and Responsive were rated as good. The CQC has identified 17 areas of improvements that the Trust 'must' take action to improve and a further 12 areas have been identified as 'should do's'. The Trust were previously rated as good.	The planned timescale for completion of the enquiry was the end of 2022. Publication of the report has been pushed back due to ongoing external factors. The report is now expected to be published in March 2023. Support continues to be offered to the Trust via the QRG, ICB and wider system. Action plans are to be formulated and submitted on the 'must do' actions by 20 February 2023. Work streams are already in place and are being overseen by a director. These will feed into the CQC quality review group and updates will be provided at QRG. Work has started around access to medicines, and NEAS are currently reviewing systems and processes. A medicines safety officer has been appointed and is in post, they have undertaken internal audits and identified further practices that are recommended to change to improve safe practice and patient care. NEAS are currently applying to change their controlled drugs licence due to the recommendations around practice/storing of controlled drugs (there is a 16-week lead time for sign off by the relevant authority).

Cumbria Northumberland Tyne and Wear NHS Foundation Trust

Quality Exception	Risks, Actions and Identified learning
18 Week Waiters: There has been an increase in patient waiting longer than 18 weeks to be seen in the Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) pathways, Older Persons Services and Children and Young People Services.	Localities have committed to meeting quality standards by the end of Q4 2022/23 which includes a focus on underperforming contract requirements. The Access and Waiting Times group has taken on more of a performance management role and an updated reporting proforma has been developed for localities to highlight issues and provide key action points for areas of improvement. Localities provide monthly updates on key deliverables and issues.

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWVFT)

Quality Exception	Risks, Actions and Identified learning
The Quality Board remains in place and meeting regularly to support the Trust with the risks identified. Discussions are ongoing between the ICB, NHSE and NECS to agree a forum for routine surveillance and how new key risks will be escalated to the Quality Board.	Further discussions are taking place in the next couple of weeks to agree next actions and a process for routine surveillance.

Tees Valley - Quality Review Group update

Quality Exception	Risks, Actions and Identified learning
STHFT and NTHFT: The first Joint Tees Clinical QRG took place in December 2022.	The meeting was very positive and both Trusts were very keen for collaborative working going forward. Discussions are ongoing to agree schedule and terms of reference for future quality meetings.

Independent Sector Providers

Quality Exception	Risks, Actions and Identified learning
Psychiatry UK: notified the ICB of a serious incident involving a locum consultant who was found to be working below acceptable standards. A number of contracts are in place with the provider. A small number of patients were affected.	Provider has contacted all affected patients, who have been allocated a new consultant, who will review and initiate a change in treatment plan, if necessary. The provider is also contacting every patient seen by locum to offer additional support and the opportunity to provide feedback. An investigation is underway, and a number of immediate interim measures have been introduced. Provider has notified relevant external agencies and communication teams to advise that they will be making a public statement.
Butterwick Hospices: Updated CQC (August) report for Stockton site, all domains now rated as good apart from safe which requires improvement. The provider continues to meet with the ICB on a regular basis in contract & recovery meetings to discuss overarching service improvement plan.	New interim Chief Executive has been appointed. The contract meeting has highlighted a number of quality issues, suggested to review improvement action plan to incorporate SMART objectives to provide assurance in relation to the status of ongoing actions.
BPAS Middlesborough CQC Inspection: The CQC undertook a comprehensive unannounced follow-up inspection of BPAS Middlesbrough in April 2022 and conditions imposed on the providers registration in respect of regulated activities remained.	BPAS has undertaken an extensive improvement programme and completed the required actions outlined within the CQC improvement plan. The conditions imposed on the registration have now been removed and associated Contract & Performance Notice has been lifted.
BPAS Patient Group Directives (PGD): Concerns were raised around BPAS PGD processes including the unauthorised use of PGDs and the use of Mifepristone for cervical preparation, which is not legally permitted.	With support of ICB and NECS colleagues the provider has reviewed all PGD's to ensure they meet the necessary legal and best practice guidance. The updated PGDs are now being reviewed for ICB sign-off. BPAS has removed the PGD relating to Mifepristone following concerns that this was not within the legal guidelines. A Patient Specific Directive (PSD) has been developed for this medication which was implemented as of 21 December 2022.
Patient Transport and Mental Health Conveyance: The ICS has been alerted that the CQC has issued an independent ambulance provider with a Section 31 notice.	Contingency arrangements are being put in place and the issue is being explored by provider management

Quality Metrics

A range of quality metrics aligned to the National Quality Board metrics are reviewed and monitored at trust level and shown in detail at Appendix 3. 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. None of the quality standards are consistently passed or failed and performance is relatively stable. A small number of metrics are showing an improving position:

- Incidence of MRSA – NCICFT, GHFT, CDDFT
- Proportion of serious incidents reported in 2 days – NCICFT, GHFT, STSFT, CNTWFT
- SHMI indicator value – NHCFT, NuTHFT, GHFT, STSFT, NTHFT
- Friends and Family Test (FFT) Emergency Dept (ED) - CDDFT
- FFT Outpatients – STSFT
- FFT maternity - CDDFT

A small number of metrics listed below show a deteriorating position and are included in the exception reporting on the subsequent pages:

- Incidence of MRSA – NTHFT, STHFT
- SHMI indicator value – NCICFT, CDDFT (Import to note that this is still within expected range)
- Staff absence rate – NHCFT, GHFT, STHFT
- Staff Turnover – NuTHFT, TEWVFT
- Proportion of RCAs submitted within 60 days – TEWVFT, CDDFT, NTHFT

Quality Metric Exceptions

Healthcare Associated Infections (HCAI) (published data – December 2022)

Quality Exception	Risks, Actions and Identified learning
MRSA: There have been 9 MRSA cases reported in NENC 22/23 to date (8 hospital onset, 1 community). **MSSA:** 332 cases have been reported across the region 22/23 to date. Several trusts are exceeding their thresholds for one or more of the healthcare associated infections: • C.Difficile • E. Coli • Klebsiella spp • P. Aeruginosa Trust level performance against thresholds is shown in Appendix 3a and 3b.	No specific risks identified. All providers are signed up to a set of principles for the management of Covid Infection, Prevention and Control (IPC), and there is a systemwide approach to antimicrobial resistance (AMR). Performance data is reviewed at the Area Quality review Groups and the NENC Infection Prevention Control Board and related actions agreed/monitored as necessary.

Never Events

Quality Exception	Risks, Actions and Identified learning
NENC ICS year to date (YTD) total n=17 as at 13 February. • STHFT has reported n=7 • The others were from a range of Trusts/providers n=10 No never events were reported in January 2023. However, it should be noted to date in February two never events have been reported and are included in the above YTD total. STHFT remains in quality escalation in relation to Never Events.	Never events continue to be monitored via serious incident management processes. The Trust has received substantial NHSE/I support, and this supportive approach is now continuing through the NENC ICB Tees Place. Associated improvement work remains a priority for provider and commissioner colleagues and progress is reported via routine contract and clinical governance processes.

Serious Incident (SI) reporting (January 2023)

Quality Exception	Risks, Actions and Identified learning
2-day reporting: Two Trust's (CDDFT, TEWVFT) were outside the 95% threshold for reporting serious incidents within two days of identification	Regular discussion on SI performance takes place at all Trust QRG meetings and ICB SI panels to gain assurance there are processes in place to manage the backlog of any cases.
STHFT Lost to Follow Up theme: The Trust has previously reported a significant number of SI's relating to lost to follow-up. A number of these remain open whilst awaiting evidence of assurance of improvement to enable closure.	Quality team colleagues continue to seek assurance in relation to the improvement work associated with long standing open serious incidents. These incident investigations are unable to be closed until this is received.
NTHFT: Continuing concern relating to serious incidents relating to care of deteriorating patients.	Thematic improvement work continues.

NHS Sickness Absence rates

Quality Exception	Risks, Actions and Identified learning
All Trusts in NENC were above the England average for September 2022 (5.0%). Workforce pressures continue due to sickness absence and vacancies, although some improvement has been seen.	A range of measures are in place to ensure operational challenges are managed, safe staffing levels are in place and support is being offered to staff to maintain their health and wellbeing. Safe staffing updates are provided at QRG meetings.

Outstanding Patient Safety Alerts Open on Central Alerting System (CAS) January 2023

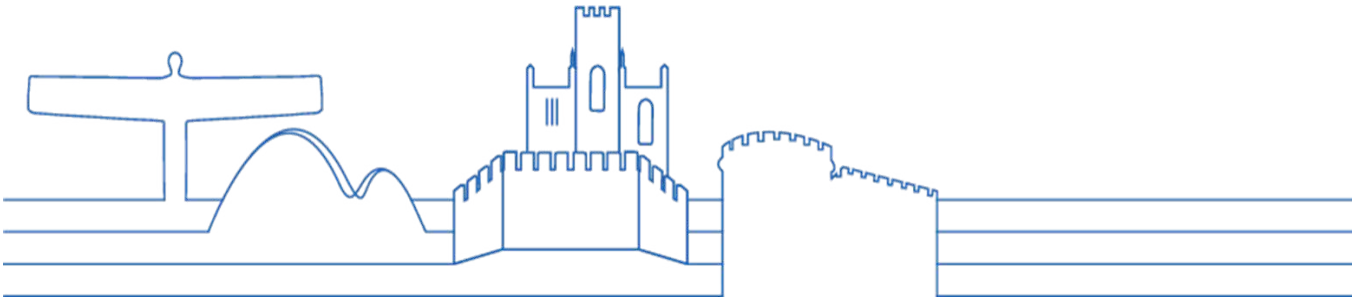
Quality Exception	Risks, Actions and Identified learning
Two Trusts are showing with outstanding patient safety alerts that were due to be completed in November.	Further discussions have taken place with both Trusts to seek assurance that the alert has been actioned as required. Both Trusts have confirmed that all actions have been completed and the alert will be closed off on the national CAS system.

Mortality – Summary Hospital-level Mortality Indicator (SHMI)

Quality Exception	Risks, Actions and Identified learning
All Trusts are showing within the 'expected range' of deaths for SHMI based on the most recently published data, which covers the October 2021 to September 2022 data.	

NHS
North East and
North Cumbria

Performance



Performance Summary

Performance - Key Changes from Previous Report

Handover delays	Following a rapid process improvement workshop (RPIW) in November 2022, a new approach whereby NEAS crews will leave patients in the care of ED staff at 59 minutes has gone live from February 2023. Handover performance has significantly improved w/e 18 February 2023 with an average of 20 hours lost per day. In addition, 88.7% of handovers were under 30 minutes compared to a 95% standard, and 92.2% under 60 minutes (expected standard of zero >60 mins). These compare favourably to previously reported levels as at w/e 15 January of 76.3% and 86.2% respectively.
12 hour delays in A&E from decision to admit	Patients waiting in A&E more than 12 hours following decision to treat has decreased significantly in January to 1583 following a significant increase to 2347 in December across NENC.
Ambulance Response times	Ambulance response times were extremely challenging through December 2022 but have shown improvements in January 2023. Category 2 mean performance has since improved from 1:36:22 in December to 32:24 in January 2023.
78+ week waiters	Although 78+ waiters have plateaued in December 2022 compared to November levels, unvalidated weekly data shows a decrease in recent weeks across NENC to 990 (w/e 29 Jan), with a particular reduction at South Tees. The majority of the long waiters which remain are at NUTH and CDDFT.
Reducing Reliance on IP for people with Learning Disabilities	Reducing Reliance on inpatient care (IP) care trajectories is off track overall as at 13/1/23, with a total of 168 patients in IP care, working towards no more than 71 adults in NENC by 2023/24. There is a significant risk to achievement of the end of year trajectory in NENC with an expected outcome of +10 above trajectory.
Diagnostics waiting times >6 weeks	The number of patients waiting greater than 6 weeks for one of the 15 key diagnostic tests has deteriorated across NENC in December and continues below the requirement of 1%, with 20.3% patients waiting over 6 weeks for a diagnostic test compared to 16.1% in November 2022. There was a comparable deterioration in the England average.

Performance – other areas of note/risk

NHSE Escalation	NENC ICB has 3 trusts which remain in Tier 2 escalation: • NUTH – elective and cancer • CDDFT – elective • NCIC - cancer

Performance Metrics

Overview

VARIANCE – is there special cause variation?		ASSURANCE – is the standard/plan achieved or not?		
		Standard or plan consistently achieved 	**Hit and Miss – not consistently achieved** 	**Standard or plan consistently failed** 
	Getting better (Special cause improvement) 		Primary Care appointments F2F	SMI Health checks
			Mean 999 call answering time	CYP access
			IAPT < 18 weeks	% of 111 calls abandoned
			Diagnostic WL	Diagnostic 6+ waits
				52+ waiters
	Stable (Common cause variation) 	IAPT <6 weeks	Primary Care attendances	Dementia Diagnosis
		104+ waiters (compared to plan)	Primary Care appointments % DNA	Inappropriate Out of Area bed days
			Primary Care Appointments	
			IAPT Access, IAPT recovery All & BAME	
			CYP ED routine <1 week, <4 weeks	
			Ambulance response C2 mean & 90th centile, C3,C4	
			% Handover <15 min	
			Faster diagnosis standard 28 days	
			Delayed discharges	
	Getting worse (Special cause Concern) 	EIP within 2 weeks	% Handover <30 mins	IAPT in-treatment waits >90 days
		Ambulance response C1 90th centile	% handover <60 mins	% A&E waits <4 hrs (T1 & all types)
		Ambulance handovers – average hours lost	Ambulance response times C1.	12 hr waits DTA
			% A&E waits >12 hrs	Incomplete waiting list
			>31 days cancer first treatments	Urgent cancer referrals >62 days
			Urgent cancer patients on PTL >62 day	
			78+ waiters	
			LOS 7+ & 21 days+	
			Bed occupancy	

*A full description of the SPC icons is included in Appendix 2.

A range of performance metrics, aligned to the NHSE Operational Planning Metrics, are reviewed and monitored and shown in detail in appendices 4 -15. 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 performance metrics are reported at ICB level, and the summary table above provides an overview of the position using the most recently published data. A small number of metrics in the green shaded areas where the standard or plan is consistently met. The areas of special cause concern and those areas which are failing are highlighted in the red shaded boxes and further detail is included in the exception reporting on the subsequent pages.

Urgent and Emergency Care Appendices 5-8

Ambulance Response – appendix 7	Cat 2 mean response (18m)	**NEAS 32m:24s**

Performance

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

NEAS:

- Response times continue to be a pressure and are not meeting the national standards in January, although there have been significant improvements over recent weeks following a significant deterioration in all standards in December where critical incidents were noted.
- Although Cat1 mean was met in January, Cat 2 mean and C2, C3, C4 90th percentile standards continue to not be met in January, although Cat2 mean performance has improved from 1:36:22 in December to 32m:24s. This remains slightly above the national level at 32:06.
- NEAS have been impacted by the industrial strike action. Support has centred around patient transport services and trying to free up capacity where possible to utilise 3rd party providers to support.

NWAS:

- Response times remain challenged in January although there was improvement in the category 2 and 4 responses.
- NWAS performance in North Cumbria continues to be notably better than other areas of the North West.

Mitigations NEAS & NWAS

- National work to review Category 2 calls with a focus on improving safety for patients waiting for an ambulance to ensure all patients receive the right response for their clinical presentation.
- A review is currently underway regarding Healthcare professional calls, care homes calls that result in Cat2 response, and calls requiring an interpreter.

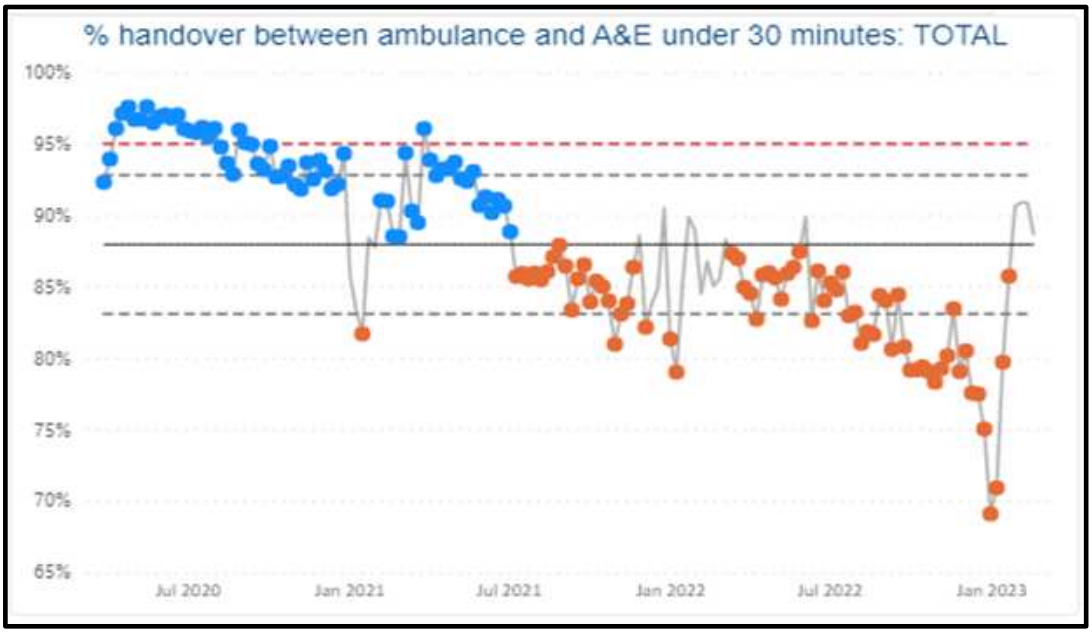
- A three-year programme to increase capacity has been identified to enable patients to be responded to in a timely manner and minimise risk to life and outcomes.
- Recruitment of additional paramedics, Clinical Care Assistants, and health advisors
- Implementation of sickness absence plan focused on mental health and wellbeing
- RPIW focussing on increasing Clinical Assessment Service across the system and increasing alternative dispositions via 2UCR.
- NWAS Improvement plan continues to be implemented but high activity levels, industrial action and long handover delays prevent consistent achievement of ARP standards.

Ambulance Handovers – appendix 5	Handovers <30 mins (95%)	**NENC 88.7%**

Performance

- Handover delays continue, although have significantly improved w/e 18 February at 20 average hours lost per day, compared to a target of 57.4.
- The overall percentage of handovers w/e 18 February which took place under 30 minutes compared to a 95% standard has also improved at 88.7% of all handovers.
- 92.2% of handovers were under 60 minutes (expected standard of zero >60 mins). These had previously been reported as 76.3% <30 mins and 86.2% <60 mins w/e 15 January 2023.

The chart below demonstrates the recent improved position in relation to the % of handovers which take place within 30 minutes at NENC, despite remaining below target levels.



- STHFT are a regional outlier for the number of Ambulance handover Delays
- These delays are felt by both Ambulance Providers who utilise the JCUH site, Northeast Ambulance Service and Yorkshire Ambulance Service. This results in an unacceptable number of hours lost to the Ambulance Services.

Mitigations

NEAS:

A rapid process improvement workshop (RPIW) took place in November 2022 regarding handover delays, which was led by the NENC Urgent and Emergency Care Network. Two approaches have been agreed:

- NEAS crews will leave patients in the care of ED staff at 59 minutes; it is suggested that Trusts have clinical responsibility for patients starting at 15 minutes from arrival (i.e., handover timescale target). Reporting is being developed.
- Cohorting of patients in ED which will enable NEAS crews to be released sooner.
- The plan went live 1 February 2023.
- Funding is via the Winter Fund.
- Work is underway with Acute Trusts regarding physical space, equipment and different staffing models
- In Tees Valley partners are working with NEAS and other partners in the region to extend the Urgent Crisis Response model where community nursing teams direct patients to more appropriate places in the community.

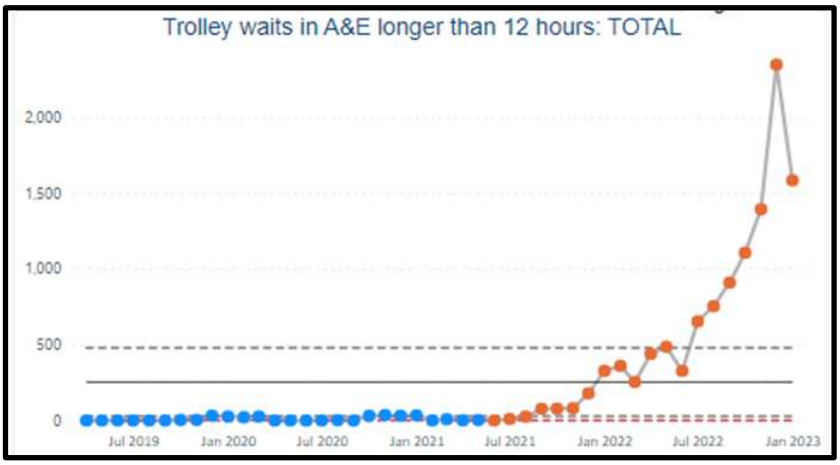
NWAS:

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

Accident and emergency – appendix 6	>4 hr waits (95%) No. waiting >12 hrs	**NENC 75.1%** **NENC 1583**

Performance

- January 23 A&E 4 hour wait performance continues to be a pressure.
- Although not meeting the 95% standard, NENC performance is performing favourably compared to the national for January 2023 (all types) at 75.1%, compared to 64.6% nationally. This is an improvement on December performance.
- The % of patients waiting longer than 12 hours from arrival to discharge is above the 2% standard for October at 4% in NENC.
- Patients waiting in A&E more than 12 hours following decision to treat has decreased significantly from 2347 in December to 1583 in January 2023 across NENC. This is shown in the chart below.



Mitigations

Central:

Performance has started to improve, and local A&E Delivery Boards continue to focus on actions to improve flow. Winter planning sessions have taken place. Additional bed capacity has been commissioned for STSFT using the various national funding arrangements with integrated discharge arrangements in place to support flow across the health and care system. Locally, work has commenced on an integrated discharge model and community bed model for Sunderland. In Durham CDDFT performance has improved due to streaming more patients to SDEC and to SDUC (same day urgent care formally GP hub). The Trust are working to ensure that they are moving patients to the most appropriate place for care and continue to implement their winter plan.

Tees Valley:

STHFT emergency care performance is below the regional and national position. The impact of challenges across the health and social care system continues to be observed at STHFT. Actions include the ECIST improvement project, and estate expansion and reconfiguration. NTHFT continue to receive a high number of ambulance diverts and is reviewing the operational model.

North Cumbria:

Urgent and emergency care remain extremely pressured, surge calls for North Cumbria held daily currently. Medically optimised patients remain very high due to the ongoing pressure in ASC and lack of home care across the county. Extremely long waits for beds for patients in ED with patients being nursed in corridors. Due to the number and high acuity of patients, discharge profile is very poor daily which has significant impact on flow within the department. Day surgery has been opened as an inpatient ward and has had up to 10 patients. 12 hour breaches are high with no real opportunity to improve this currently.

North:

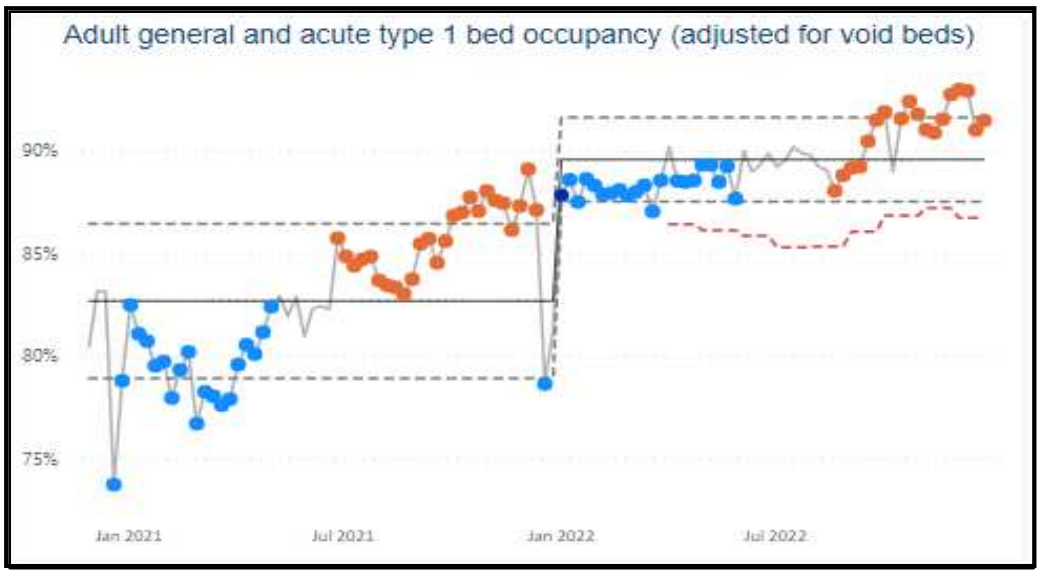
Trust wide urgent and Emergency Care (UEC) action plans are in place corresponding to the national UEC 10 point plan. Key focuses include increasing staffing in both the short term and long term. Through the North ICP Strategic A&E Board and NEAS transformation board we will continue to work with each Trust to refine and develop their SDEC model to provide consultant assessment and diagnosis, rapid treatment and early facilitated discharge. Pressures continue to be particularly acute at GH who continue to report the highest level of bed occupancy in NENC area with significant 12 hour breaches and delays in the department, although these are improving. High bed occupancy, lower social care and discharges. has caused additional challenges in the managing and placing of patients.

Patient Flow and Discharge – appendix 8	Bed occupancy (85%) Delayed discharge	**NENC 91.8%** **NENC 8.1%**

Performance

- Although some UEC pressures have eased slightly in January 2023, pressures due to high level of attendances has meant high bed occupancy continues across NENC.
- Length of stay for patients residing in hospital over 7 and 21 days has continued to increase and is above trajectory.
- Patients who no longer meet the criteria to reside and whose discharge is delayed is at 8.1% w/e 11 February 23 with some improvements seen over recent weeks.

- Type 1 General and Acute bed occupancy remains high increasing further to 91.8% in January 2023, as demonstrated in the chart below.
- This is above the 85% national expectation, and above the operational plan level in NENC.
- Trusts have recently been asked to submit updated trajectories which will be monitored locally. For the purposes of this report we will continue to monitor against the operational planning trajectories.



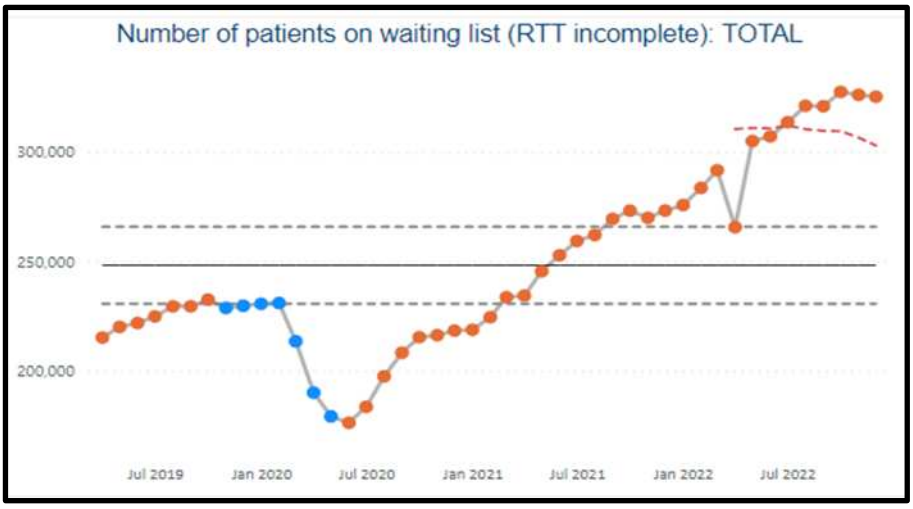
Mitigations

- Plans are underway to transform and build community services capacity to deliver more care at home and improve hospital discharge across NENC ICS.
- The ICS is committed to implementing new and enhancement of current virtual wards to support plans for elective recovery and improvement of UEC pathways.
- Local systems with their partners are making sure that their Urgent Crisis Response (UCR) models are part of the wider local health and care integration redesign. UCR data is being standardised across the ICS and will be included in future reports to ensure delivery of the 2 hour standard across the ICS.
- Both Virtual wards and Urgent crisis response wok plan has been established together with ICS wide working groups to explore and share pathway models to standardise across the ICS.

Elective Care – appendix 9	>78 week waits (367)	**NENC :990**

Referral to Treatment

- The total number of patients on the waiting list has plateaued over recent months, although continues to exceed the operational plan trajectory for December 22 in NENC at 325,193. This is demonstrated in the chart below. More recent weekly unvalidated data shows a further increase in waiting list size across NENC to 350,773 w/e 29 Jan 2023).



- There were 23 104+ week waiters as at end of December 2022, the key pressure being spinal patients at Newcastle upon Tyne Hospitals NHS FT. This is within the planned level for NENC (44 plan) however. The Trust continues to manage patients and seek additional capacity including through the independent sector (IS) providers, and although current unvalidated weekly data shows this to have increased slightly to 29 w/e 29 January, it is anticipated that this level will be at 20 by the end of March 2023.
- 78+ waiters have plateaued in NENC and remain above planned levels in December (1079 compared to 327 plan). The majority of 78+ waiters are at NUTH, with a proportion at CDDFT and South Tees in addition. More recent unvalidated weekly data shows a decrease in recent weeks across NENC to 990 (w/e 29 Jan), with a particular reduction at South Tees. All trusts other than NUTH expect to reach 0 by end of March.
- 52+ week waiters have plateaued across NENC but remain above planned levels in December 8520 compared to a plan of 4485). Of the 4485 in total as at the end of December, the majority were at NUTH, followed by CDDFT, and South Tees. Pressures exist across high volume specialties at NUTH including T&O, Dermatology, Ophthalmology and Plastic Surgery. The plan is expected to maintain this level through to March 2022 with a significant focus at NUTH on 78+ waiters. More recent unvalidated weekly data shows a further increase in NENC to 8701 (w/e 29 Jan), although this has appeared to have peaked and showing a gradual Improvement over recent weeks.

Mitigations
North:

Additional sessions through waiting list initiatives at NUTH, implementation of digital pathways in Dermatology, continued use of the Newcastle Westgate Cataract Centre and subcontracting with the IS has helped reduce long waiters. The Newcastle elective treatment centre was opened at the end of September and is creating additional capacity, as well as utilisation of the IS and local providers. Capacity alerts to distribute demand have been implemented in key specialties. NUTH is currently participating in regular tier 2 meetings which are focussed on identifying and deploying high-quality support to aid rapid performance improvement. Feedback from a Getting it right first time (GIRFT) Spinal review in January notes some areas of work are exemplar and the trust's recovery plan was robust, with some short/medium term improvement recommendations anticipated.

Tees Valley:
The focus remains on the longest waiters at STHFT– maintaining a zero position with 104 week waits, eliminating 78 week waits and reducing 52 week waits. Actions to manage 52ww remain in place; tracking, validation and appropriate prioritisation which are now impacting positively on position. NTHFT maintains its trajectory position in line with NHSE phase 1 and 2 elective recovery and reports no patients waiting more than 78 and 104 weeks. 90% of elective 78+ week waiters have been booked in before March 2023. The Trust continues to see an increase in referrals, with a quarterly increase of 6% compared to 2019/20 levels and whilst the overall waiting list size continues to grow this has plateaued over recent months.

Central:
CDDFT have been moved into tier 2 escalation due to an increasing number of 78+ waiters and the Trust has submitted an improved plan for zero 78+ waiters by March 2023, and to deliver 0 52+ by March 24. Additional elective recovery schemes approved and being operationalised. Key pressure areas General Surgery and Gynaecology in relation to 78+ waits. Access to the I.S. across the Central patch continues with providers sub-contracting to secure additional capacity within pressure specialties such as orthopaedics and general surgery. Across Durham additional theatre capacity has been put in place to support recovery with a continued focus on clinical prioritisation and maximising capacity. The Trust are reviewing the service model within Respiratory Medicine.

North Cumbria:

NCIC is continuing to focus on elimination of 78 week waits by the end of the current financial year and are ahead of trajectory according to data for the end of January, although the position has remained static during the month. NCIC has reduced 52 week waits by 65% since March 21 but the reduction has slowed and is now off track against plan. Large reductions in orthopaedics and urology are being offset by increases across other specialties. The areas experiencing an increase are being supported to recover the plan, with additional insourced activity planned. Pathways at risk of breaching 104ww, 78ww and 52ww by the end of March 2023 are monitored weekly through RTT and Waiting List Elective Recovery Operational Subgroup.

Elective Waiting List – Inequalities
Work continues across NENC to analyse the waiting list in accordance with ethnicity and deprivation.

As the waiting list continues to grow, the numbers of patients within the Trusts who have an unknown ethnicity status has increased.

Index of multiple deprivation (IMD) classifies the relative deprivation levels of small areas, with 1 being the most deprived through to 10 being the most affluent. Work is underway to review the waiting list by IMD level. Initial findings as demonstrated in the charts in appendix 9b that the there is little difference between the areas with highest deprivation levels when compared to the areas with least deprivation in terms of waiting list growth.

Diagnostic Waiting Times – appendix 10	>6 week waits (1%)	**NENC :20.3%**

Diagnostics >6 week performance for the 15 key diagnostic tests has deteriorated across NENC in December and continues below the requirement for 1% of patients to wait longer than 6 weeks, with 20.3% patients waiting over 6 weeks for a diagnostic test compared to 16.1% in November 2022. This has also deteriorated nationally which stands at 31.3%. Key pressure areas include Echo-cardiography, Endoscopy and Audiology and performance ranges from 4.4% (Northumbria HC) to 33.1% at North Tees NHS FT.

ICSs have been asked to develop a local diagnostic performance improvement plan that delivers 95% achievement of the 6ww diagnostic target by March 25. The NENC Diagnostics workstream has recently set trajectories with FTs with a focus on a subset of 8 of the key diagnostic tests.

Mitigations

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

Central:
The diagnostic position continues to improve overall with the number of long waiters decreasing. Significant progress has been made in echocardiography due to the increased capacity secured in 2022/23. Pressures now remain in some areas of imaging and in sleep studies where additional resources have been agreed to improve performance. Non-obstetric ultrasound is now a key pressure and subject to performance escalation.

North:
Significant echo backlogs have been cleared at NUTH through additional capacity. Gateshead continue with insourcing to clear echo backlog with a trajectory to do so in 2023. Cystoscopies continue to be a pressure at Northumbria with review of the Urology pathway across the North and Audiology workforce pressures are significant. A paper is being reviewed to understand how pathway changes in audiology could positively impact the position at NUTH.

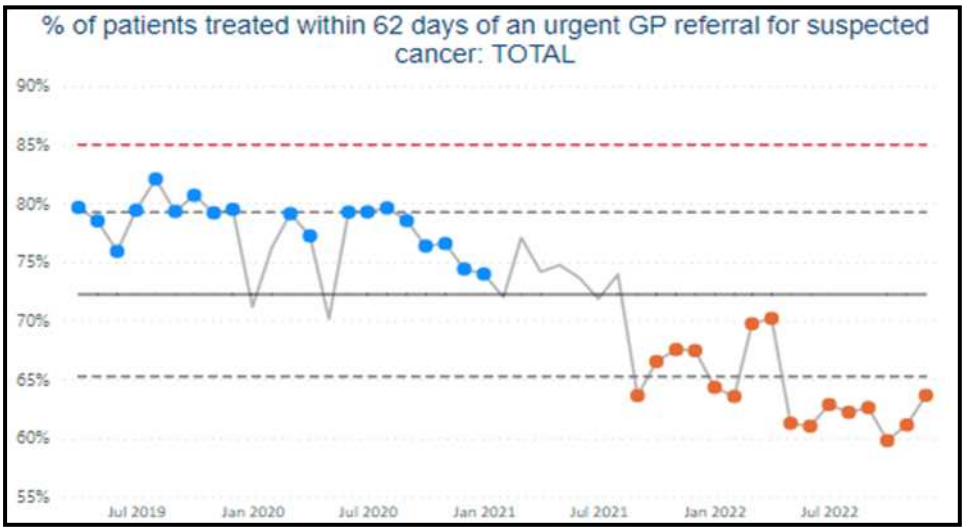
North Cumbria:
An additional cardio-echo machine at West Cumberland Hospital, provides a further 30% capacity in Cumbria. Community diagnostics funded schemes are increasing capacity in Radiology and endoscopy across NENC as well as additional capacity sought through the Independent sector. Audiology workforce pressures remain a risk across NENC. Endoscopy activity has improved through a mobile unit, although a backlog of complex patients remains.

Tees Valley:
Diagnostic access has improved at STHFT, tests for waiting list patients are being balanced against increasing volumes of urgent demand and surveillance. Additional capacity has improved the Endoscopy position at JCUH and FHN. Performance at NTHFT has seen a slight improvement in November. Non obstetric ultrasound has seen an improved position in long waiters, with a further increase in capacity anticipated by March 2023.

Cancer – appendix 11	Faster diagnosis standard (75%)	77.7%
	Cancer 62 day referral (85%)	63.6%

Performance

- NENC are currently achieving the faster diagnosis standard for December 22 which stands at 77.7% v the 75% target, a further slight improvement. This compares favourably to the national performance (70.7%). Variation between Trusts exists with highest performance at NUTH at 83.2% and lowest at NCIC (69.9%).
- Currently 63.6% patients are waiting less than 62 days from referral to initial treatment compared to the 85% standard in NENC, this is slightly below the national at 61.8% for December. Variation between Trust 62 day performance ranges from 86% at Northumbria HC, the only Trust achieving the standard in NENC in December to 50.9% at NUTH.
- NENC planned to have reduced the number of people waiting for 62 days or more for cancer treatment to 1189 in January 2023; at w/e 29 January performance was slightly behind plan.
- The chart below demonstrates the deterioration in the % of patients who are currently treated within 62 days in NENC compared to the 85% standard.



Mitigations

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

Central: An improvement plan is being developed by ATB which is impacting positively on chest x-ray performance. To support the personalised care agenda, additional roles have been recruited by PCNs across the ICP.

N. Cumbria - NCIC continues to receive additional support from NHS England through Tier 2 meetings, and improved performance has seen NCIC move out of the lowest performing Trusts. Key actions include a robust clinical harm process for 104-day breaches, cancer education days held in October, completion of pathway analysis for Prostate, Skin and Lower GI and the successful recruitment of ACPs and Band 7s.

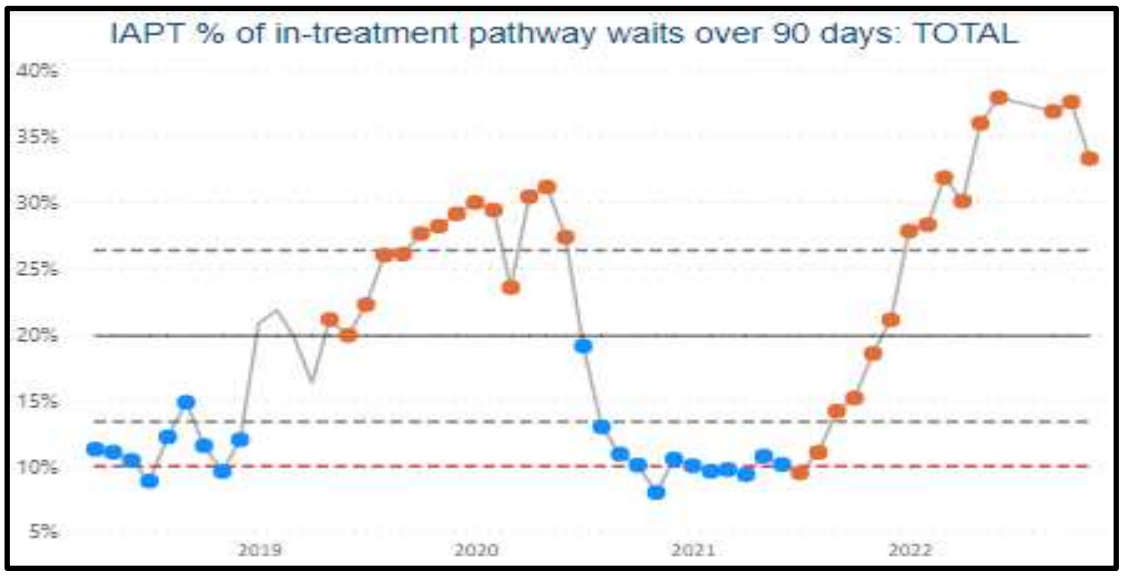
Tees Valley – Both North and South Tees have now moved out of tier 2 escalation for cancer due to significant improvements in reducing backlog. The Trusts remain committed to a collaborative approach through the Cancer cell initiative, ensuring equitable access to treatment for all patients. Initiatives include additional lists, cancer delivery groups led by lead clinicians and specialist nurses and cancer navigator posts in all tumour groups. Key pressures remain in Gynaecology, Urology and upper and lower GI.

North - NUTH remains in tier 2 for cancer support, key pressures in Skin, Urology, Upper and Lower GI. Mitigations continuing including additional 2ww sessions, additional CT capacity for colorectal, and 4th endoscopy room for backlog. A Urology Task & Finish group across the North is currently looking to review MDT and MRI straight to test pathway.

Mental Health – appendix 12-14	IAPT % waits >90 days (10%) Dementia diagnosis (67%)	**NENC 33.3%** **NENC 65.4%**

Adult mental health – IAPT Performance – appendix 12

- Access rates continue to be sporadic and have been below plan and target. Over more recent months the IAPT access numbers have started to increase and more in line with pre-pandemic numbers.
- Moving to recovery rates are above the 50% expectation in NENC for all patients and above the national at 49.5%. The recovery rate for black, Asian or minority groups is slightly lower at 45%.
- % of in treatment waits over 90 days continue above the 10% standard in Nov 22, at 33.3%, above the national at 22.4%, and demonstrated in the chart below.



Mitigations

IAPT providers in the NENC are working to recovery plans to achieve national standard access rates and improve waiting times from first to second treatment which have remained static and are significantly above the national expectation of 10%. Actions across the ICS include: mobilisation of the NENC ICS IAPT Delivery & Oversight Group, as well as publicity,

targeting pathways such as older persons, DNA initiatives as well as recruitment drives, and subcontracting.

Adult Mental Health – Dementia diagnosis and health checks performance – appendix 13

- Dementia diagnosis is slightly below the 67% standard for NENC at 65.4% for September 22 and continues to increase. There was a dip in performance throughout the pandemic and teams are working to recover.
- The Number of SMI Health checks completed has started to increase throughout 21/22 and into 22/23 and although below the 22/23 standard it is progressing above plan in NENC.

Mitigations

SMI heath checks - deployment of portable testing equipment, continued mobilisation of community mental health transformation models at place and local support to PCNs and clinical teams to ensure continued focus.

Children and Young People (CYP) Mental Health – appendix 14

CYP Access - Performance

- The number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact is showing some improvement in NENC throughout 22/23. In December 22 CYP access is above plan but below target.
- The % of CYP with urgent eating disorders across NENC ICS starting treatment within 1 week of referral has deteriorated throughout 20/21 and into 21/22. However from September 21 onwards there has been a continual improvement. Current performance at September 22 is at 89.9% against the 95% target which is above the operational planned levels.
- The % routine CYP patients with eating disorders across NENC ICS starting treatment within 4 weeks of referrals has deteriorated throughout 20/21 and continues to do so. Current performance at September 22 is at 74.3% against the 95% target which is below planned levels.

Mitigations

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

Sunderland - As a result of increased demand into CYP MH services, work has commenced on the mobilisation of a single point of access for CYP MH services. This is expected to be live April'23 and will ensure needs are met and CYP access the most appropriate services. The THRIVE model was also launched in November'22 which will change the way services are delivered in Sunderland for the long term. Additional support to schools via MH Support Teams is also in the process of being implemented.

Learning Disabilities and Autism – appendix 15	LD patients in IP care (71 by 23/24)	**NENC 168**

Performance

Reducing Reliance on IP care trajectories is off track overall as at 13/1/23, with a total of 168 patients in IP care, working towards no more than 71 adults in NENC by 2023/24. 85 are ICB commissioned and 75 secure services, ,and 7 CAMHS. There is a significant risk to achievement of the end of year trajectory in NENC with an expected outcome of +10 above trajectory.

Ability to achieve the trajectories is impacted by:

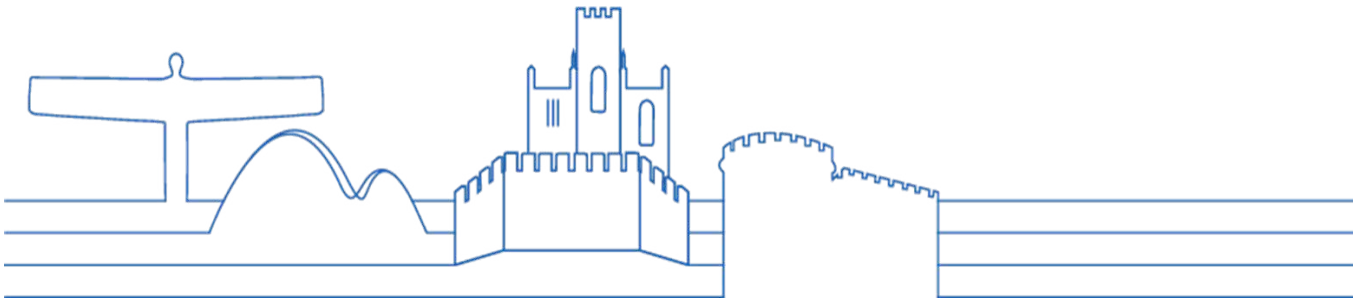
- Availability of independent care sector providers; retention and recruitment across the system
- Blocked care pathways; including the impact of MM Judgement
- Unavoidable admissions to hospital
- Complexity of caseload

Mitigations

- Use of 12 point discharge plan, escalation processes, RCA completion and development of Dynamic Support Systems. Detailed housing market analysis and Accommodation Plan in place; consideration of alternative accommodation, care and support solutions. Exploring Care Pathways and the use of rehabilitation wards; Operational Delivery Network work with NW&Y; meeting with MOJ and legal advice re the impact of MM.
- ICB Learning Disability and Autism Team established April 2022 onwards to focus on delivery of Building the Right Support through an increase in capacity and expertise in stimulating the provider market and case management. Joint project with ADASS.

NHS
North East and
North Cumbria

Finance



Executive Summary

Executive Summary

	M10 - January 2023		YTD	Forecast
Key Statutory Financial Duties	**Overall ICS 2022/23 In Year Financial Position - (Surplus) / Deficit**			
	For the financial year 2022/23 the ICS, including the Q1 position of the NENC CCGs, is on track to deliver the planned breakeven position reporting a small surplus of £0.4m at Month 10	Plan	£6.29 m	£0.00 m
		Actual	£19.06 m	(£0.38) m
	Overall ICB 2022/23 In Year Financial Position - (Surplus) / Deficit			
	Overall ICB 2022/23 In Year Financial Position prior to retrospective funding - (Surplus) / Deficit	Plan	(£1.75) m	(£2.63) m
	The ICB is reporting a year to date variance of £6.61m and an outturn variance of £6.20m, prior to expected retrospective funding adjustments of £8.93m - Deficit / (Surplus)	Actual	£6.61 m	£6.20 m
	Expected ICB 2022/23 In Year Financial Position after retrospective funding - (Surplus) / Deficit	Plan	(£1.75) m	(£2.63) m
	The ICB is reporting an outturn variance of £2.74m, after expected retrospective funding adjustments of £8.93m, an improved position of £0.1m against the planned surplus of £2.63m - Deficit / (Surplus)	Actual	£4.09 m	(£2.74) m
	ICB Running Costs Position - July 2022 to March 2023			
	The ICB is reporting a year to date and forecast outturn underspend of £2.48m and £3.93m respectively, compared with the submitted financial plan	Plan	£34.78 m	£46.06 m
		Actual	£32.30 m	£42.12 m
		Variance	(£2.48) m	(£3.93) m
	Overall ICS 2022/23 Capital Funding			
	The ICS is reporting a forecast outturn against the capital allocation in line with plan for primary care and £4.74m over on provider capital. At Month 10 there is a year to date underspend against the capital allocation of £57m.	Allocation	£175.78 m	£201.89 m
		Actual	£118.78 m	£206.63 m
		Variance	(£57.00) m	£4.74 m
Other Financial Performance Metrics				
	Overall ICS 2022/23 QIPP/Efficiency	Plan	£202.85 m	£248.83 m
	The ICS is reporting year to date QIPP savings of £188.26m and forecast savings of £241.94m with the ICB delivering £48.46m which is slightly over the submitted QIPP/Efficiency plan. Providers are currently forecasting an under-delivery against target of £6.92m.	Actual	£188.26 m	£241.94 m
		Variance	(£14.59) m	(£6.89) m
	Overall 2022/23 Mental Health Investment Standard (MHIS)		6.68%	6.68%
	The ICB is on track to achieve the MHIS target for 2022/23 (growth in spend of 6.68%), the target now includes the impact of the pay award and additional uplift.			

ICB Financial Position - Overview

Month 10 - January 2023	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Revenue Resource Limit	(3,919,259)			(5,104,564)		
Programme						
Acute Services	1,986,124	2,003,898	17,774	2,545,999	2,569,195	23,195
Mental Health Services	473,081	477,070	3,989	609,679	613,442	3,763
Community Health Services	387,223	377,185	(10,038)	496,478	489,068	(7,409)
Continuing Care	232,090	233,565	1,476	300,420	303,535	3,116
Prescribing	333,535	348,015	14,480	427,842	442,908	15,066
Primary Care	65,618	60,232	(5,386)	86,827	79,018	(7,808)
Primary Care Co-Commissioning	324,399	330,642	6,243	418,894	426,874	7,981
Other Programme Services	32,392	31,985	(406)	44,459	44,258	(201)
Other Commissioned Services	16,614	16,685	71	21,406	20,895	(511)
Programme Reserves	13,505	(299)	(13,804)	81,650	61,944	(19,705)
Contingency	3,563	0	(3,563)	4,725	0	(4,725)
Total ICB Programme Costs	**3,868,145**	**3,878,980**	**10,835**	**5,038,377**	**5,051,139**	**12,762**
Admin						
Running Costs	34,781	32,304	(2,477)	46,055	42,123	(3,932)
Total ICB Admin Costs	**34,781**	**32,304**	**(2,477)**	**46,055**	**42,123**	**(3,932)**
(Surplus) / Deficit	1,750	0	(1,750)	2,632	0	(2,632)
Total In Year ICB Financial Position	**3,904,676**	**3,911,283**	**6,608**	**5,087,064**	**5,093,262**	**6,198**
Central Funding expected for ARRS costs	2,517	0	(2,517)	8,934	0	(8,934)
Total In Year ICB Financial Position after expected retrospective funding	**3,907,193**	**3,911,283**	**4,091**	**5,095,998**	**5,093,262**	**(2,736)**

The ICB is forecasting surplus of £2.7m after expected retrospective central funding of £8.9m relating to the Primary Care Additional Roles Reimbursement Scheme (ARRS).

The main factors driving the ICB position are:
•Acute overspend mainly relating to Independent Sector provider activity where Elective Recovery Fund income has not been assumed.
•Mental Health overspend in particular pressures on s117 packages and specialist packages of care.
•Continuing Healthcare pressures, in particular backdated high cost packages of care, partially mitigated by release of prior year accruals.
•Prescribing overspend based on latest Prescription Pricing Data showing continued pressures from price concessions and Cat M impacts.
•Management of reserves to balance overall ICB position and release of non-recurring benefits across a number of budget areas.

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

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

Mitigations have been identified to manage the majority risks, in month 10 there is no unmitigated risk within the ICB. A number of potential risks to the wider ICS financial position have also been identified for NHS provider trusts, with unmitigated financial risk assessed at £7m.

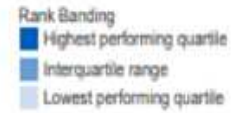
Appendices

Appendix 1a: NHS Oversight Framework (NHS OF) – Preventing ill health and reducing inequalities domain

Sub Category	Indicator	Aggregation	Period	Value	Direction	National Value	Rank Banding	Standard	Standard Met
Prevention and long term conditions	S051a: Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled	ICB	22-23 Q2	71.6%	Increase	32.5%	Highest Performing Quartile		
	S053a: % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	SubICB	2021-22	89.8%	Increase	89%	Interquartile Range	90%	Not Met
	S053b: % of hypertension patients who are treated to target as per NICE guidance	SubICB	2021-22	65.9%	Increase	60.4%	Highest Performing Quartile	80%	Not Met
	S053c: % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	SubICB	22-23 Q1	59.4%	Increase	57.2%	Highest Performing Quartile	45%	Met
	S055a: Number GP referrals to NHS Digital weight management services per 100k population	SubICB	22-23 Q2	71.4 per 100,000	Increase	63.8 per 100,000	Interquartile Range		
	S115a: Proportion of diabetes patients that have received all eight diabetes care processes	ICB	21-22 Q4	46.5%	Increase	46.7%	Interquartile Range		
	S116a: Proportion of adult inpatient settings offering tobacco dependence services	ICB	2022 10	20%	Increase	14.3%	Interquartile Range	100%	Not Met
	S116b: Proportion of maternity settings offering tobacco dependence services	ICB	2022 10	25%	Increase	13%	Highest Performing Quartile	100%	Not Met
	S117a: Proportion of patients who have a first consultation in a post covid service within six weeks of referral	Provider	2022 12	37.2%	Increase	47.8%	Interquartile Range		
Screening, vaccination and immunisation	S046a: Population vaccination coverage: MMR for two doses (5 year olds)	SubICB	22-23 Q1	91.9%	Increase	84.4%	Highest Performing Quartile	95%	Not Met
	S047a: Proportion of people over 65 receiving a seasonal flu vaccinatio	SubICB	2022 10	68.9%	Increase	65.4%	Highest Performing Quartile	85%	Not Met
	S050a: Cervical screening coverage : % females aged 25 : 64 attending screening within the target period	SubICB	21-22 Q4	74.7%	Increase	70.8%	Highest Performing Quartile	75%	Not Met

NHS OF – People domain

Sub Category	Indicator	Aggregation	Period	Value	Direction	National Value	Rank Banding	Standard	Standard Met
Belonging in the NHS	S071a: Proportion of staff in senior leadership roles who are from a BME background	Amb Provider	2021	6.9%	Increase	75.2%	Interquartile Range	12%	Not Met
		MH Provider	2021	5.7%	Increase	664.3%	Lowest Performing Quartile	12%	Not Met
		Provider	2021	14%	Increase	1152.1%	Interquartile Range	12%	Met
	S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	ICB	2021	60.7%	Increase		Highest Performing Quartile		
Growing for the future	S074a: FTE doctors in General Practice per 10,000 weighted patients	ICB	2022 11	0 per 10,000	Increase	0 per 10,000	Highest Performing Quartile		
	S075a: Direct patient care staff in GP practices and PCNs per 10,000 weighted patients	ICB	22-23 Q1	5.68 per 10,000	Increase	4.98 per 10,000	Interquartile Range		
Looking after our people	S063a: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	ICB	2021	9.95%	Decrease		Interquartile Range		
	S063b: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	ICB	2021	16.6%	Decrease		Highest Performing Quartile		
	S063c: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	ICB	2021	26.1%	Decrease		Interquartile Range		
	S067a: Leaver rate	ICB	2022 10	8.93%	Decrease	9.07%	Interquartile Range		
	S068a: Sickness absence rate	ICB	2022 08	5.67%	Decrease	5.09%	Lowest Performing Quartile		
	S069a: Staff survey engagement theme score	ICB	2021	6.07/10	Increase		Highest Performing Quartile		



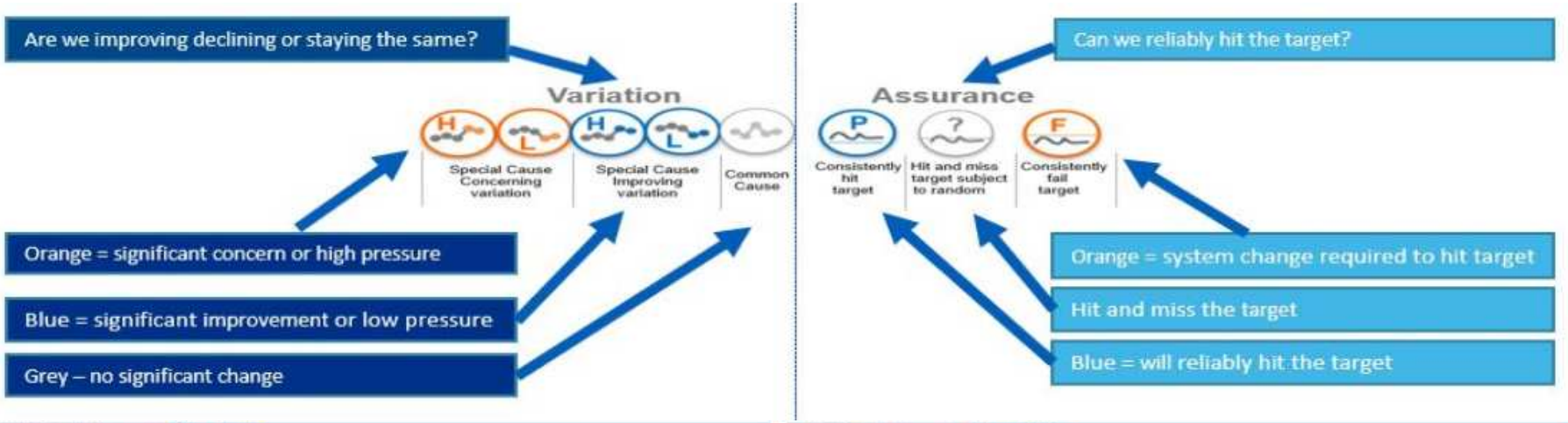
Appendix 1b: NHS Oversight Framework (NHS OF) - Quality, Access and outcomes domain

Sub Category	Indicator	Aggregation	Period	Value	Direction	National Value	Rank Banding	Standard	Standard Met
Cancer	S010a: Total patients treated for cancer compared with the same point in 2019/20	ICB	2022 11	103.4%	Increase		Interquartile Range	100%	Met
	S011a: Cancer - percentage of patients on the waiting list who have been waiting more than 62 days	Provider	w/e 08/01/2023	88.7%	Decrease	1771.2%	Lowest Performing Quartile		
	S012a: Proportion of patients meeting the faster cancer diagnosis standard	ICB	2022 11	76.9%	Increase	69.7%	Highest Performing Quartile	75%	Met
Leadership	S060a: Aggregate score for NHS staff survey questions that measure perception of leadership culture	ICB	2021	6.87/10	Increase		Interquartile Range		
Maternity and children's health	S022a: Stillbirths per 1,000 total births	ICB	2020	3.13 per 1,000	Decrease	3.29 per 1,000	Interquartile Range		
	S104a: Neonatal deaths per 1,000 total live births	ICB	2020	1.41 per 1,000	Decrease	1.5 per 1,000	Interquartile Range		
Mental health services	S081a: Access rate for IAPT services	ICB	22-23 Q2	54.3%	Increase		Lowest Performing Quartile	100%	Not Met
	S084a: Number of children and young people accessing mental health services as a % of population	ICB	2022 10	95.1%	Increase		Interquartile Range	100%	Not Met
	S085a: Proportion of people with severe mental illness receiving a full annual physical health check and follow-up interventions	ICB	2022 09	79.4%	Increase	74.5%	Interquartile Range	100%	Not Met
	S086a: Inappropriate adult acute mental health placement out of area placement bed days	ICB	Aug 2022 - Oct 2022	2,360	Decrease		Lowest Performing Quartile	0	Met
	S110a: Access rates to community mental health services for adult and older adults with severe mental illness	ICB	2022 10	94.6%	Increase		Interquartile Range	100%	Not Met
	S125a: Adult Acute LoS Over 60 Days % of total discharges	MH Provider	2022 10	16.8%	Decrease	20.1%	Highest Performing Quartile		
	S125b: Older Adult Acute LoS Over 90 Days % of total discharges	MH Provider	2022 10	37%	Decrease	38.5%	Interquartile Range		
Safe, high quality care	S037a: Percentage of patients describing their overall experience of making a GP appointment as good	ICB	2022	58.7%	Increase	56.2%	Interquartile Range		
	S040a: Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Provider	2022 11	8	Decrease	265	Interquartile Range	0	Met
		SubICB	2022 11	31	Decrease	762	Lowest Performing Quartile	0	Met
	S041a: Clostridium difficile infection rate	Provider	2022 11	105.8%	Decrease	117.2%	Interquartile Range	100%	Met
		SubICB	2022 11	102.6%	Decrease	110.7%	Interquartile Range	100%	Met
	S042a: E. coli bloodstream infection rate	Provider	2022 11	103.4%	Decrease	109.4%	Interquartile Range	100%	Met
		SubICB	2022 11	105.1%	Decrease	107.7%	Interquartile Range	100%	Met
	S044a: Antimicrobial resistance: total prescribing of antibiotics in primary care	SubICB	Nov 2021 - Oct 2022	107.5%	Decrease	88.5%	Lowest Performing Quartile	87.1%	Met
	S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	SubICB	Nov 2021 - Oct 2022	7.58%	Decrease	8.37%	Highest Performing Quartile	10%	Not Met
	S121a: NHS Staff Survey compassionate culture people promise element sub-score	ICB	2021	7.2/10	Increase		Interquartile Range		
	S121b: NHS Staff Survey raising concerns people promise element sub-score	ICB	2021	6.7/10	Increase		Highest Performing Quartile		

Sub Category	Indicator	Aggregation	Period	Value	Direction	National Value	Rank Banding	Standard	Standard Met
Elective care	S007a: Total elective activity undertaken compared with 2019/20 baseline	ICB	2022 09	103.7%	Increase		Highest Performing Quartile	104%	Not Met
	S007b: Elective Activity : Completed pathway elective activity growth	ICB	2022 10	102.8%	Increase		Interquartile Range	110%	Not Met
	S009a: Total patients waiting more than 52 weeks to start consultant led treatment	Provider	2022 11	8,853	Decrease	360,656	Interquartile Range		
		SubICB	2022 11	8,586	Decrease	347,944	Interquartile Range		
	S009b: Total patients waiting more than 78 weeks to start consultant led treatment	Provider	2022 11	911	Decrease	43,090	Interquartile Range		
		SubICB	2022 11	866	Decrease	40,872	Interquartile Range		
	S009c: Total patients waiting more than 104 weeks to start consultant led treatment	Provider	2022 11	29	Decrease	1,152	Lowest Performing Quartile	0	Met
		SubICB	2022 11	19	Decrease	1,212	Interquartile Range	0	Met
	S013a: Diagnostic activity levels: Imaging	Provider	2022 11	107%	Increase	106.1%	Interquartile Range	120%	Not Met
		SubICB	2022 11	105.6%	Increase	104.6%	Interquartile Range	120%	Not Met
	S013b: Diagnostic activity levels: Physiological measurement	Provider	2022 11	115%	Increase	105%	Interquartile Range	120%	Not Met
		SubICB	2022 11	114.7%	Increase	103.4%	Interquartile Range	120%	Not Met
	S013c: Diagnostic activity levels: Endoscopy	Provider	2022 11	83.3%	Increase	92.9%	Interquartile Range	120%	Not Met
		SubICB	2022 11	81.1%	Increase	90.9%	Interquartile Range	120%	Not Met
	S013d: Diagnostic activity levels: Total	Provider	2022 11	105.7%	Increase	105%	Interquartile Range	120%	Not Met
		SubICB	2022 11	104.3%	Increase	103.5%	Interquartile Range	120%	Not Met
Outpatient transformation	S101a: Outpatient follow up activity levels compared with 2019/20 baseline	ICB	2022 11	101.9%	Decrease		Interquartile Range	75%	Met
Personalised care	S031a: Rate of personalised care interventions	ICB	22-23 Q2	110.18 per 1,000	Increase	75.33 per 1,000	Highest Performing Quartile		
	S032a: Personal health budgets	ICB	22-23 Q1	1.13 per 1,000	Increase	1.45 per 1,000	Interquartile Range		
Primary care and community services	S001a: Number of general practice appointments per 10,000 weighted patients	ICB	2022 11	0 per 10,000	Increase	5349.31 per 10,000	Highest Performing Quartile		
	S106a: Available virtual ward capacity per 100k head of population	ICB	2022 12	13.3 per 100,000	Increase	13.2 per 100,000	Interquartile Range	40 per 100,000	Not Met
	S107a: Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	ICB	2022 10	78.9%	Increase	81%	Interquartile Range	70%	Met
	S108a: Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a general practice	ICB	2022 03	28.9 per 100,000	Increase	40.7 per 100,000	Interquartile Range		
	S108b: Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from NHS111 per 100,000 population	ICB	2022 03	94.2 per 100,000	Increase	71.3 per 100,000	Highest Performing Quartile		
	S109a: Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	ICB	2022 09	67.1%	Increase	70.2%	Interquartile Range	100%	Not Met
Screening, vaccination and immunisation	S046a: Population vaccination coverage: MMR for two doses (5 year olds)	SubICB	22-23 Q1	91.9%	Increase	84.4%	Highest Performing Quartile	95%	Not Met
	S047a: Proportion of people over 65 receiving a seasonal flu vaccinatio	SubICB	2022 10	68.9%	Increase	65.4%	Highest Performing Quartile	85%	Not Met
	S050a: Cervical screening coverage : % females aged 25 : 64 attending screening within the target period	SubICB	21-22 Q4	74.7%	Increase	70.8%	Highest Performing Quartile	75%	Not Met

Rank Banding
- Highest performing quartile
- Interquartile range
- Lowest performing quartile

Appendix 2: Variance and assurance icons



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

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

Appendix 3a: Quality – North & North Cumbria

-	-	NCIC				Northumbria				NuTH				Gateshead FT			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Serious Incidents	Proportion of RCAs submitted within 60 days - January 2023	0%	95%			50%	95%			46.2%	95%			0%			
	Proportion of incidents reported within 2 days - January 2023	100%	95%			100%	95%			100%	95%			100%			
	Number of Serious Incidents reported - January 2023	4				7				22				3			
	Number of Serious Incident Never Events reported - January 2023	0				0				0				0			
Quality - Mortality	Summary Hospital-level Mortality Indicator (SHMI) value - September 2022	1.0797				0.9334				0.9105				0.901			
Quality - HCAI	Incidence of P. aeruginosa - December 2022	2	1			1	1			5	3			0	0		
	Incidence of MSSA - December 2022	4				4				5				3			
	Incidence of MRSA - December 2022	0	0			0	0			0	0			0	0		
	Incidence of Klebsiella spp - December 2022	3	2			4	4			9	13			3	2		
	Incidence of E Coli - December 2022	12	7			12	11			10	16			8	5		
	Incidence of C Difficile - December 2022	1	4			7	4			15	14			4	2		

-	-	NCIC				Northumbria				NuTH				Gateshead FT			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Staff	Staff Absence Rate - September 2022	5.1%				5.6%				5.2%				5.3%			
	Staff Turnover Rate - October 2022	0.9%				1.2%				1.3%				1.3%			
Quality - Friends and Family	Proportion of service users that would recommend Community Health Services - November 2022	98.2%				92.6%				88.6%				100%			
	Proportion of service users that would recommend Emergency Department - November 2022	77.8%				80.4%								80.3%			
	Proportion of service users that would recommend Inpatient Services - November 2022	97.6%				95.2%				95.9%				94.6%			
	Proportion of service users that would recommend Maternity Services - November 2022	96.2%				71.5%				100%				0%			
	Proportion of service users that would recommend Mental Health Services - November 2022					87.2%											
	Proportion of service users that would recommend Outpatient Services - November 2022	98.6%				92.6%				97.9%				93.6%			

Appendix 3b Quality – Central and South

-	-	STSFT				CDDFT				NTHFT				STHFT			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Serious Incidents	Proportion of RCAs submitted within 60 days - January 2023	0%	95%			16.7%				0%	95%			42.9%	95%		
	Proportion of incidents reported within 2 days - January 2023	100%	95%			66.7%				100%	95%			100%	95%		
	Number of Serious Incidents reported - January 2023	1				6				2				4			
	Number of Serious Incident Never Events reported - January 2023	0				0				0				0			
Quality - Mortality	Summary Hospital-level Mortality Indicator (SHMI) value - September 2022	1.0857				1.0969				0.9791				1.0598			
Quality - HCAI	Incidence of P. aeruginosa - December 2022	2	2			2	1			0	1			2	1		
	Incidence of MSSA - December 2022	7				3				7				7			
	Incidence of MRSA - December 2022	0	0			0	0			1	0			2	0		
	Incidence of Klebsiella spp - December 2022	7	4			2	3			1	2			4	4		
	Incidence of E Coli - December 2022	15	10			4	9			5	6			15	11		
	Incidence of C Difficile - December 2022	5	5			4	5			2	4			11	9		

-	-	STSFT				CDDFT				NTHFT				STHFT			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Staff	Staff Absence Rate - September 2022	5.7%				5.6%				5.4%				5.8%			
	Staff Turnover Rate - October 2022	1.2%				1.3%				0.9%				1.2%			
Quality - Friends and Family	Proportion of service users that would recommend Community Health Services - November 2022	96.8%				100%				95.6%				98.3%			
	Proportion of service users that would recommend Emergency Department - November 2022	88.6%				96.8%				71.2%				75.3%			
	Proportion of service users that would recommend Inpatient Services - November 2022	97.7%				97.7%				92%				97.4%			
	Proportion of service users that would recommend Maternity Services - November 2022	76.9%				99.3%				81.8%				88.5%			
	Proportion of service users that would recommend Mental Health Services - November 2022	94.7%															
	Proportion of service users that would recommend Outpatient Services - November 2022	94.5%				99.1%				94.3%				95%			

Appendix 3c: Quality – Mental Health and Ambulance

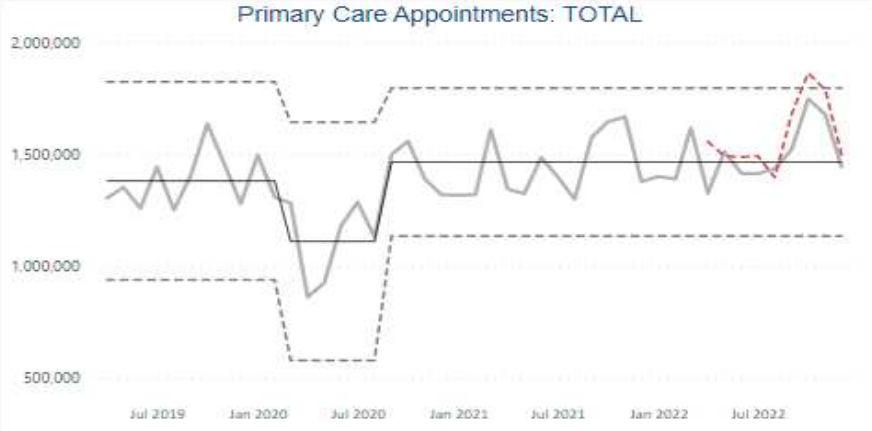
		NEAS				TEWV				CNTW			
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Serious Incidents	Proportion of RCAs submitted within 60 days - January 2023	0%				0%	95%			100%	95%		
	Proportion of incidents reported within 2 days - January 2023	100%				90.9%	95%			100%			
	Number of Serious Incidents reported - January 2023	7				11				8			
	Number of Serious Incident Never Events reported - January 2023	0				0				0			

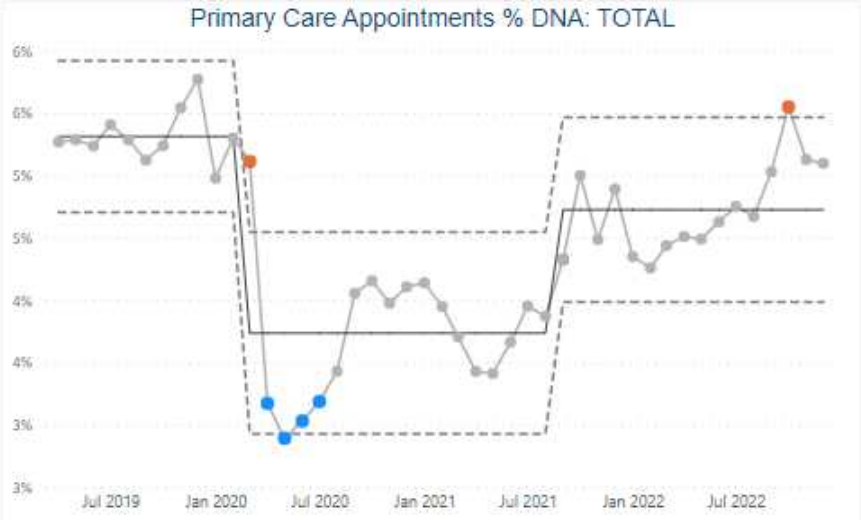
-	Indicator	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.	Value	Traj.	Var	Ass.
Quality - Staff	Staff Absence Rate - September 2022	7.4%				5.6%				6.2%			
	Staff Turnover Rate - October 2022	1.4%				1.1%				1.2%			
Quality - Friends and Family	Proportion of service users that would recommend Mental Health Services - November 2022					91.4%				82%			

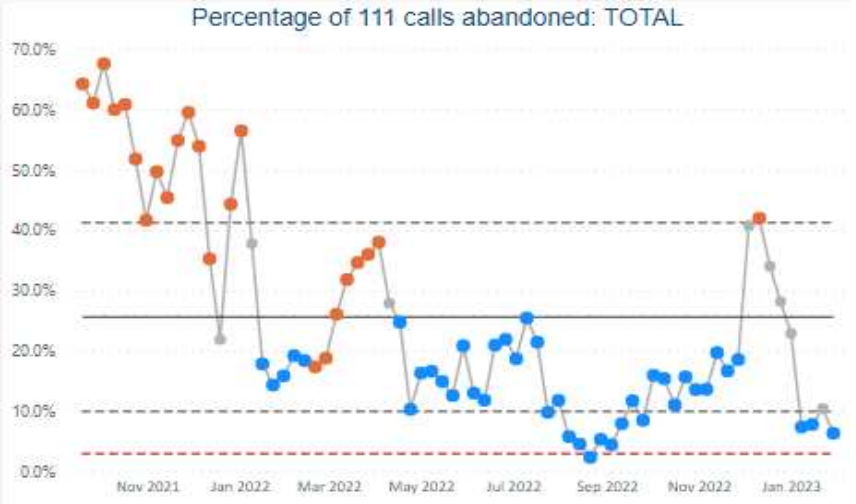
Appendix 4: Primary Care

Target

Metric	Latest date	Value	National	Target	Variation	Assurance
Primary Care Attends	Dec-22	1371573				
Primary Care Appointments	Dec-22	1445207		1498466		
Primary Care Appointments % DNA	Dec-22	5.1%	5.2%			
Proportion of primary care appointments delivered face to face	Dec-22	72.1%	67.3%			
Percentage of 111 calls abandoned	Jan-23	6.4%		3%		



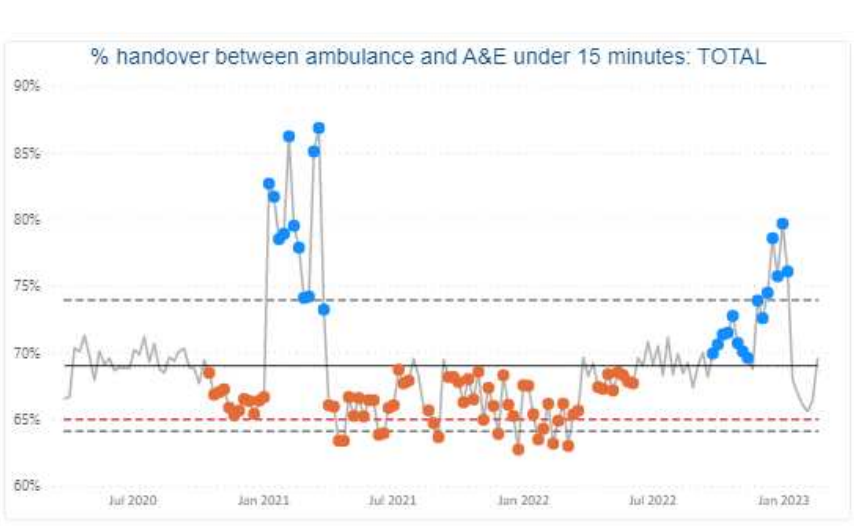


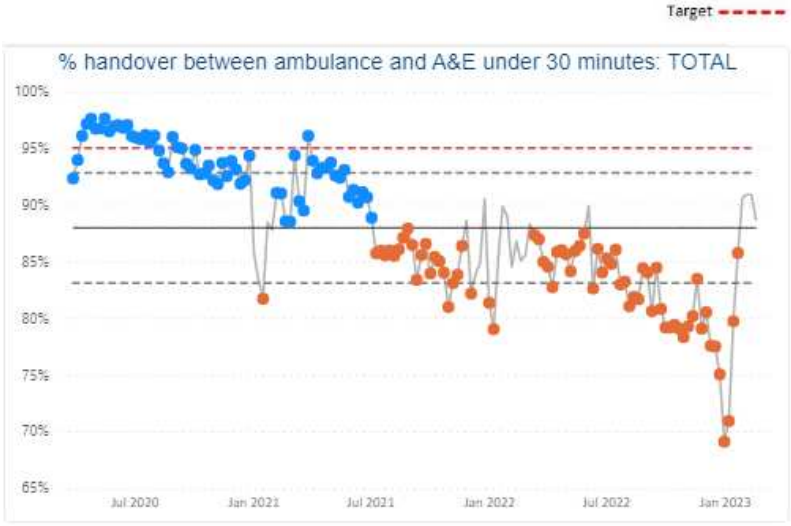


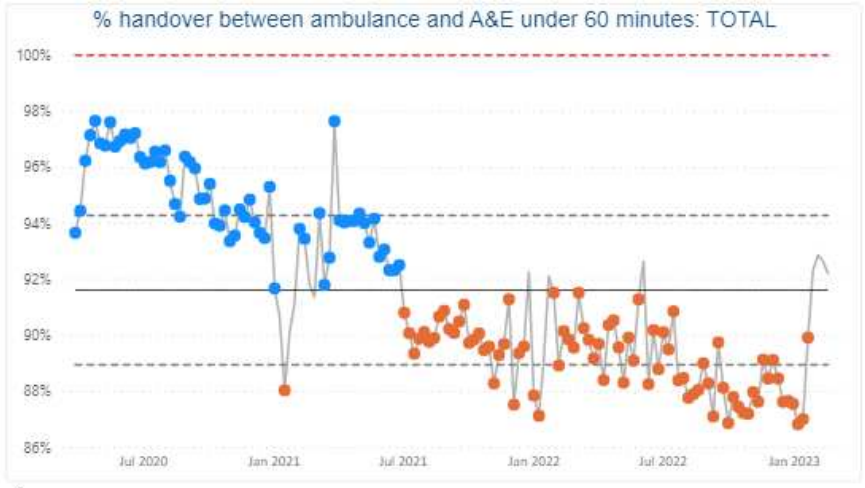
Latest data 29/01/23

Appendix 5: Ambulance handover

Metric	Latest date	Value	National	Target	Variation	Assurance
Average hours lost to handover delays per day vs local trajectory	Feb-23	20		57.4		
% handover between ambulance and A&E under 60 minutes	Feb-23	92.2%		100%		
% handover between ambulance and A&E under 30 minutes	Feb-23	88.7%		95%		
% handover between ambulance and A&E under 15 minutes	Feb-23	69.6%		65%		





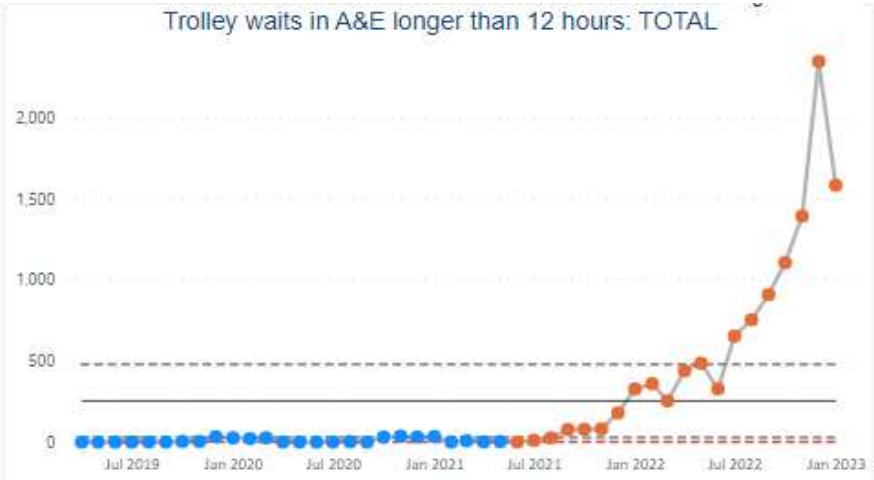


Latest Data 18/02/2023

Appendix 6: Accident and Emergency

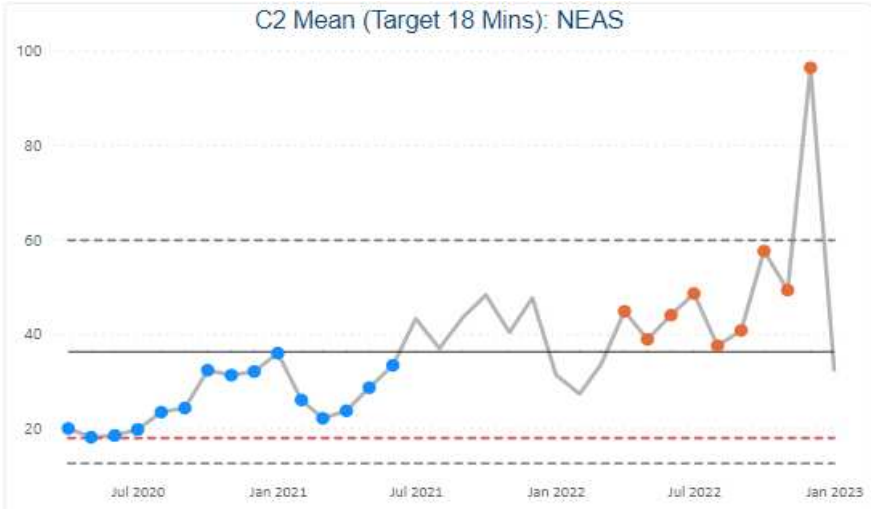
Target

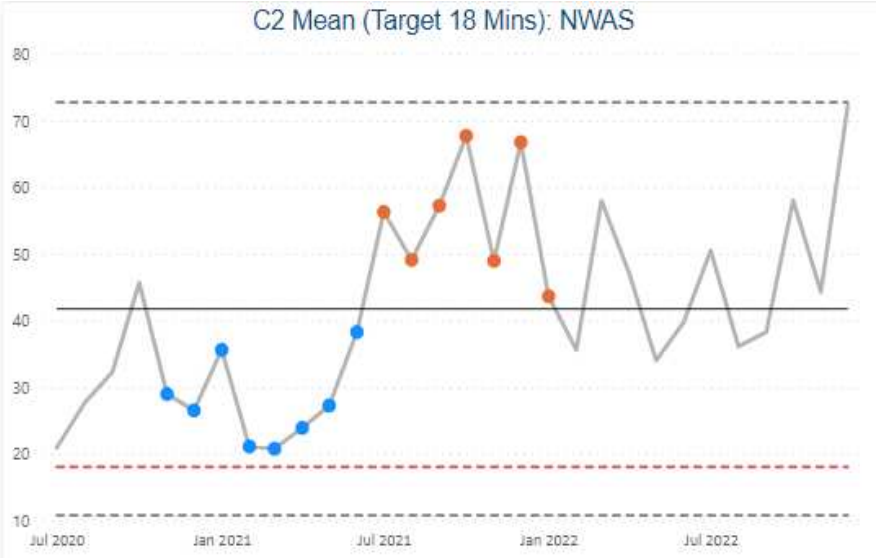
Metric	Latest date	Value	National	Target	Variation	Assurance
% Patients spending 4 Hours or less in A&E	Jan-23	75.1%	64.6%	95%		
A&E 4 Hours (T1 only)	Jan-23	59.2%	50.8%	95%		
Trolley waits (from DTA) in A&E longer than 12 hours	Jan-23	1583		0		
% A&E waits from arrival to discharge, admission or transfer longer than 12 hours	Oct-22	4%		2%		
Mean 999 Call Answering Time (seconds)	Feb-23	8.8		20		



Appendix 7: Ambulance response times

Metric	Latest date	Value	National	Target	Variation	Assurance
Latest data 11/02/23						
	Dec-22	01:12:11		00:18:00		
C2 Mean (Target 18 Mins): NEAS	Jan-23	00:32:24	00:32:06	00:18:00		



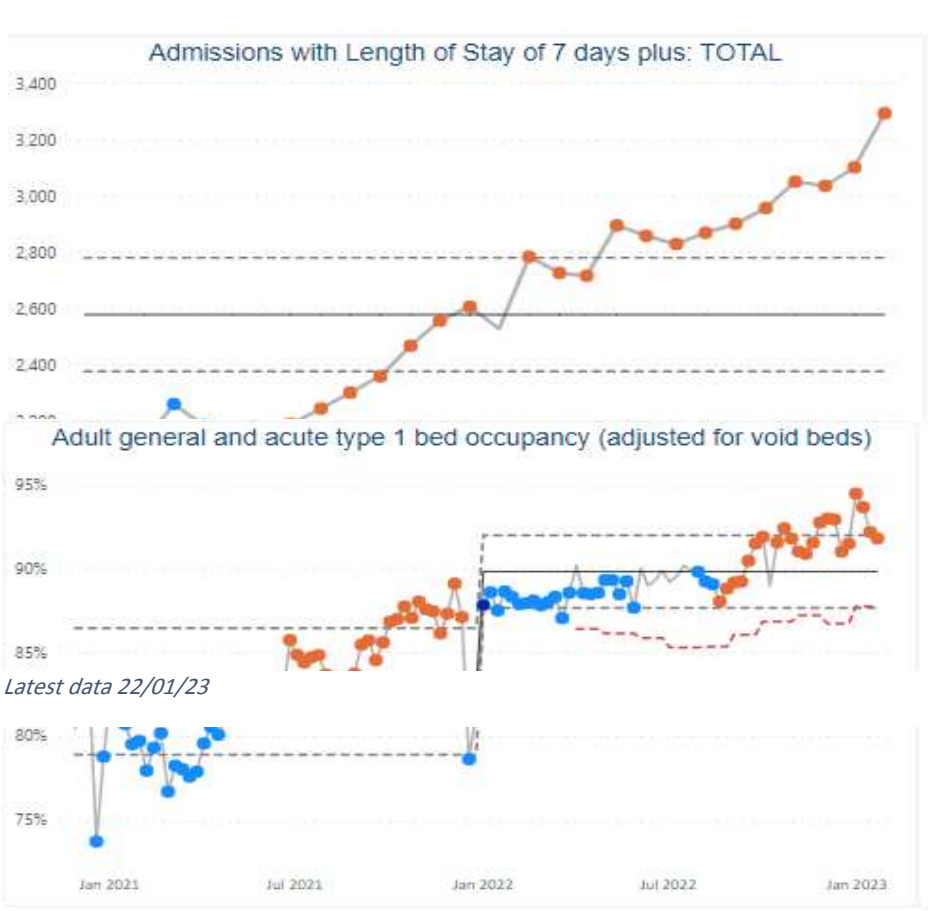


Target

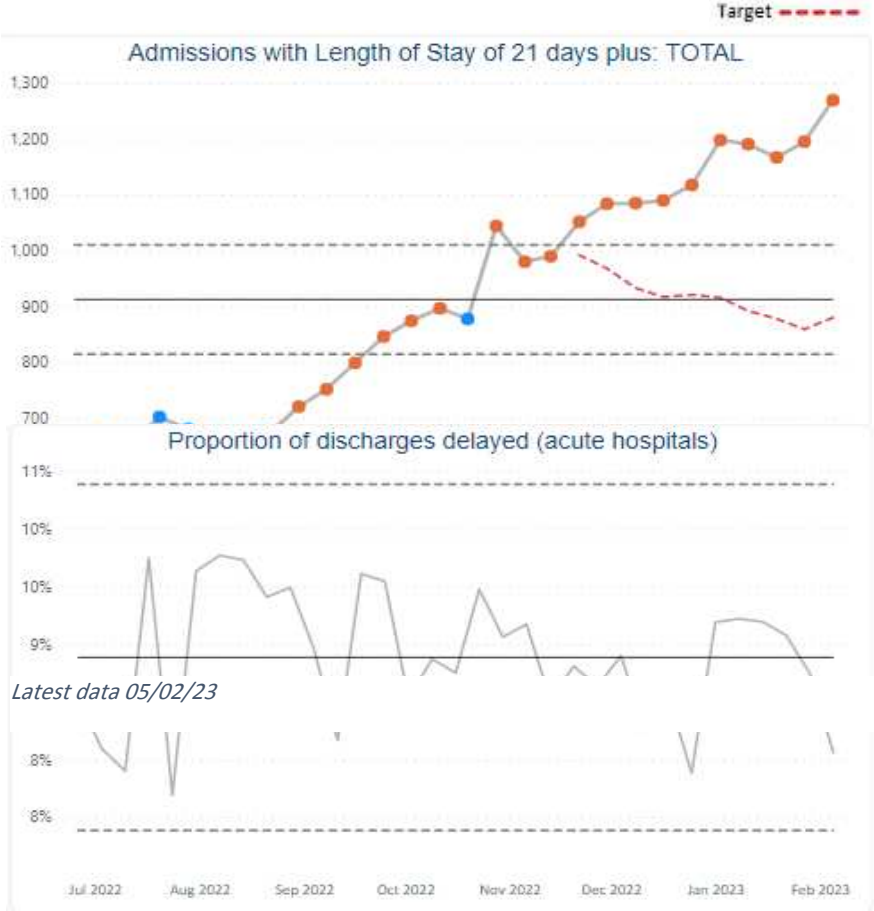
		NEAS			NWAS		
Metric	Target	Value	Variation	Assur.	Value	Variation	Assur.
C1 Mean (Target 7 Mins)	00:07:00	00:07:07	H	?	00:09:58	H	F
C1 90th Centile	00:15:00	00:12:18	H	P	00:16:56		?
C2 Mean (Target 18 Mins)	00:18:00	00:32:24		?	01:12:11		?
C2 90th centile	00:40:00	01:08:07		?	02:45:19		?
C3 90th centile	02:00:00	02:19:11		?	12:54:30	H	?
C4 90th centile	03:00:00	02:41:28		?	15:56:11		?

Appendix 8: Patient Flow and Discharge

Metric	Latest date	Value	National	Target	Variation	Assurance
Admissions with Length of Stay of 21 days plus	Jan-23	1269.5		880		
Admissions with Length of Stay of 7 days plus	Jan-23	3293.5				
Adult general and acute type 1 bed occupancy (adjusted for void beds)	Jan-23	91.8%		87.7%		
Proportion of discharges delayed (acute hospitals)	Feb-23	8.1%				



Latest data 22/01/23

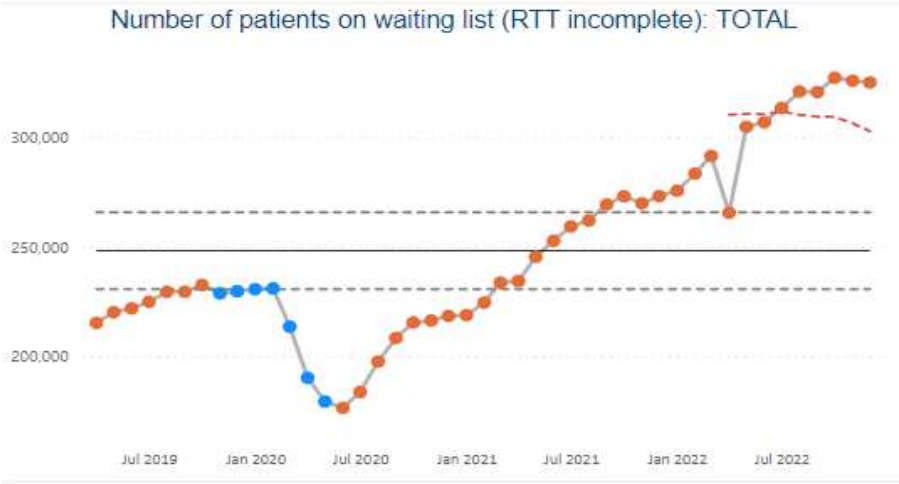


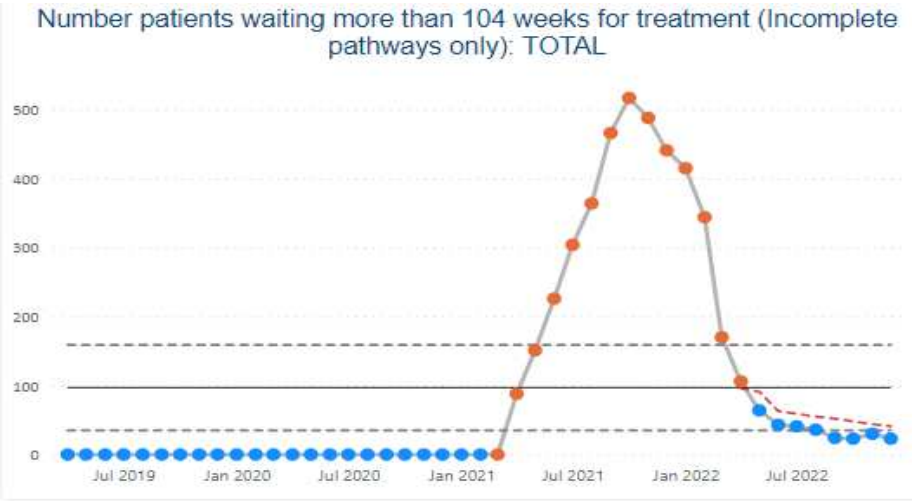
Latest data 05/02/23

Target

Appendix 9a: Elective waiting list and long waiters – Referral to Treatment

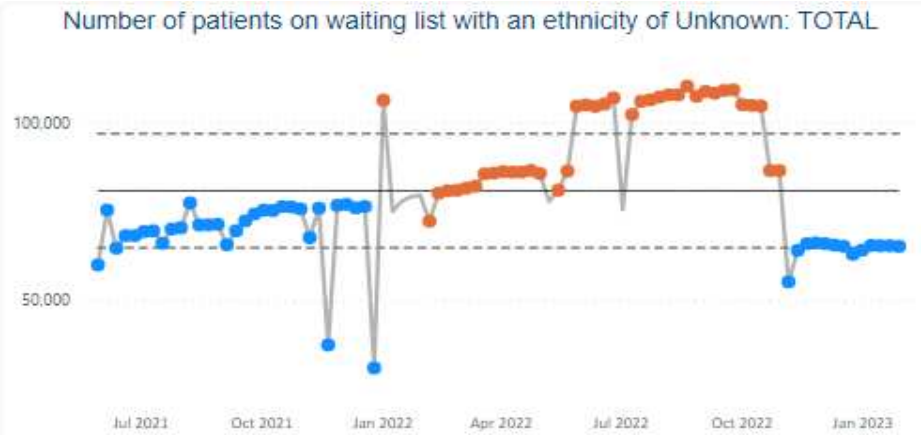
Metric	Latest date	Value	National	Target	Variation	Assurance
Number patients waiting more than 52 weeks for treatment (Incomplete pathways only)	Dec-22	8520		4485		
Number patients waiting more than 78 weeks for treatment (Incomplete pathways only)	Dec-22	1079		327		
Number patients waiting more than 104 weeks for treatment (Incomplete pathways only)	Dec-22	23		41		
Number of patients on waiting list (RTT incomplete)	Dec-22	325193		302915		



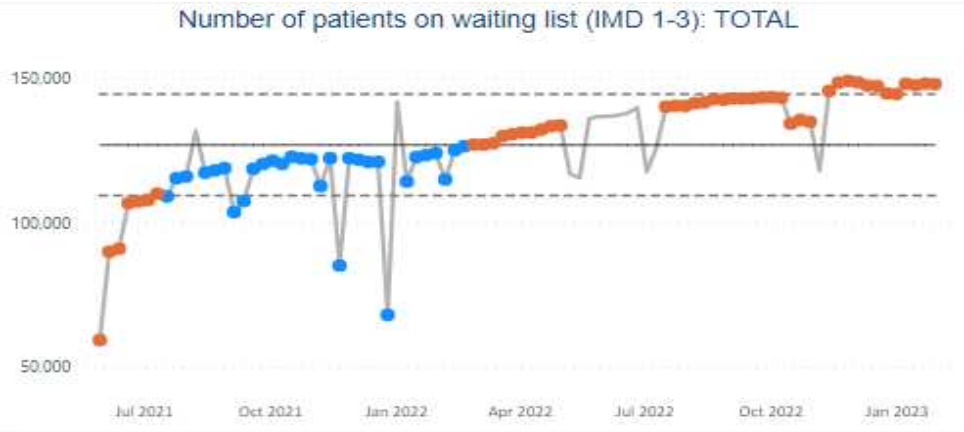


Appendix 9b: Elective Waiting List – health inequalities

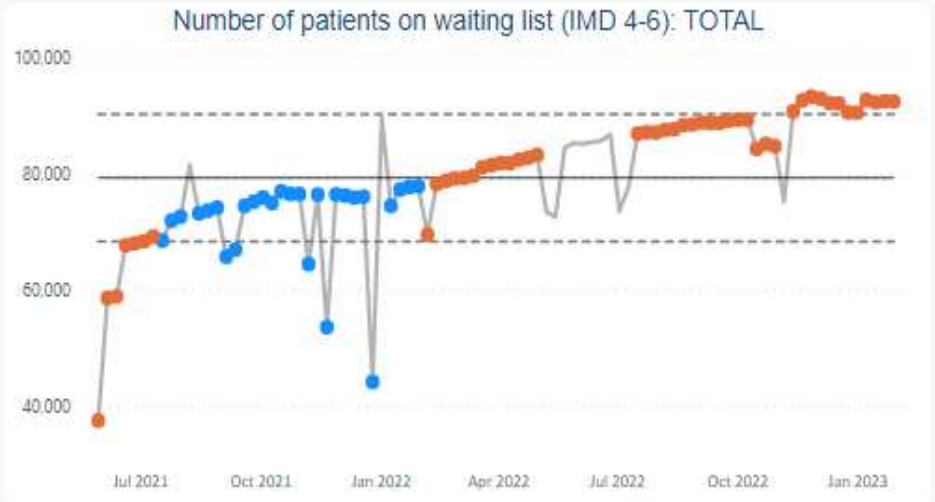
Provider	TOTAL		CDDFT		Gateshead FT		NCIC		Northumbria		NTHFT		NuTH		STHFT		STSFT	
	Val.	Var.	Val.	Var.	Val.	Var.	Val.	Var.	Val.	Var.	Val.	Var.	Val.	Var.	Val.	Var.	Val.	Var.
Number of patients on waiting list (Ethnicity White)	271465		35984		9636		28225		27470		14456		71809		38351		45534	
Number of patients on waiting list (Ethnicity BAME)	13441		669		274		436		349		1259		6363		2289		1802	
Number of patients on waiting list (Ethnicity Unknown)	65136		5328		2840		8679		5552		3435		22172		9515		7615	
Number of patients on waiting list (IMD 1-3)	147969		18573		6214		10787		10559		9979		41909		19828		30120	
Number of patients on waiting list (IMD 4-6)	92380		12177		3318		13746		9995		3248		25164		11428		13304	
Number of patients on waiting list (IMD 7-10)	104584		10785		3042		12054		12294		5781		31653		18071		10904	



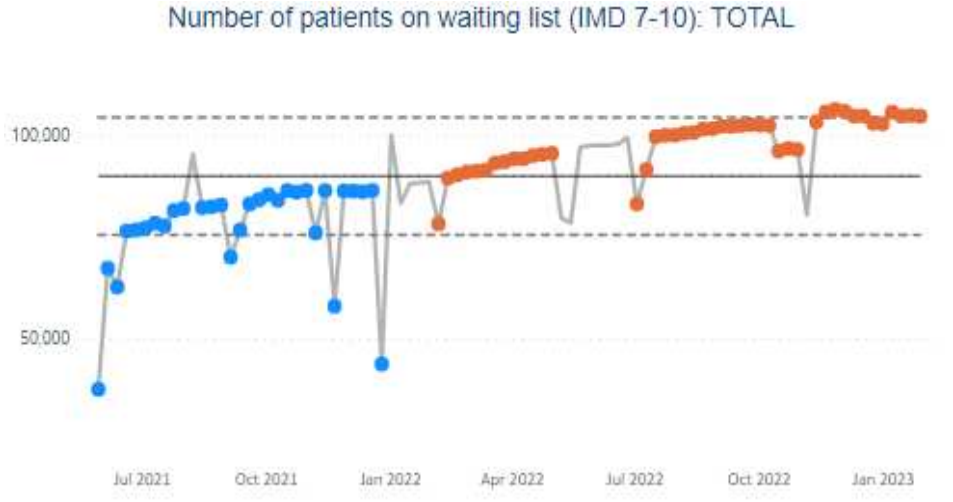
Latest data 29/01/23



Latest data 29/01/23



Latest data 29/01/23



Latest data 29/01/23

Appendix 10: Diagnostic waiting list

Metric	Latest date	Value	National	Target	Variation	Assurance
Number of patients waiting more than 6 weeks from referral for a diagnostic test	Dec-22	15717				
% Patients waiting more than 6 weeks from referral for a diagnostic test	Dec-22	20.3%	31.3%	1%		

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

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

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

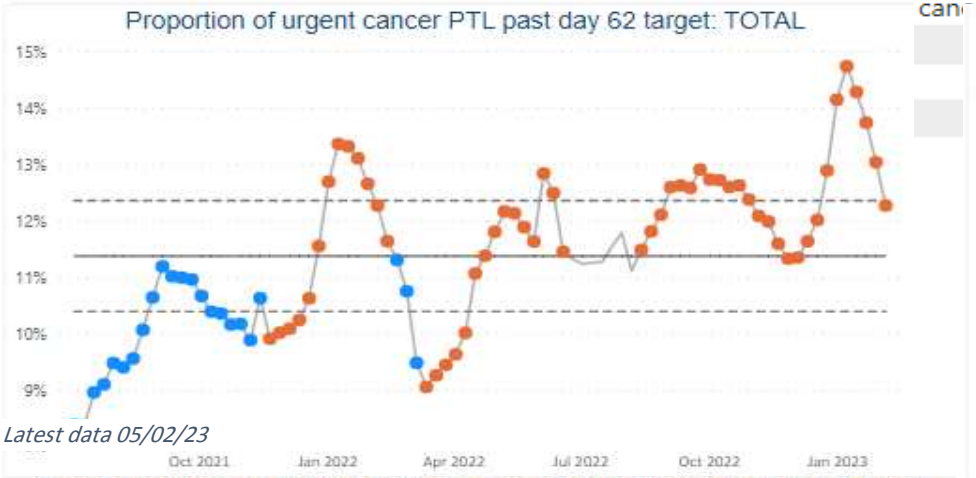
Metric	% Patients waiting more than 6 weeks from referral for a diagnostic test			Number of patients waiting more than 6 weeks from referral for a diagnostic test		
	Value	Variation	Assur.	Value	Variation	Assur.
TOTAL	20.3%			15717		
CDDFT	10.6%			1102		
Gateshead FT	19.2%			931		
NCIC	22.4%			1853		
Northumbria	4.4%			458		
NTHFT	33.1%			3035		
NuTH	25%			3551		
STHFT	26.7%			2705		
STSFT	21.9%			1807		

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

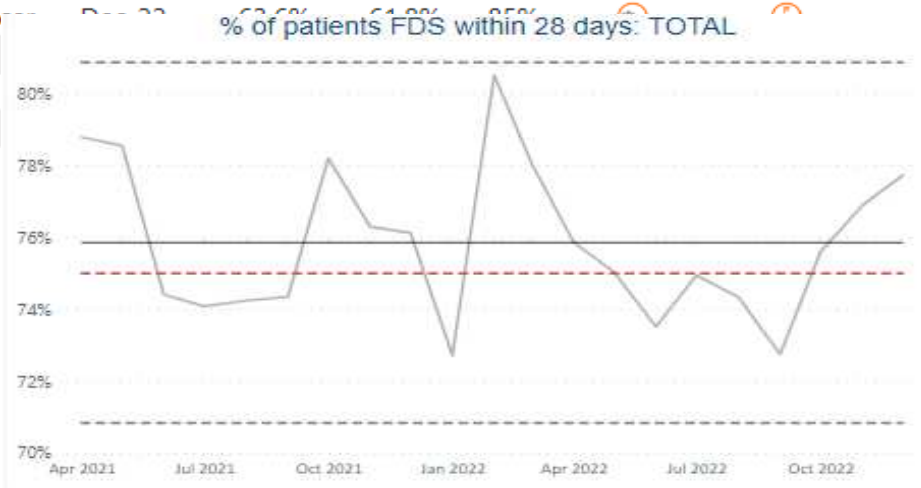
Appendix 11: Cancer

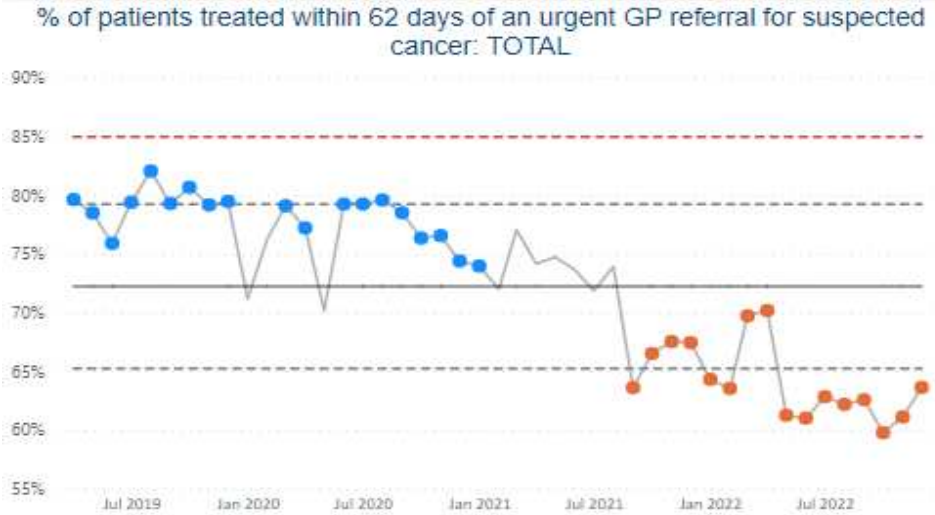
Target

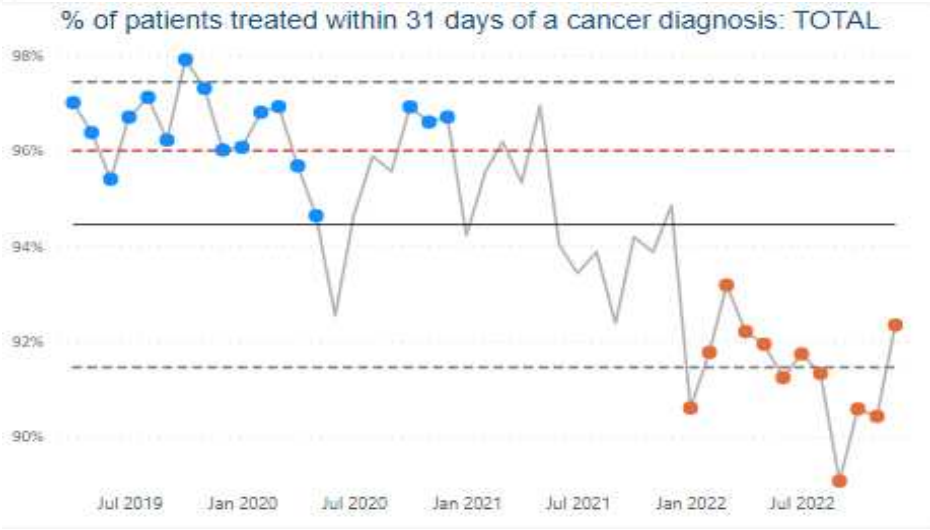
Metric	Latest date	Value	National	Target	Variation	Assurance



Latest data 05/02/23







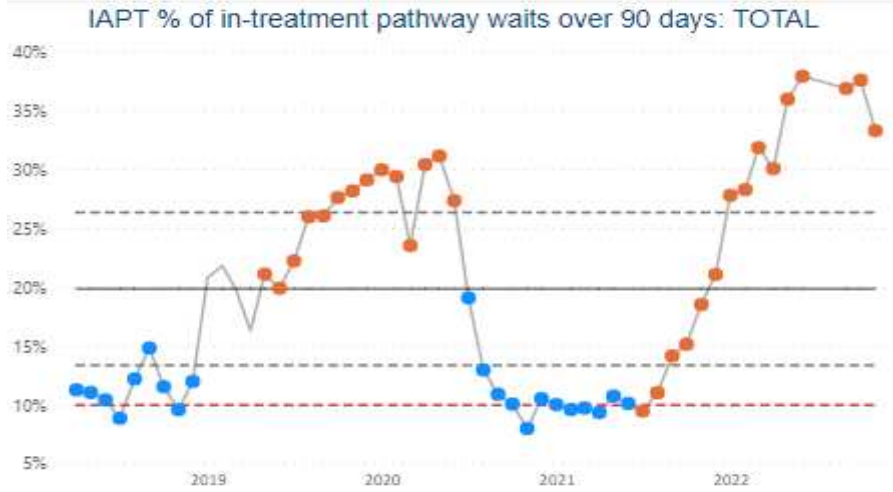
Appendix 12: Improving Access to Psychological Therapies

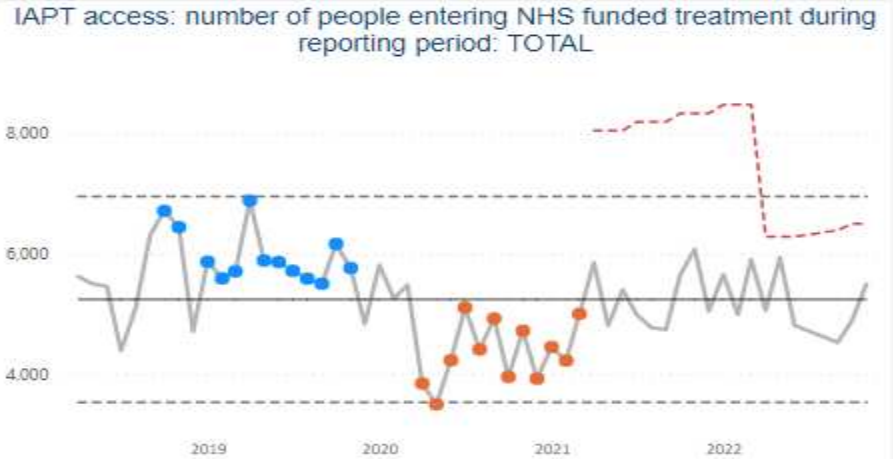
Target

Metric	Latest date	Value	National	Target	Variation	Assurance
IAPT access: number of people entering NHS funded treatment during reporting period	Nov-22	5500		6500		
IAPT recovery rate for Black, Asian or Minority Ethnic groups	Sep-22	45%		50%		
IAPT % of in-treatment pathway waits over 90 days	Nov-22	33.3%	22.4%	10%		
IAPT recovery rate: % of people that attended at least 2 treatment contacts and are m...	Nov-22	50.6%	49.5%	50%		
IAPT % of people receiving first treatment appointment within 6 weeks of referral	Nov-22	96.4%		75%		
IAPT % of people receiving first treatment appointment within 18 weeks of referral	Nov-22	99.3%		95%		

IAPT Recovery by Sub ICB location

Metric	IAPT recovery rate for Black, Asian or Minority Ethnic groups			IAPT recovery rate: % of people that attended at least 2 treatment contacts and are moving to recovery		
	Value	Variation	Assur.	Value	Variation	Assur.
TOTAL	45%			50.6%		
Co Durham	48%			46.1%		
N Cumbria	50%			51.7%	H	
N Tyneside	66.7%			57.5%	H	
Ncl-Gateshead	43.9%			56.1%		
Northumberland	20%			52.8%	L	
S Tyneside	33.3%			46.3%		
Sunderland	50%			54.3%		
Tees Valley	44%			47.4%		

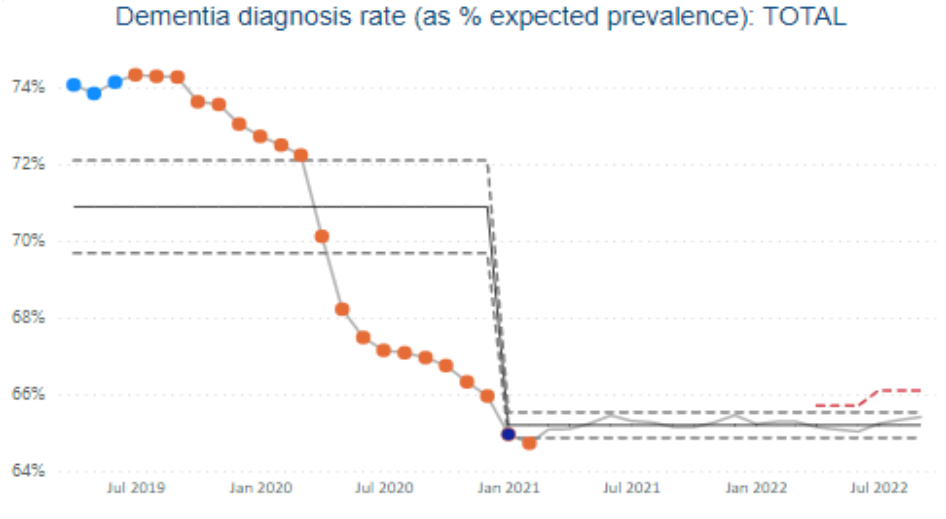


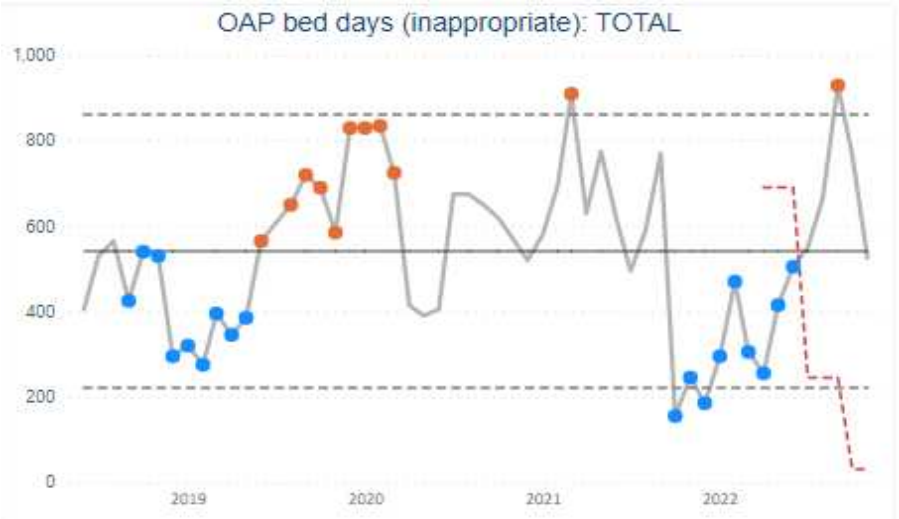


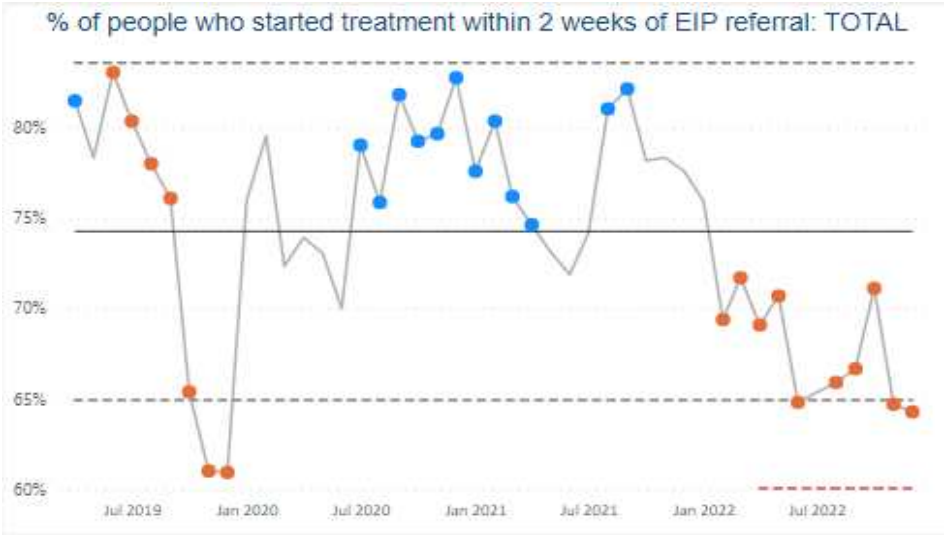
Appendix 13: Mental Health -Adult

Target

Metric	Latest date	Value	National	Target	Variation	Assurance
EIP % of people who started treatment within 2 weeks of referral - All ages	Dec-22	64.3%		60.1%		
Number of people on GP SMI register receiving full physical health check in primary care setting	Dec-22	14592		16325		
Total number of inappropriate Out of Area bed days	Nov-22	525		30		
Dementia diagnosis rate (as % expected prevalence)	Sep-22	65.4%		66.1%		



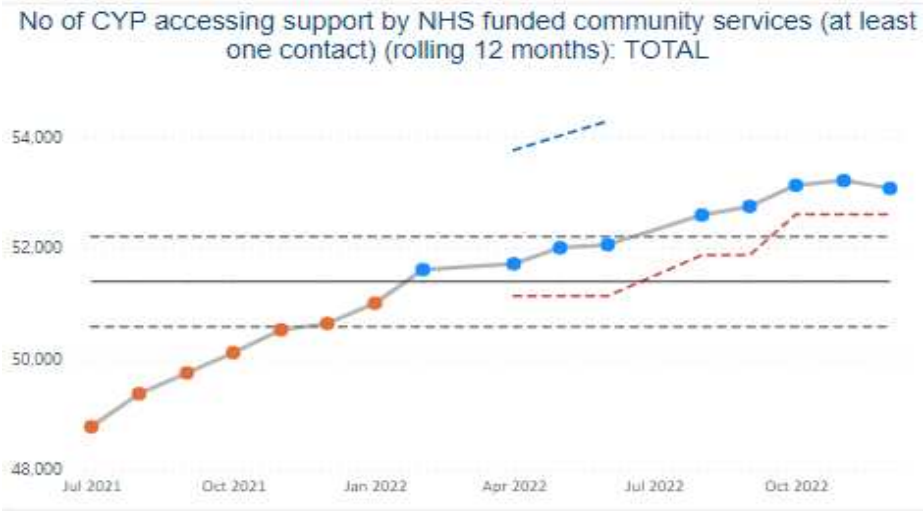


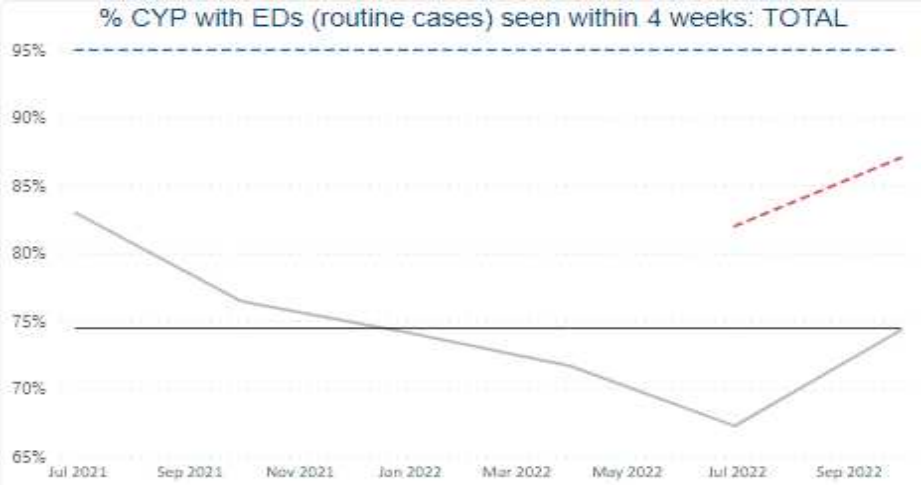


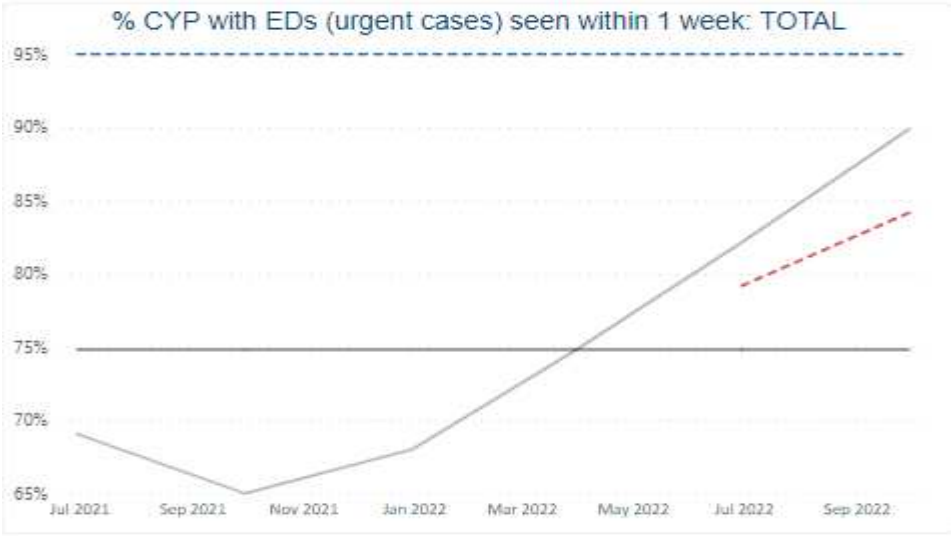
Appendix 14: Mental Health – Children and Young People

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

Metric	Latest date	Value	National	Target	Variation	Assurance
No of CYP accessing support by NHS funded community services (at least one contact) (rolling 12 months)	Dec-22	53075		52606		
% of CYP with eating disorders (routine cases) seen within 4 weeks of referral for NICE approved treatment	Sep-22	74.3%		87%		
% of CYP with eating disorders (urgent cases) seen within 1 week of referral for NICE approved treatment	Sep-22	89.9%		84.2%		







Appendix 15: Learning Disability Long Term Plan Deliverables

Long Term Plan commitment or mandate	Current Position	Mitigations	RAG
Reducing reliance on inpatient care: • By 2023/24 there will be a reduction in reliance on inpatient care for people with a learning disability, autism or both to no more than 30 inpatients per million adult population; i.e. no more than 71 adults in NENC (Secure and ICS commissioned services) • By 2023/24 no more than 12 to 15 children or young people with a learning disability, autism or both per million, will be cared for in an inpatient facility; i.e. no more than 8 children or young people in NENC	**As at 13/1/2023: NENC ICS Total: 168** ICB Place based: 84 increase of 2 Secure Services: 76 increase of 1 in month CAMHS: 8 increase of 1 in month **Significant risk to achieving the Q4 trajectory, expected +10 above trajectory at end Q4** **Ability to achieve the Q4 trajectory is effected by:** • Availability of independent care sector providers; retention and recruitment across the system • Blocked care pathways; including the impact of MM Judgement • Unavoidable admissions to hospital • Complexity of caseload	• Use of 12 point discharge plan, escalation processes, RCA completion and development of Dynamic Support Systems. • Detailed housing market analysis and Accommodation Plan in place; consideration of alternative accommodation, care and support solutions. Exploring Care Pathways and the use of rehabilitation wards; Operational Delivery Network work with NW&Y; meeting with MOJ and legal advice re the impact of MM. • ICB Learning Disability and Autism Team established April 2022 onwards to focus on delivery of Building the Right Support through an increase in capacity and expertise in stimulating the provider market and case management. • Joint project with ADASS.	
Care (Education) and Treatment Reviews (CETRs); compliance with national policy	NENC overall compliant with 2 ICB places not meeting the metrics: 1x adult pre or post admission CTR 1x adult repeat CTR	• Community C(E)TRs are shown to prevent admissions e.g. Q2 53 meetings took place (Leaps/C(E)TRs etc) and 48 admissions were avoided • ICB Programme Team increased capacity to support place based teams to maintain compliance.	
Annual health checks • By 2023/24 - 75% of people on the learning disability register will have had an annual health check.	As of January 2023, 48% of the register for 22/23 has received an Annual Health Check with 6338 still to be completed. 2022-23 Long Term Plan Target 73% by March 23 (achieved 77% in 20-21) 2023-24 Target 75%	The Learning Disability Network lead on the promotion of AHCs and the development of resources to aid Primary Care to deliver e.g. videos, pre-appointment questionnaires etc The aim is to increase the number and quality of AHCs across the ICB.	

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

BOARD MEETING 28 March 2023	
Report Title:	**NENC ICB and ICS Finance Report – M10**

Purpose of report

To provide the Board with an update on the financial performance of the North East and North Cumbria Integrated Care Board (NENC ICB) and NENC Integrated Care System (ICS) in the financial year 2022/23 for the period to 31 January 2023 ("month 10").

Key points

The full financial report for the period was reviewed in detail by the Finance, Performance and Investment Committee (FPIC) at its meeting on 2nd March 2023. The report presented here provides a high level summary of the position.

ICB Revenue Position:

As at 31st January 2023 the ICB is reporting a forecast deficit of £6.2m, prior to expected receipt of additional funding from NHS England (NHSE) of £8.9m to cover costs associated with the Primary Care Additional Roles Reimbursement Scheme (ARRS). Once this funding is received, the ICB will report a forecast surplus of £2.7m against a planned surplus of £2.6m.

Significant financial pressures are being seen in independent sector (IS) acute activity linked to elective recovery with a forecast overspend of over £21m on IS contracts. Additional funding of £5.7m has now been received from NHSE in respect of additional IS activity performed in the first 6 months of the year. Further information is awaited on any additional funding for the second half of the year.

Significant pressures are also evident in prescribing predominantly linked to the impact of price concessions (£13.7m impact year to date and forecast impact of £20.4m) with further pressure experienced in month due to Category M price uplifts.

Pressures are also being reported on continuing healthcare and section 117 packages of care. These pressures are currently being offset through underspends on other budgets, non-recurring benefits and use of programme reserves.

The significant forecast overspend on primary care delegated budgets largely relates to the additional costs associated with the ARRS. As part of national funding arrangements in this area

only a portion of this funding is included within ICB baseline budgets, with the remainder to be drawn down from NHSE only once baseline budgets are exceeded. Total additional funding of £8.9m is expected based on current forecast ARRS costs.

ICS Revenue Position:

From an ICS perspective the forecast out-turn is a surplus against plan of £0.4m, as shown in Table 2. Significant further work has taken place, supported by the FPIC, with ICS Directors of Finance and ICS Chief Executives to review positions and agree forecast outturn positions across the ICS to enable overall delivery of a balanced position.

NHS Provider Foundation Trusts (FT) are forecasting an overall deficit of £2.3m compared to a planned deficit of £2.6m (a £3.3m favourable movement compared to month 9). When combined with the ICB forecast, this gives and an overall forecast surplus of £0.4m for the ICS.

ICB Running Costs:

A forecast underspend is expected on ICB running costs, largely due to the impact of vacancies in the current year. This remains a potential risk area on a recurring basis if vacancies are filled.

ICS Capital Position:

There is a potential forecast pressure of £4.74m on capital spending plans across the ICS in comparison to the confirmed ICS capital departmental expenditure limit (CDEL) allocation. This forecast pressure continues to reduce as work continues to review relevant capital plans with individual provider trusts and discussions continue with NHSE in respect of additional capital funding allocation for the year. It is anticipated capital spending will be within the allocation by the end of the year.

2023/24 Planning:
Work is progressing to develop financial plans across the ICS in line with the relevant planning guidance and financial allocations published by NHS England, with draft plans submitted on 23 February 2023. A further update is included in the separate draft financial plan and budgets 2023/24 paper.

Risks and issues

Whilst the ICB has reported a forecast in line with plan, a number of potential financial risks have been identified, totalling £9m for the ICB (reduced from £14m at month 9).

Key risks identified at this stage include:

- Risk that prescribing price concessions continue at current exceptionally high levels until the end of the financial year and
- Risk that growth in continuing healthcare (CHC) expenditure is above planned levels.

Mitigations have been identified to manage the potential ICB risks, with additional elective recovery funding mitigating previously identified risks around IS activity pressures.

In addition to ICB specific financial risks there are a number of potential risks to the wider ICS financial position within Foundation Trusts, including pressures associated with the pay award alongside other general cost pressures such as those linked to winter, covid and delivery of cost savings. These risks though have generally been mitigated by the application of non-recurrent funding pressures monies from NHSE and realignment of covid funding. Unmitigated financial risk is reduced from earlier in the year and now assessed at £7m at month 10. This is a further reduction from the previous month (unmitigated risk of £13m) reflecting continued work to manage the system position and additional mitigations identified. This forecast and risk mitigations include additional funding offered from NHSE to support system pressures and funding receipt is dependent on the ICS delivery of a break-even position for year end.

An additional risk is that the due to unforeseen additional income or pressure reduction that the ICS could forecast or achieve a greater surplus. This could put at risk the receipt of some or all of the additional funding from NHSE and as such the ICB Executive Director of Finance will work with ICS Directors of Finance to collectively manage the mitigation of this risk as much as possible.

There is also a potential risk in respect of an under-spend against the capital funding allocation due to either:

- Continued reduction in forecast spend as spending plans may no longer be achievable, and/or
- Late funding allocation of c£20m expected to be received from NHSE for the CEDARs development.

Assurances

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

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

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

Recommendation/action Required

The Board is asked to:

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

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

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

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

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

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

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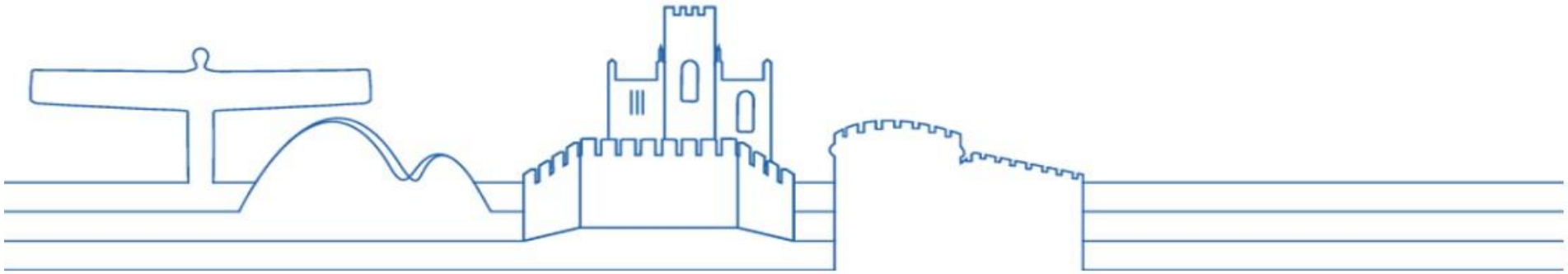
Version Control

Version	Date	Author	Update comments
1.0	13/03/2023	Anthea Thompson	Reviewed and updated by Richard Henderson
2,0	15/03/2023	David Chandler	Final approved

NHS
North East and North Cumbria

NENC ICB

Finance Report for the period ending 31st January 2023



Executive Summary

	M10 - January 2023		YTD	Forecast
Key Statutory Financial Duties	**Overall ICS 2022/23 In Year Financial Position - (Surplus) / Deficit**			
	For the financial year 2022/23 the ICS, including the Q1 position of the NENC CCGs, is on track to deliver the planned breakeven position reporting a small surplus of £0.4m at Month 10	Plan	£6.29 m	£0.00 m
		Actual	£19.06 m	(£0.38) m
	Overall ICB 2022/23 In Year Financial Position - (Surplus) / Deficit			
	Overall ICB 2022/23 In Year Financial Position prior to retrospective funding - (Surplus) / Deficit	Plan	(£1.75) m	(£2.63) m
	The ICB is reporting a year to date variance of £6.61m and an outturn variance of £6.20m, prior to expected retrospective funding adjustments of £8.93m - Deficit / (Surplus)	Actual	£6.61 m	£6.20 m
	Expected ICB 2022/23 In Year Financial Position after retrospective funding - (Surplus) / Deficit	Plan	(£1.75) m	(£2.63) m
	The ICB is reporting an outturn variance of £2.74m, after expected retrospective funding adjustments of £8.93m, an improved position of £0.1m against the planned surplus of £2.63m - Deficit / (Surplus)	Actual	£4.09 m	(£2.74) m
	ICB Running Costs Position - July 2022 to March 2023			
	The ICB is reporting a year to date and forecast outturn underspend of £2.48m and £3.93m respectively, compared with the submitted financial plan	Plan	£34.78 m	£46.06 m
		Actual	£32.30 m	£42.12 m
		Variance	(£2.48) m	(£3.93) m
	Overall ICS 2022/23 Capital Funding			
	The ICS is reporting a forecast outturn against the capital allocation in line with plan for primary care and £4.74m over on provider capital. At Month 10 there is a year to date underspend against the capital allocation of £57m.	Allocation	£175.78 m	£201.89 m
		Actual	£118.78 m	£206.63 m
		Variance	(£57.00) m	£4.74 m
Other Financial Performance Metrics				
	Overall ICS 2022/23 QIPP/Efficiency	Plan	£202.85 m	£248.83 m
	The ICS is reporting year to date QIPP savings of £188.26m and forecast savings of £241.94m with the ICB delivering £48.46m which is slightly over the submitted QIPP/Efficiency plan. Providers are currently forecasting an under-delivery against target of £6.92m.	Actual	£188.26 m	£241.94 m
		Variance	(£14.59) m	(£6.89) m
	Overall 2022/23 Mental Health Investment Standard (MHIS)		6.68%	6.68%
	The ICB is on track to achieve the MHIS target for 2022/23 (growth in spend of 6.68%), the target now includes the impact of the pay award and additional uplift.			
	Cash		0.20%	<1.25%
	The ICB cash balance for January is 0.2% and within the target set by NHS England of <1.25% of the monthly cash drawdown.			
	BPPC		by volume	by value
	The BBPC target is for 95% of NHS and Non NHS invoices to be paid within 30 days	NHS	99.71%	100.00%
		Non NHS	99.08%	99.28%

Overview of the Financial Position

This report provides an update on the financial performance of the ICB and wider ICS in the financial year 2022/23 for the period to 31st January 2023.

The ICB is currently reporting a forecast outturn deficit of £6.2m, prior to expected retrospective central funding of £8.9m relating to the Primary Care Additional Roles Reimbursement Scheme (ARRS). Once this funding is received, the ICB will report a forecast surplus of £2.7m against a planned surplus of £2.6m.

In previous months the ICB forecast surplus was increased by £3.0m in order to offset a forecast deficit across NHS providers. Following further work to review the position and potential risks across the system, revised forecast outturns have been agreed for each organisation within the ICS. This has resulted in the ICB position reducing back in line with plan. The latest ICB forecast, together with a favourable forecast variance across NHS providers of £0.3m has resulted in an overall forecast surplus for the ICS of £0.4m.

The main factors driving the ICB position are:

- Acute overspend mainly relating to Independent Sector provider activity where Elective Recovery Fund income has not been assumed
- Mental Health overspend in particular pressures on s117 packages and specialist packages of care, although this is reduced from the previous month
- Continuing Healthcare pressures, in particular backdated high cost packages of care partially mitigated by release of prior year accruals now reconciliations are finalised
- Prescribing overspend based on latest Prescription Pricing Data with significant cost pressure arising from continued impact of price concessions and Cat M impacts
- Management of reserves to balance overall ICB position and release of non-recurring benefits across a number of budget areas

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

The ICB is on track to deliver the Mental Health Investment Standard, the target investment has increased from 5.26% to 6.68% and now includes the impact of the pay award and additional inflationery uplift.

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

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

There are still some limitations with the data available for many of the commissioned services, with a time lag of two months in respect of prescribing data and other activity based contract information. This adds a level of risk and uncertainty to the reported forecast outturn position.

For month 10 the ICB is forecasting expenditure of £5.6m against the additional £200m of national discharge funding which the ICB will need to drawdown from NHSE central funds. Neither the income nor associated expenditure are included in the reported position in this finance report.

Whilst the ICB has reported a forecast in line with plan, a number of potential financial risks have been identified, totalling £9m. This includes in particular potential risks around prescribing, continuing healthcare and independent sector acute activity, linked to the elective recovery programme.

Mitigations have been identified to manage the majority of potential risks, and for month 10 there is no unmitigated risk within the ICB. A number of potential risks to the wider ICS financial position have also been identified for NHS provider trusts, with unmitigated financial risk assessed at £7m. Total unmitigated risk has reduced significantly from the previous month (£17m) as additional mitigations have been identified, including additional funding expected from NHSE to support system pressures. Work is continuing across the system to review potential pressures and manage the remaining potential risk.

Table 1: ICB Financial Position

Month 10 - January 2023	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Revenue Resource Limit	(3,919,259)			(5,104,564)		
Programme						
Acute Services	1,986,124	2,003,898	17,774	2,545,999	2,569,195	23,195
Mental Health Services	473,081	477,070	3,989	609,679	613,442	3,763
Community Health Services	387,223	377,185	(10,038)	496,478	489,068	(7,409)
Continuing Care	232,090	233,565	1,476	300,420	303,535	3,116
Prescribing	333,535	348,015	14,480	427,842	442,908	15,066
Primary Care	65,618	60,232	(5,386)	86,827	79,018	(7,808)
Primary Care Co-Commissioning	324,399	330,642	6,243	418,894	426,874	7,981
Other Programme Services	32,392	31,985	(406)	44,459	44,258	(201)
Other Commissioned Services	16,614	16,685	71	21,406	20,895	(511)
Programme Reserves	13,505	(299)	(13,804)	81,650	61,944	(19,705)
Contingency	3,563	0	(3,563)	4,725	0	(4,725)
Total ICB Programme Costs	**3,868,145**	**3,878,980**	**10,835**	**5,038,377**	**5,051,139**	**12,762**
Admin						
Running Costs	34,781	32,304	(2,477)	46,055	42,123	(3,932)
Total ICB Admin Costs	**34,781**	**32,304**	**(2,477)**	**46,055**	**42,123**	**(3,932)**
(Surplus) / Deficit	1,750	0	(1,750)	2,632	0	(2,632)
Total In Year ICB Financial Position	**3,904,676**	**3,911,283**	**6,608**	**5,087,064**	**5,093,262**	**6,198**
Central Funding expected for ARRS costs	2,517	0	(2,517)	8,934	0	(8,934)
Total In Year ICB Financial Position after expected retrospective funding	**3,907,193**	**3,911,283**	**4,091**	**5,095,998**	**5,093,262**	**(2,736)**
Cumulative Surplus Position for information:						
Historic (Surplus) / Deficit	14,583	0	(14,583)	17,500	0	(17,500)
Total Cumulative ICB Financial Position	**3,921,776**	**3,911,283**	**(10,492)**	**5,113,498**	**5,093,262**	**(20,236)**

Table 1.1: ICB In Year Financial Position

Month 10 - January 2023	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Financial Position at 'Place/Area' level						
North Cumbria	393,539	405,857	12,318	510,359	524,279	13,920
North Cumbria Area	**393,539**	**405,857**	**12,318**	**510,359**	**524,279**	**13,920**
Newcastle	429,692	427,121	(2,571)	551,984	549,521	(2,463)
Gateshead	336,049	333,627	(2,422)	434,196	431,884	(2,312)
North Tyneside	243,851	240,736	(3,115)	313,211	309,365	(3,846)
Northumberland	368,779	371,827	3,048	474,370	478,581	4,212
North Area	**1,378,371**	**1,373,310**	**(5,060)**	**1,773,759**	**1,769,351**	**(4,409)**
County Durham	658,950	658,774	(176)	856,638	853,902	(2,735)
South Tyneside	195,279	191,330	(3,949)	251,727	247,682	(4,045)
Sunderland	352,769	351,485	(1,284)	455,780	453,444	(2,336)
Central Area	**1,206,998**	**1,201,589**	**(5,410)**	**1,564,145**	**1,555,028**	**(9,117)**
Tees Valley	806,301	814,582	8,281	1,044,483	1,052,165	7,682
Tees Valley (South) Area	**806,301**	**814,582**	**8,281**	**1,044,483**	**1,052,165**	**7,682**
System	**121,983**	**115,945**	**(6,039)**	**203,252**	**192,439**	**(10,813)**
Total ICB Financial Position excl. Allocations	**3,907,193**	**3,911,283**	**4,091**	**5,095,998**	**5,093,262**	**(2,736)**

Table 2: Overall ICS (Surplus) / Deficit

Month 10 - January 2023	YTD Plan (Surplus) / Deficit	YTD Actual (Surplus) / Deficit	YTD Variance (Surplus) / Deficit	Annual Plan (Surplus) / Deficit	Forecast (Surplus) / Deficit	Forecast Variance (Surplus) / Deficit
	£000s	£000s	£000s	£000s	£000s	£000s
NENC Commissioner (ICB)						
Q1 CCG	22,903	0	(22,903)	22,903	0	(22,903)
Q2-Q4 ICB	(24,653)	6,608	31,261	(25,536)	6,198	31,734
Total In Year ICB Position	**(1,750)**	**6,608**	**8,358**	**(2,633)**	**6,198**	**8,831**
Central Funding expected for ARRS costs	0	(2,517)	(2,517)		(8,934)	(8,934)
Total In Year ICB Position after central funding	**(1,750)**	**4,091**	**5,841**	**(2,633)**	**(2,736)**	**(103)**
NENC Providers	8,044	14,973	6,929	2,633	2,359	(274)
Total Provider Position	**8,044**	**14,973**	**6,929**	**2,633**	**2,359**	**(274)**
Total ICS Financial Position 2022/23	**6,294**	**19,064**	**12,770**	**0**	**(377)**	**(377)**

Table 3: ICS Efficiencies

Month 10 - January 2023	YTD Plan	YTD Actual	YTD Variance	2022/23 Annual Plan	2022/23 Forecast Outturn	2022/23 Forecast Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Acute	2,058	2,058	0	2,650	2,650	0
Community Healthcare	6,785	6,785	0	8,144	8,144	0
Primary Care (inc. Primary Co-Commissioning)	13,821	13,016	(805)	16,592	15,787	(805)
Continuing Healthcare	16,848	18,443	1,595	20,229	21,062	833
Other Programme Services	678	678	0	818	818	0
Total ICB Efficiencies	**40,190**	**40,980**	**790**	**48,433**	**48,461**	**28**
Of Which:						
Recurrent	14,398	15,993	1,595	17,280	18,115	835
Non Recurrent	25,792	24,987	(805)	31,153	30,346	(807)
Total ICB Efficiencies	**40,190**	**40,980**	**790**	**48,433**	**48,461**	**28**
Providers within system	162,658	147,277	(15,381)	200,396	193,478	(6,918)
Total Provider Efficiencies (within system)	**162,658**	**147,277**	**(15,381)**	**200,396**	**193,478**	**(6,918)**
Of Which:						
Recurrent	99,461	46,271	(53,190)	124,103	59,647	(64,456)
Non Recurrent	63,197	101,005	37,808	76,293	133,830	57,537
Total Provider Efficiencies (within system)	**162,658**	**147,277**	**(15,381)**	**200,396**	**193,478**	**(6,918)**
Total ICS Efficiencies	**202,848**	**188,257**	**(14,591)**	**248,829**	**241,939**	**(6,890)**
Of Which:						
Recurrent	113,859	62,264	(51,595)	141,383	77,762	(63,621)
Non Recurrent	88,989	125,992	37,003	107,446	164,176	56,730
Total ICS Efficiencies	**202,848**	**188,257**	**(14,591)**	**248,829**	**241,939**	**(6,890)**

ICS Efficiencies key points

The tables above shows the efficiency targets set out in the ICS plan. For the ICB this is by ISFE category and at Month 10 the ICB is forecasting a slight over-delivery against the efficiency target mainly due to CHC schemes partially offset by an under-delivery against prescribing schemes.

For providers within the system there is a YTD under-delivery against target of £15.4m and forecast under-delivery of £6.92m. The forecast outturn for recurrent efficiencies is an underachievement of £64.46m and is partly mitigated by a forecast over delivery of non-recurrent schemes totalling £57.5m. Of the eleven providers within the ICS, there is now only one forecasting achievement of recurrent efficiencies. For the other providers the main reasons for under delivery include costs associated with COVID continuing longer than planned, continued use of agency staffing and delays in progressing development schemes.

Table 4: ICS Risks and Mitigations

Risks	Potential impact before mitigations	Mitigating actions	Potential impact after mitigations
	£000s		£000s
ICB Risks			
Continuing Healthcare - risk around activity increases and fee rates	(3,738)	NR measures / stretch efficiency	0
Prescribing	(3,588)	NR measures / stretch efficiency	0
Winter pressures including Covid Medicines Delivery Unit (CMDU) Surge and PC Extended Access	(1,025)	NR measures / stretch efficiency	0
Other (including backdated FNC, dom care rates & s117s)	(680)	NR measures / stretch efficiency	0
System Risks			
ERF and other pay/non-pay provider risks	(43,969)	System actively working collaboratively to develop plans to mitigate this risk	(7,000)
Total ICS Risks	**(53,000)**		**(7,000)**

NHS
North East and North Cumbria

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

BOARD MEETING 28 March 2023	
Report Title:	Updated Governance Handbook (Issue 5)

Purpose of report

To request approval from the Board on the proposed amendments to documents held and published in the ICB's Governance Handbook, including the Scheme of Reservation and Delegation, and committee, subcommittee and joint committee terms of reference.

Key points

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

The ICB's Constitution and supporting documents create the framework for the ICB to delegate decision-making authority, functions and resources to ensure it meets the diverse needs of our citizens and communities. The Constitution sets out the functions that the ICB will undertake and is supported by the governance handbook.

The handbook includes several key documents including a functions and decisions map, scheme of reservation and delegation, financial limits and committee terms of reference. The documents were approved by the Board on 1 July 2022 (issue 1), with further amendments to one or more documents approved by Board on 27 September 2022 (issue 2) and 29 November 2022 (issue 3) and 31 January 2023 (issue 4).

As part of a process of ongoing review of the documents within the Governance Handbook, further amendments have been identified to ensure the documents remain fit for purpose. The amended documents are attached with changes highlighted or tracked and summarised below:

Material Changes to the Scheme of Reservation and Delegation (SORD) - Appendix 1

- Page 10 - revised delegation to parent committees to approve their sub committee terms of reference
- Page 13 - ICB statutory duties copied from Constitution for completeness
- Pages 26 to 28 - added delegations relating to primary care services
- Appendix 1 - updated list of committees, Subcommittees and Joint committees
- Appendix 2 - Primary Care Services Appendix 2 replaced to include Pharmacy, Optometry and Dentistry
- Appendix 3 - Delegation summaries added to the SORD
- Appendix 4 - remuneration Guidance added to the SORD

Functions and Decisions Map - Appendix 2

Minor updates to ensure consistency with the SORD.

Executive Committee Terms of Reference

Following receipt of the recent NHS England Armed Forces – ICB Guidance which sets out several requirements for ICBs in terms of commissioning services for veterans, the following amendment to the Executive Committee's terms of reference was discussed and approved by the Committee (subject to approval by the Board) to provide clarity on where the responsibility of commissioning for veterans sits:

- Commissioning services for veterans and families, who form part of the NENC registered populations.

Please note that this is the only amendment to the committee terms of reference and therefore they have not been included on this occasion.

North East and North Cumbria Integrated Care Partnership - Appendix 3

The Board is asked to formally approve the NENC Strategic Integrated Care Partnership (ICP) and Area ICPs terms of reference. Once approved, these will be shared with health and wellbeing boards and with local authority partners across the NENC. Any material changes arising from engagement with partners will be brought back to a future Board for approval.

The Board is asked that members may be added, amended, or deleted in the terms of reference and/or minor amendments made with the approval of Executive Director of Corporate Governance, Communications, and Involvement. Any changes will be versioned controlled until the next formal issue.

Establishment of place-based governance arrangements - Appendix 4

Working with partners, each place will establish an ICB Place subcommittee (as part of the place-based governance arrangements). These will follow a standard format for the terms of reference but enable local variation, e.g., membership.

The Board is being asked to approve the establishment of ICB subcommittees at each place or places where it is appropriate to work across a wider footprint, and to approve the standard terms of reference for such subcommittees.

Following approval to establish these, the Board is asked to delegate authority to the Executive Committee for the approval of individual place subcommittee terms of reference.

The Board is also asked to agree that any subcommittees established at place will be listed in the Governance Handbook by the Executive Director of Corporate Governance, Communications, and Involvement, as is required by the Constitution.

Establishment of Subcommittees

The Constitution requires the Board to formally approve the establishment of all subcommittees and the need for further subcommittees to be established to support the function of the Executive and Quality and Safety Committees.

The proposed subcommittees for these parent committees are listed in **Annex 1** below and the Board is asked to approve the establishment of these subcommittees, along with the terms of reference for each one.

Risks and issues

There is a risk the ICB does not have a robust and clear control environment in relation to the effective stewardship and management of public funds and levels of delegation may not support local decision-making.

Assurances

The SORD, and terms of reference have been reviewed to ensure they remain fit for purpose and are in line with statutory guidance.
Parent committees have reviewed the proposed subcommittee terms of reference.
Members of the NENC ICP recommended approval of its terms of reference in December 2022 and edits since have been minor in nature only.
A draft of the updated SORD was circulated to Audit Committee members for review prior to its submission to the Board. This was due to the timing of meetings prohibiting a formal review of the SORD at the next Audit Committee meeting on 13 April 2023. The changes to the SORD were accepted by members following minor edits.

Recommendation/action required

The Board is asked to note the proposed changes to the governance documents described above and to approve the updated versions for insertion into the Governance Handbook (issue 5), as follows:

- Scheme of Reservation and Delegation **(Appendix 1)** – version 3-0
- Functions and decisions Map **(Appendix 2)** – version 2-0
- Strategic and Area Integrated Care Partnerships **(Appendix 3)** version v1-0
- Approve the establishment of ICB subcommittees at each place
- Approve the standard terms of reference for such subcommittees at **Appendix 4** version 1-0.
- Delegate the approval of place subcommittees' terms of reference to the Executive Committee, including any variation to the template terms of reference except the purpose of the subcommittees.
- Approve the establishment of other subcommittees listed in **Annex 1** and to approve their terms of reference **(Appendices 5 to 11).**

The Board to asked to approve that the following documents may be updated and replaced in the Governance Handbook by the Executive Director of Corporate Governance, Communications and Involvement as updates arise:

- Functions and Decisions Map
- Committee Structure
- Register of Interests
- Delegation Agreement Summaries
- Remuneration Guidance (subject to the approval of Remuneration Committee)
- NENC List of eligible providers of primary medical services

Acronyms and abbreviations explained	
SORD - Scheme of Reservation and Delegation NENC – North East and North Cumbria SOP - Standard Operating Procedures IFR - Individual Funding Request ICP - Integrated Care Partnership	
Sponsor/approving director	Claire Riley, Executive Director of Corporate Governance, Communications, and Involvement
Reviewed by	Deborah Cornell, Director of Corporate Governance and Involvement
Report author	Irene Walker, Head of Governance

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

Relevant legal/statutory issues

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

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

Annex 1

Establishment of Subcommittees

Parent Committee	Proposed Subcommittees	Purpose	Reference Appendix Number
Executive Committee	Independent Funding Review (IFR) Panels x 2	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.	**Appendix 5**
Executive Committee	Medicines Subcommittee	The purpose is 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 Integrated Care System.	**Appendix 6**
Quality and Safety Committee	Quality and Safety Area Subcommittees x 4	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.	**Appendix 7**
Quality and Safety Committee	Safeguarding Health Executive Group: Children, Adults and Cared for Children subcommittee	Providing a single strategic oversight body providing assurance to the Safeguarding Partnerships/Adult Boards, ICB and ICP and local organisations on quality, outcomes, finance and performance. To make formal recommendations to the Safeguarding Partnerships/Adult Boards' Board, ICB and ICP and local organisations, e.g., future provision, investments/disinvestments.	**Appendix 8**
Quality and Safety Committee	Antimicrobial Subcommittee	To support the Quality and Safety Committee to discharge its duties relating to is to bring together key	**Appendix 9**

Parent Committee	Proposed Subcommittees	Purpose	Reference Appendix Number
		stakeholders across health and social care from the North East and North Cumbria and integrated care system to deliver the national strategy tackling antimicrobial resistance 2019-2024, Healthcare Acquired Infection (HCAI) reduction objectives, information sharing and best practice and system level assurance.	
Executive Committee	Primary Care Strategy and Delivery Sub Committee	To support the Executive Committee to discharge its duties in relation to primary care.	**Appendix 10**
Executive Committee	Pharmaceutical Services Regulatory [Sub] Committee (PSRSC)	To receive and determine, on behalf of the ICB, applications submitted under the NHS (Pharmaceutical Services) Regulations 2013 as amended ('the Regulations'). Please note this is a nationally mandated [sub] committee by NHS England.	**Appendix 11**

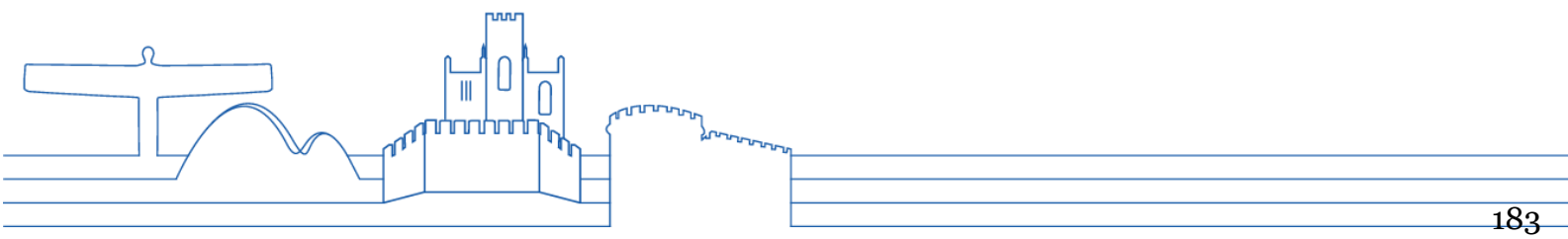
Item: 9.2
Appendix: 1

NHS North East and North Cumbria

NHS North East and North Cumbria

Scheme of Reservation and Delegation

Version 3-0, approved 28 March 2023 TBC



Schedule of Matter Reserved to NHS North East and North Cumbria and Scheme of Delegation

Introduction

The arrangements made by the North East and North Cumbria, hereafter referred to as the Integrated Care Board (ICB) for the reservation and delegation of decisions are set out in this scheme of reservation and delegation.

The ICB remains accountable for all its functions, including any that it has delegated.

Readers – this contents page will be updated once the SORD is approved and re-formatted.

Table of Contents

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Regulation and Control						
Constitution 1.6	Consideration and approval of applications to NHS England on any matter concerning changes to the ICB's constitution, including arrangements for taking urgent decisions, and standing orders	✓ Approval of proposed changes		✓ Chair and/or Chief Executive may periodically propose amendments to the constitution		
Constitution 1.6.2	Approve Constitution (including Standing Orders)	✓ Approves (subject to NHSE approval)			✓ NHSE	
Constitution 4.4.2	Approve the ICB scheme of reservation and delegation (SoRD) and amendments to the SoRD	✓ Approves	✓ Audit Committee (Recommends)	✓ Chief Executive (Prepares)		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Constitution Appendix 2, Section 5	Suspension of Standing Orders			✓ Chair in discussion with at least two other members		
Constitution Appendix 2, 4.9.4	Urgent Decisions			✓ Chair and Chief Executive (or relevant lead director in the case of committees)		In the first instance, every attempt will be made for the Board to meet virtually. Where this is not possible, the delegation to the Chair and Chief Executive (or relevant lead director in the case of committees) applies. The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit Committee for oversight

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Establish governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations.	✓				
Constitution 4.6	~~Approve terms of reference and membership for ICB Committees & Sub-Committees~~ Establish ICB Committees, Sub Committees, and Joint Committees	✓ Board approves the establishment of ICB Committees, and Sub Committees. Board approves ICB Committees terms of reference. Board and partners approve the establishment of Joint Committees and their terms of reference.	✓ Parent Committees approve sub committees' terms of reference following Board approval to establish ICB sub committee/s			Definition: A Committee is established by and accountable to the ICB Board. A Sub-Committee is established by Board and accountable to its parent Committee. Parent Committees Audit Committee; Finance, Performance & Investment Committee; Quality & Safety Committee; Remuneration Committee; and Executive Committee

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve the ICB operating framework	✓ (Approves)		✓ Chief Executive (Recommends)		
	Approve the ICB operating structure	✓ (Approves)		✓ Chief Executive (Recommends)		
Constitution 1.4 Health & Care Act 14Z32 to 14Z44 & 14Z49	Approve the arrangements for discharging the ICB's functions including but not limited to: a) Having regard to and acting in a way that promotes the NHS Constitution (14Z32) b) Exercising its functions effectively, efficiently, and economically (14Z33) c) Securing continuous improvement in the quality of services (14Z34) d) Reducing inequalities (14Z35)	✓				

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	e) Promote involvement of each patient (14Z36) f) Patient choice (14Z37) g) Obtaining appropriate advice (14Z38) h) Promote innovation (14Z39) j) Research (14Z40) k) Education & training (14Z41) l) Promote integration (14Z42) m) Duty to have regard to effect of decisions (14Z43) n) Duties as to climate change etc (14Z44) o) Duty to keep experience of members under review (14Z49)					

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Constitution 1.4.5 c-g	Approve the arrangements for discharging the ICB's statutory duties, including but not limited to: c) Duties in relation to children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014) d) Adult safeguarding and carers (the Care Act 2014) e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35); f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000), and					

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	g) Provisions of the Civil Contingencies Act 2004					
Constitution 3.3.1	Appointment of ICB Chair				✓ NHSE, with the approval of the Secretary of State	
Constitution 3.4.1 & 3.4.2	Appointment of ICB Chief Executive			✓ Appointed by ICB Chair in accordance with any guidance issued by NHS England*		*Appointment subject to approval of NHSE in accordance with any procedure published by NHS England
	Exercise or delegation of those functions of the ICB which have not been retained as reserved by the ICB Board, delegated to a committee or sub-committee or specified individual			✓ ICB Chief Executive		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Constitution 3.5.4, 3.6.5, 3.7.4	Appointment of Partner Member/s: • Trusts • Primary Medical Services • Eligible Local Authorities			✓ Approval ICB Chair*		*Supported by an Appointment Panel
Constitution 3.8.3, 3.9.3, 3.10.3, 3.12.3	Appointment of: • Executive Medical Director • Executive Chief Nurse • Executive Director of Finance • Other Executive Board Members			✓ Appointed by ICB Chief Executive* ✓ Approval ICB Chair		*Supported by an Appointment Panel
Constitution 3.11.2	Appointment of Independent Non-Executive Member/s			✓ Approved by ICB Chair*		*Supported by an Appointment Panel
	Approve the System Collaboration and Financial Management Agreement	✓ (Approves)	✓ Finance, Performance & Investment Committee (Recommends)			In consultation with partners

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Constitution 1.7.3 (c)	Approve Standing Financial Instructions (SFIs), Financial Delegations and Financial Limits	✓ (Approves)	✓ Audit Committee (Recommends)	✓ Executive Director of Finance (Prepares)		
	Approval of individual funding requests in accordance with the ICB policy		✓ IFR Panels[2]		Individual members appointed as decision makers (as approved by the Executive Medical Director) to make decisions on behalf of the ICB relating to individual funding requests, in line with ICB Policy[1]	[1]Appointed decision makers may make decisions not reserved to the IFR Panels. [2]The IFR Panels are sub-committees of the Executive Committee (as approved by board)

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Standing Orders, Section 6	Set out who can execute a document by signature / use of the seal	✓ In approving Standing Orders		✓ Authorised to authenticate the use of the seal by their signature: - ICB Chair - Chief Executive - Executive Director of Finance		
~~Constitution 4.7~~	~~Approve terms of reference for place based partnership arrangements~~	~~✓ Approval ICB Board and Partners~~		~~✓ Proposed by Executive Area Director~~		Deleted as now covered by page 10
	Appoint ICB: • Caldicott Guardian • Conflicts of Interest Guardian • Senior Information Risk Officer • Data Protection Officer • Chief Information Officer • EPRR Accountable Emergency Officer			✓ ICB Chief Executive		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve Patient Group Directions			✓ ICB Medical Director, following review by the Quality & Safety Committee		
Strategy and Planning						
	Agree the vision, values, and overall strategic direction of the ICB	✓				
	Approving the strategy for improving population health and reducing health inequalities	✓				Having regard to the Integrated Care Partnership, Integrated Care Strategy
	Approve the Commissioning Strategy	✓ (Approves)	✓ Executive Committee (Recommends)			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Health & Social Care Act 2022,14Z52	Agree a system plan [with partner trusts] to meet the health and healthcare needs of the population within the North East and North Cumbria	✓ (Approves)	✓ Executive Committee* (Recommends)			*The Executive Committee will consult the Finance, Performance & Investment Committee in the development of the plan
	Complementary to the System Plan, agree a plan to meet the health and healthcare needs of the population within each place	✓ (Approves)		✓ Executive Area Director (Recommends)		
	Approval of the ICB's non-programme budgets	✓ (Approves)	✓ Finance, Performance & Investment Committee (Recommends)			
	Approval of the ICB's programme budgets	✓ (Approves)	✓ Executive Committee (Recommends)			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Develop an approach to distribute ICB resources through commissioning and direct allocation to drive agreed change based on the ICB strategy	✓ (Approves)	✓ Finance, Performance & Investment Committee (Recommends)			
	Approve all ICB programme costs	✓ Approved by the Board or as delegated in accordance with financial delegations and financial limits	✓ Executive Committee*	✓ Refer to financial delegations*		*Contracts will be approved by either the ICB Board, Executive Committee, or relevant individual in accordance with the financial delegations and financial limits

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve all ICB non programme costs	✓ Approved by the Board or as delegated in accordance with financial delegations and financial limits	✓ Finance, Performance & Investment Committee*	✓ Refer to financial delegations*		* Non-programme contracts will be approved by either the ICB Board, Finance, Performance & Investment Committee, or relevant individual in accordance with the financial delegations and financial limits
	Approve the strategic financial framework of the ICB, and manage overall resources, manage financial risk, monitor system financial performance and report material exceptions to the Board	✓ (Approves the strategic financial framework)	✓ Finance, Performance & Investment Committee (Recommends)			
	Approve a Performance and Outcomes Framework for Providers	✓ (Approves)	✓ Executive Committee (Recommends)			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Monitor provider performance against contract and report material exceptions to the Board		✓ Executive Committee			
	Agree arrangements regarding the System Oversight Framework		✓ Executive Committee			
	Approval of variations to annual planned budgets	✓ Approved by the Board or as delegated in accordance with financial delegations and financial limits	✓ Finance, Performance & Investment Committee*	✓ Refer to financial delegations*		*Variations to budgets will be approved by the Board, or Finance, Performance & Investment Committee, or an individual, in accordance with financial delegations and financial limits

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approval of variations to non-programme contracts	✓ Approved by the Board or as delegated in accordance with financial delegations & limits	✓ Finance, Performance & Investment Committee*	✓ Executive Director*		*Variations to non-programme contracts will be approved by the Board, or Finance, Performance & Investment Committee, or an Executive Director, in accordance with financial delegations and financial limits
	Approval of variations to programme contracts	✓ Approved by the Board or as delegated in accordance with financial delegations & limits	✓ Executive Committee*	✓ Executive Director*		*Variations to programme contracts will be approved by the Board, or Executive Committee, or an Executive Director, in accordance with financial delegations and financial limits

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	In accordance with ICB policy, lead significant service reconfiguration programmes to achieve agreed outcomes	✓ (Approves)	✓ Executive Committee (Assurance)	✓ Executive Director (Recommends)		In leading service reconfiguration, the ICB will work with providers at scale and place
	Planning and commissioning of services (to include Procurement & Evaluation Strategies and Recommended Bidder Reports).	✓ Approved by the Board or as delegated in accordance with financial delegations & limits	✓ Executive Committee*	✓ Executive Director*		* Approval by the Board, or Executive Committee, or an Executive Director. in accordance with financial delegations and financial limits
Delegation agreement	Specialist Commissioning delegation from NHSE Approve decisions on the review, planning and procurement of specialist commissioned services (consistent with the terms of the delegation agreement with NHSE)		✓ Executive Committee			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
~~Delegation agreement~~	~~Primary Medical Services delegation from NHSE~~ ~~Approve decisions on the review, planning and procurement of primary medical services (consistent with the terms of the delegation agreement with NHSE)~~		✓ ~~Executive Committee~~ ~~(Except for those items delegated to the Executive Area Director as shown in Appendix 2)~~	✓ ~~Executive Area Director~~ ~~(Except for those items delegated to the Executive Committee, or other ICB Committee, as shown in Appendix 2)~~		Deleted as replaced by 2 rows immediately below

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Delegation agreement	Primary Care Services delegation from NHSE Approve decisions on the review, planning and procurement of primary care services (consistent with the terms of the delegation agreement with NHSE)	✓ Primary Care Services Approval of strategies as shown in Appendix **2b**	✓ Primary Care Services Delegation to the Primary Care Strategy & Delivery Sub Committee as shown in Appendix **2c(1-4 and 6)** ✓ Primary Medical Services Delegation to the to ICB sub committees at Place as shown in Appendix **2d**	✓ Primary Medical Services - delegation to ICB Chief Executive or Executive Director of Finance or ICB Chair as shown in Appendix **2a**		Primary Care Services consists of: • Primary Medical Services • Pharmacy • Optometry • Dentistry

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Delegation Agreement	Pharmaceutical Services delegation from NHSE Determination of applications submitted under the NHS (Pharmaceutical Services) Regulations 2005 (as amended), which fall to be determined by virtue of the transitional provisions set out in the Pharmacy Manual, Version 2, 10 February 2023*		✓ Primary Care Services Delegation to the Pharmaceutical Services Regulations (sub) Committee as shown in Appendix **2c(5)***			*The Pharmacy Manual complements the Regulations and any Directions issued by the Secretary of State for Health and Social Care and should be read alongside them (and not in place of them). Where any discrepancy or contradiction between the content of this manual and the Regulations/Directions is identified, the legal underpinning documents (i.e. Regulations/Directions, etc) are to take precedence
	Primary Care Services – Urgent Decisions			✓ ICB Senior Responsible Officer (SRO) for Primary Care Services or his/her named deputy		See Appendix 2

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Primacy Medical Services – Special Allocation Scheme, decisions on reviews and commissioner instigated removals			✓ ICB Medical Director		
	Workforce planning		✓ Executive Committee			
	Agree system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce' including through closer collaboration across the health and care sector, with local government, the Voluntary and Community Sector (VCS) and volunteers	✓ (Approves strategy)	✓ Executive Committee (Monitors)	✓ Executive Chief People Officer (System leadership)		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Agree system-wide strategy and action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services	✓ (Approves strategy)	✓ Executive Committee (Monitors)	✓ Executive Chief Digital and Information Officer (System leadership)		
	Agree joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability	✓ (Approves strategy)	✓ Finance Committee	✓ Executive Director (System leadership)		
Annual Report and Accounts						
	Approval of the ICB's annual report and annual accounts	✓ (Approves)	✓ Audit Committee (Assurance)			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Human Resources						
	Code of Conduct for staff (titled: Standards of Business Conduct Policy/Conflicts of interest policy and procedures)	✓ Approves	✓ Executive Committee (Recommends)			
Constitution3.14	Approve the arrangements for determining the terms and conditions, remuneration and travelling or other allowances for Board members, employees and others who provide services to the ICB, including pensions and gratuities	✓ In approving Terms of reference of Remuneration Committee			✓ NHSEI (Terms of appointment of the Chair will be determined by NHS England)	

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Constitution 3.14	Approve the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities (subject to Prime Minister limit)	✓ (The Panel of the Board determines Remuneration for Non-Executive Members)	✓ ICB Remuneration Committee (Approves all except those delegated to the Panel of the Board or NHSEI)		✓ NHSEI (Remuneration for the Chair will be set by NHS England)	The Panel of the Board comprises the Chair, Chief Executive and Executive Chief People Officer
	Approve the terms and conditions, remuneration and travelling or other allowances for employees of the ICB and to other persons providing services to the ICB		✓ ICB Remuneration Committee			
	Approve arrangements for staff appointments		✓ Executive Committee (Approves)	✓ Executive Chief People Officer (Prepares)		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Changes to staffing establishment, Tier 1			✓ Director (Approves)		Tier 1 Definition Exact like-for-like replacement of a leaver or any changes to post, grade or WTE with positive financial implications (ie a reduction in cost). This can be approved by the relevant place-based or corporate Director (ie a Director who reports to an Executive Director)
	Changes to staffing establishment, Tier 2			✓ Executive Director (Approves)		Tier 2 Definition Backfill for maternity, secondments or sickness absence; temporary acting up where funding is already available; and hosted/seconded-in posts where funding is already available. These can be approved by the relevant Executive Director

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Changes to staffing establishment, Tier 3		✓ Executive Committee (Approves)			Tier 3 Definition Any changes to post, grade or WTE with negative financial implications (ie an increase in cost); permanent re-gradings; agency workers; and any other changes not covered in Tiers 1 or 2. Changes of this type can only be approved by the ICB Executive Committee.
Quality and Safety						
	Approve arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes		✓ Quality and Safety Committee			
	Provide the ICB with assurance that it is delivering its functions in a way that delivers high quality safe patient care in commissioned services and secures continuous improvement in the quality of services		✓ Quality and Safety Committee (assures the Board)			Local Quality Groups will review quality & safety issues and escalate any concerns or issues to the Quality and Safety Committee

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Operational and Risk Management						
	Approve the appointment of Internal Auditors		✓ Audit Committee (Approves)	✓ Executive Director of Finance (Recommends)		
	Approve the appointment of External Auditors	✓ (Approves)	✓ Auditor Panel (Recommends)			Note: the Auditor Panel is made up wholly of Audit Committee members (see Audit Committee Terms of Reference)
	Approve the ICB's counter fraud and security management arrangements	✓ (Approves)	✓ Audit Committee (Recommends)			
	Approve the ICB's risk management arrangements	✓ (Approves)	✓ Executive Committee (Recommends)			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve the ICB's arrangements for managing conflicts of interest	✓				In proposing ICB Constitution to NHSE
	Establish a comprehensive system of internal control across the ICB		✓ Executive Committee			
	Approve arrangements for action on litigation against or on behalf of the ICB		✓ Executive Committee			
	Approve arrangements for planning, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement		✓ Executive Committee			
	Approve the ICB's arrangements for handling complaints		✓ Executive Committee			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve arrangements for ensuring the ICB has an integrated approach to the management standards of health and safety and has appropriate strategy and policies in place		✓ Executive Committee			
	Approve arrangements for complying with the NHS Provider Selection Regime		✓ Executive Committee			
	Approve Communications and Engagement Strategy	✓ (Approves)	✓ Executive Committee (recommends)			
	Approve and implement the ICB's information governance policies, including handling Freedom of Information requests, ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data		✓ Executive Committee			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
Policies						
	~~Approval of policies not specified elsewhere in this scheme of reservation and delegation~~	~~✓~~				Not required as covered by three rows below
	Approve human resources policies for employees and for other persons working on behalf of the ICB	✓ (Approves)	✓ Executive Committee (Recommends)	✓ Executive Chief People Officer (Prepares)		
	Approve clinical, quality and safety policies		✓ Quality and Safety Committee			
	Approve ICB Corporate Policies (unless specified elsewhere)		✓ Executive Committee			
	Approve ICB Standard Operating Procedures (SOPs)			✓ Directors, as relevant to their function		

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve the ICB's risk management policy		✓ Executive Committee			
	Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change)		✓ Remuneration Committee			
	Approve the ICB's complaint's policy		✓ Executive Committee			
	Approve health and safety policies		✓ Executive Committee			
	Approve information governance policies		✓ Executive Committee			

Reference	Decision	Reserved to the ICB Board	Delegated to a Committee or Sub-Committee (Subject to the Financial Delegations/ Financial Limits)	Delegated to an Individual (Subject to the Financial Delegations/ Financial Limits)	Delegated to Others (Subject to the Financial Delegations/ Financial Limits)	Supporting Notes
	Approve Value Based Commissioning Policy		✓ Executive Committee			
Partnership Working						
Integrated care boards Guide to developing a SoRD, page 9	Approve arrangements for coordinating supra* commissioning arrangements with other ICBs or with local authorities, where appropriate	✓ (Approves)	✓ Executive Committee (Recommends)			*Where one service provider spans more than one ICB
Constitution 4.3.2 – 4.3.3 and 4.7	Authorisation of arrangements made under section 65Z5 or section 75 of the 2006 Act	✓ Approved by the Board or as delegated in accordance with financial delegations and financial limits	✓ Executive Committee*	✓ Refer to financial delegations*		*Arrangements will be approved by either the ICB Board, Executive Committee, or relevant individual in accordance with the financial delegations and financial limits See Table 1
	Approve decisions that individual members or employees of the ICB participating in joint arrangements on behalf of the ICB can make	✓				Such delegated decisions must be disclosed in this scheme of reservation and delegation

Table 1: Key legislative mechanisms for collaborative working

Mechanism for collaboration	Organisations	Description of mechanism
Section 65Z5 delegation	NHS England, ICBs, NHS trusts and foundation trusts	This is a voluntary arrangement whereby NHS organisations listed under s65Z5 delegate responsibility for carrying out specific functions to other listed NHS organisations and/or to LAs and/or to CAs. There are some constraints on what functions can be delegated and how these delegations are made, which are set out in the 2022 Regulations and in Annex E of the statutory guidance. NHS organisations cannot delegate their functions to non- statutory, non-public organisations (that is, independent or voluntary sector providers). LAs and CAs cannot delegate their functions to statutory NHS organisations using this mechanism – although they can receive delegated responsibility for the functions of NHS organisations under s65Z5 arrangements. For delegation of LA functions, see s75 arrangements below.
Sections 65Z5 and 65Z6 joint exercise arrangements	NHS England, ICBs, NHS trusts and foundation trusts	Two or more NHS organisations within the scope of s65Z5 can choose to come together (including via a joint committee) to make legally-binding decisions and pool funds across agreed functions. Any constraints on how these arrangements are made and which functions can be part of them are set out in the 2022 Regulations and in Annex E of the statutory guidance. LAs and CAs can be part of these arrangements – but they cannot include their own functions in any joint decision- making using this mechanism. Joint working between Las and NHS organisations, including for LA functions, can be achieved using s75 and s65Z5 arrangements.

Mechanism for collaboration	Organisations	Description of mechanism
Section 75 partnership arrangements	NHS England and/or ICBs with LAs and/or CAs NHS trusts and/or foundation trusts with LAs and/or CAs	Section 75 partnership arrangements are a longstanding collaboration mechanism under the 2006 Act. These enable collaborative working between at least one NHS organisation (NHS England/ICB **or** NHS trust/foundation trust) and at least one LA to exercise or delegate a range of the NHS organisation's functions and the LA's health-related functions. Any delegation/joint exercise of health-related LA functions to/with NHS organisations will continue to be achieved using the powers in s75 of the 2006 Act and the associated partnership arrangement regulations. The 2022 Act requires ICPs to consider the use of section 75 arrangements in preparing their strategy for their system.
Conferral of discretions	NHS England, ICBs, NHS trusts and foundation trusts	This provision has been included to make clear the lawful scope of contractual arrangements between commissioners and providers. It confirms that a commissioner can lawfully give providers a wide degree of latitude as to the services they provide under a contract, both in terms of which services are delivered and how they are delivered, so as to resolve any doubt on this issue. The commissioner will still set the broad scope of what the provider is expected to achieve (clinical outcomes, for example) under a contract. A contract that confers discretion on a provider in respect of some or all services under the contract may be a useful alternative or precursor to delegation to trusts or foundation trusts under s65Z6.

[Extract from publication reference PR1560 - Statutory guidance: Arrangements for delegation and joint exercise of statutory functions, Guidance for integrated care boards, NHS trusts and foundation trusts (September 2022)]

Appendix 1

Committees and Sub Committees of NHS North East and North Cumbria Integrated Care Board (ICB)

1. Committees

The ICB has established the following Committees

- Audit Committee
- Remuneration Committee
- Finance, Performance, and Investment Committee
- Quality and Safety Committee
- Executive Committee

2. Sub Committees

The ICB has established the following sub committees:

- Healthier and Fairer Advisory Group (sub committee)
- Individual Funding Requests Panel (sub committee) x 2
- ICB Sub Committees at Place
- Primary Care Strategy & Delivery
- Medicines
- Safeguarding
- Quality & Safety (Area) x4
- Pharmaceutical Services Regulatory [Sub] Committee
- Antimicrobial Resistance and Healthcare Associated Infection

3. Joint Committees

The ICB and Partners have established the following joint committees:

North East and North Cumbria Integrated Care Partnership (ICP), and the following Area ICPs:

- **North Area** Integrated Care Partnership (ICP)
- **Central Area** Integrated Care Partnership (ICP)
- **Tees Valley Area** Integrated Care Partnership (ICP)
- **North Cumbria Area** Integrated Care Partnership (ICP)

Appendix 2

Primary Care Services: Allocation of Roles & Responsibilities within the ICB

Delegation of Primary Care Services from NHS England (NHSE) to NHS North East & North Cumbria (ICB)

These tables set out how the ICB Board has delegated responsibilities (within the organisation).

Accountability for Pharmacy, Optometry, and Dentistry will be delegated to the ICB from 1st April 2023.

The Primary Care Services delegation is from NHSE to NHS North East and North Cumbria (ICB) and the ICB has not delegated decisions outside of the ICB (see Primary Care Delegation Agreement Frequently Asked Questions 29 July 2022 – Version 2, Publication reference: PR1749).

For the period 1st April 2023 to 30 June 2023, NHSE staff supporting pharmacy, optometry, and dentistry on behalf of the ICB may not make decisions and instead must make recommendations to the Primary Care Strategy and Delivery Sub Committee or the Pharmaceutical Services Regulations Committee (as appropriate) for decision.

Where a decision is urgent, the ICB Board has determined that the ICB Senior Responsible Officer (SRO) for Primary Care Services or his/her named deputy may make primary care services urgent decisions for reporting to Primary Care Strategy and Delivery Sub Committee or the Pharmaceutical Services Regulations Committee (as appropriate), or formal ratification by the Executive Committee (in line with financial limits).

Appendix 2a

Primary Medical Services - delegation to ICB Chief Executive or Executive Director of Finance or ICB Chair

Reference	Delegation	NHS England Approval
1	Taking any step or action in relation to the settlement of a Claim, where the value of the settlement exceeds £100,000	NHS England Head of Legal Services and Local NHS England Team Director or Director of Finance
2	Any matter in relation to the primary care Delegated Functions which is novel, contentious or repercussive	Local NHS England Team Director or Director of Finance or NHS England Region Director or Director of Finance or NHS England Chief Executive or Chief Financial Officer
3	The entering into of any Primary Medical Services Contract which has or is capable of having a term which exceeds five (5) years	Local NHS England Team Director or Director of Finance

Appendix 2b

Primary Care Services – reserved to ICB Board

Reference	Delegation
1	Approval of strategies

Appendix 2c(1)

Primary Care Services - delegation of Primary Care Services to Primary Care Strategy & Delivery Sub Committee: **GENERIC**

(decisions by sub committees are limited to the financial limits of the most senior ICB officer present)

Reference	Delegation
1	Occupational health contract commissioning and management
2	Escalation of disputes
3	Forward plans for all functions
4	Enabler plans for all functions including estates, workforce and digital
5	Local professional network proposals (for decision)
6	Decisions in respect of Quality Assurance Frameworks
7	Commissioning needs analysis and commissioning of ad-hoc primary care services
8	Decisions in respect of investigations (commencement and outcome excluding Primary Medical Care Services)
9	Clinical Waste contract commissioning and management

Appendix 2c(2)

Primary Care Services - delegation to Primary Care Strategy & Delivery Sub Committee - **OPTOMETRY**

(decisions by sub committees are limited to the financial limits of the most senior ICB officer present)

Reference	Delegation
1	Primary Care Audits - Assurance Framework outcome
2	Optometry National & Local Enhanced Services commissioning and contracting
3	New optometry contracts
4	Variations decisions affecting existing contracts

Appendix 2c(3)

Primary Care Services - delegation to Primary Care Strategy & Delivery Sub Committee - **DENTISTRY**

(decisions by sub committees are limited to the financial limits of the most senior ICB officer present)

Reference	Delegation
1	Commissioning needs analysis for dental services
2	Primary Care Audits - Assurance Framework
3	Dental National & Local Enhanced Services commissioning and contracting
4	New dental contracts
5	Variations decisions affecting existing contracts

Appendix 2c(4)

Primary Care Services - delegation to Primary Care Strategy & Delivery Sub Committee – **PHARMACY**

(decisions by sub committees are limited to the financial limits of the most senior ICB officer present)

Reference	Delegation
1	Primary Care Audits- Community Pharmaceutical Assurance Framework (CPAF)
2	Community Pharmacy National & Local Enhanced Services commissioning and contracting
3	Pharmacy Integration Fund decisions

Appendix 2c(5)

Pharmaceutical Services - Delegation to the Pharmaceutical Services Regulations (sub) Committee - **PRSC**
(decisions by sub committees are limited to the financial limits of the most senior ICB officer present)

Reference	Delegation
1	Determination of applications (current and future)
2	Determination of controlled localities including "serious difficulty" applications
3	Contract commissioning, performance, and management decisions
4	Designation, review, and cancellations relating to LPS areas
5	Fitness to practice
6	Disputes and appeals

Please refer to the NHS Pharmacy Manual 2023 for full detail breakdown on regulations

Appendix 2c(6)

Primary Medical Services - delegation to Primary Care Strategy & Delivery Sub Committee: (decisions by sub committees are limited to the financial limits of the most senior ICB officer present)

Reference	Delegation
1	Decision to procure a new Primary Medical Services contract[1]
2	Decision to award (following procurement) of a new Primary Medical Services contract[1]
3	Interface and management of assurance to ICB Executive - ICB wide strategy development and delivery oversight
4	Govern and manage assurance of delegated commissioning from Place to ensure the ICB meets its duties in relation to delegation
5	Strategic oversight of Place operational planning, delivery and management in respect of Primary Medical Services
6	Interface and management of assurance to NHS E N&Y region
7	Clinical waste contract oversight (General Practice)
8	National funding scheme development and oversight
9	Quality on Outcomes Framework (QOF) annual sign off of scheme and approval of payments
10	Manage the design (where applicable) and commissioning of any regional services, including re-commissioning these services annually where appropriate

Reference	Delegation
11	Decision making and budget management regarding primary care estates strategies and overarching revenue consequences
12	Decision making and budget management regarding primary care GPIT
13	Revenue decisions relating to premises (affecting more than one Place)
14	Decisions escalated from Place where it exceeds financial limits and risk

Notes
[1] For contracts which have or are capable of having a term which exceeds five (5) years, see Appendix 2a.

General Note
Any matter in relation to the primary medical delegated functions which is novel, contentious or repercussive must be referred to the ICB Chief Executive or Executive Director of Finance or ICB Chair (see Appendix 2a)

Appendix 2d

Primary Medical Services - ICB sub committee at Place

(decisions by sub committees are limited to the financial limits of the most senior ICB officer present)

Reference	Delegation
1	Management of delegated funds in relation to Primary Medical Services
2	Assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities) in collaboration with others in the ICB with responsibility for quality and safety
3	Take decisions relating to dispersing the patient lists of Primary Medical Services Providers at place
4	Approving Primary Medical Services closures including branch closures[1]
5	Manage the Primary Medical Services Contracts and perform all NHSE's obligations under each of the Primary Medical Services Contracts
6	Planning Primary Medical Services including carrying out needs assessments[1]
7	Undertaking reviews of Primary Medical Services
8	APMS contract management
9	Actively manage each of the relevant Primary Medical Services Contracts including agreeing local prices, managing agreements or proposals for local variations and local modifications
10	Commissioning Needs Analysis for Primary Medical Services contracting[1]
11	Disputes
12	Estates (Primary Care)[1]
13	General Practice investigations (for sanctions see Appendix 2a)
14	Home Office Resettlement Schemes
15	Local Resilience Schemes/Support for General Practice Contractors
16	Mergers, boundary changes, list closures, incorporations[1]
17	Patient list management and allocations
18	Primary Care Network (PCN) contracting and commissioning[1]
19	Local Primary Care workforce plans[1]
20	Collation of General Practice data/information; performance management and quality assurance of General Practice
21	Management of Quality and Outcomes Framework (QOF)[2]
22	Winter pressures – primary care
23	Operational Plan
24	Access

Reference	Delegation
25	Manage the design (where applicable) and commissioning of any Local Enhanced Services, including re-commissioning these services annually where appropriate
26	Design and offer Local Incentive Schemes for Primary Medical Services Providers, sensitive to the differing needs of their particular communities. This includes in addition to or as an alternative to the national contractual frameworks (including as an alternative to QOF or Enhanced Services), provided that such schemes are voluntary, and the ICB continues to offer the national schemes.
27	Make decisions on Discretionary Payments or Support at place (subject to available budget)
28	Manage Primary Medical Services Providers providing inadequate standards of patient care at place
29	Revenue decisions relating to premises[1]
30	General Practice sanctions
31	Decision to extend an existing Primary Medical Services contract in accordance with contract terms

Notes

[1] Must be escalated for action or decision to the Primary Care Strategy & Delivery Sub Committee where the action/decision would impact across more than one place.
[2] For authorisation of QOF annual scheme and approval of payments see Appendix 2c(2)

General Note
Any matter in relation to the primary care delegated functions which is novel, contentious or repercussive must be referred to the ICB Chief Executive or Executive Director of Finance or ICB Chair (see Appendix 2a) via the Primary Care Strategy & Delivery Sub Committee and the Executive Committee.

Appendix 3

Delegation Summaries

NHS North East and North Cumbria has entered into the following delegation agreements from NHS England:

Delegated Functions	Schedule	Effective Date of Delegation
Primary Medical Services Functions	Schedule 2A –	1 July 2022
Primary Dental Services and Prescribed Dental Services Functions	Schedule 2B –	1 April 2023
Primary Ophthalmic Services Functions	Schedule 2C –	1 April 2023
Pharmaceutical Services and Local Pharmaceutical Services Functions	Schedule 2D –	1 April 2023

NHS North East and North Cumbria has not delegated any of its functions to other organisations.

Appendix 4

NHS NENC REMUNERATION GUIDANCE

Introduction

This statement summarises NHS North East and North Cumbria's (hereafter referred to as the ICB) approach to staff remuneration.

The ICB Chair is appointed by NHS England with the approval of the Secretary of State. The ICB Chief Executive is appointed by the ICB Chair subject to approval of NHS England.

The ICB Chair approves the appointment of Board members.

Governance

The ICB has established a Remuneration Committee (made up wholly of non-executive director members) responsible for:

Approving the terms and conditions, remuneration and travelling or other allowances for employees of the ICB and other persons providing services to the ICB. The ICB is guided by Agenda for Change.

Approving the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities, except for the following:

- A Panel of the Board (comprising the Chair, Chief Executive and Executive Director of People) determines remuneration for non-executive members of the Board
- Remuneration for the ICB Chair is set by NHS England.

Where a conflict arises then the Chair will remove conflicted parties from the meeting.

Contact

For further information about how the ICB remunerates its board and staff, please contact: Leanne Furnell, Director of Workforce, leanne.furnell@nhs.net

GLOSSARY

2006 Act	National Health Service Act 2006
2012 Act	Health and Social Care Act 2012 (this Act amends the 2006 Act)
Chief Executive	An individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by the NHS Commissioning Board, with responsibility for ensuring the ICB: • complies with its obligations under: o sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act), o sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act), o paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and o any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Board for that purpose. • exercises its functions in a way which provides good value for money.
Area	The geographical area that the ICB has responsibility for, as defined in Chapter 2 of the Constitution
Audit Committee	A committee of the Board
Board	The body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that an ICB has made appropriate arrangements for ensuring that it complies with: • its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and • such generally accepted principles of good governance as are relevant to it.
Board Member	Any member appointed to the Board of the ICB
Budget	A resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any, or all of the functions of the ICB.
Budget Holder	The director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.
C***hair of the Board***	The individual appointed by the ICB to act as chair of the Board

Executive Director of Finance	The qualified accountant employed by the ICB with responsibility for financial strategy, financial management and financial governance
Commissioning	The process for determining the need for and for obtaining the supply of healthcare and related services by the ICB within available resources.
Committee	A committee created and approved by the ICB Board
Sub-Committee	A sub-committee created by ICB Board or a committee of the ICB Board, and approved by the Board
Committee Members	Persons formally appointed by the Board to sit on or specific committees.
Constitution	A Constitution is the set of principles and rules by which an organisation is governed and managed.
Board Secretary	A person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the ICB's compliance with the law, Standing Orders, and Department of Health guidance.
Contracting and Procurement	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Director of Public Health	A health care professional who is a specialist in Public Health or a Consultant in Public Health medicine who may hold the post of Director of Public Health.
Financial Directions	Any and all Directions made by the Secretary of State from time to time which relate to financial entitlements and or requirements.
Financial Year	This usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when an ICB is established until the following 31 March.
Health and Wellbeing Board	The role of the Health and Wellbeing Board is to bring together the Local Authority, Voluntary Sector, Local Healthwatch, NHS and Public health to work together to improve the health and wellbeing of local people.
Health and Wellbeing Strategy	A strategy developed with Local Authorities for the purpose of purpose of advancing the health and wellbeing of the people in its area and implemented by the Health and Wellbeing Board

Healthcare Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Integrated Care System (ICS)	The ICS is a geographical partnership that brings together providers and commissioners of NHS services across the North East and North Cumbria.
Non – Executive Members	Independent members of the Board.
NHS England	NHS England (operating as the National Health Service Commissioning Board Authority prior to its formal establishment as a non-departmental public body).
Officer	Employee of the ICB or any other person holding a paid appointment or office with the ICB.
Officer Member	A member of the ICB who is either an officer of the ICB or is to be treated as an officer (i.e., the Chair of the ICB, or any person nominated by such a committee for appointment as an ICB member).
Registers of Interests	Registers an ICB is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of: • the members of the ICB. • the members of its Board. • the members of its committees or sub-committees and committees or sub-committees of its Board; and • its employees.
Remuneration Committee	A Committee of the Board
Scheme of Reservation and Delegation	Delegates powers and authority to the various elements of the ICB.
Standing Orders	The standing orders of the ICB
Standing Financial Instructions	They are part of the ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions. They define the purpose, responsibilities, legal framework, and operating environment of the ICB.
Vice-Chair	The non-officer member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

North East and North Cumbria Integrated Care Board - functions and decisions map v2-0

NHS North East and North Cumbria

System

North East and North Cumbria Integrated Care Partnership (ICP)

- Agrees North East and North Cumbria Integrated Care Strategy - built from Place health and wellbeing strategies

Strategy

North East and North Cumbria Integrated Care Board (ICB)

- Setting strategy, managing overall resources, performance and financial risk
- Planning and commissioning specialised, in-hospital, ambulance and core general practice services
- Improvement programmes for quality and patient safety (including safeguarding)
- Workforce planning
- Health emergency planning and resilience
- Improving population health and reducing health inequalities
- Statutory functions which cannot be delegated e.g. annual ICB financial plan, system quality assurance, ICB annual report and accounts

** See overleaf for expanded list/examples*

Delegation

Assurance

ICB Committees (and supporting sub-Committees)

- The following committees provide the ICB Board with assurance about specific ICB functions e.g. audit; remuneration; quality & safety; finance, performance & investment; and executive. A number of sub committees have also been established – see DOC 15 in the Governance Handbook

Strategy

Delegation

Assurance

Place

Health and Wellbeing Boards (x13)

- Agree health and wellbeing strategies for each Place

Strategy

Sub-system functions discharged at Place include:

- Commissioning local integrated community-based services for children and adults
- As delegated in the Scheme of Reservation & Delegation, Local Primary care commissioning – building the capacity of local Primary Care Networks and supporting their clinical leadership role.
- Local Clinical Leadership including clinical pathway redesign and helping shape the commissioning of acute services
- Monitoring the quality of local health and care services
- Forging strong working relationships with the wider local system including HealthWatch, the Voluntary Sector, and other local public services.

** See overleaf for expanded list/examples*

Delegation

Assurance

ICB Place Committees

- Sub-committee of the ICB Executive Committee - bringing local partners together to make decisions on ICB place delegated functions (ICB members in the majority)

North East and North Cumbria Integrated Care Board - functions and decisions map

ICB functions discharged at system level

- Setting strategy
- Managing overall resources, performance and financial risk
- Planning and commissioning specialised, in-hospital, ambulance and core general practice services
- Improvement programmes for quality and patient safety (including safeguarding)
- Workforce planning
- Horizon scanning and futures
- Harnessing innovation
- Building research strategy and fostering a research ecosystem
- Driving digital and advanced analytics as enablers
- Health emergency planning and resilience
- Improving population health and reducing health inequalities
- Strategic communications and engagement
- Statutory functions which cannot be delegated e.g. annual ICB financial plan, system quality assurance, ICB annual report and accounts

Sub-system functions discharged at Place*

- Building strong relationships with communities
- Fostering service development and delivery with a focus on neighbourhoods and communities
- Commissioning local integrated community-based services for children and adults (including care homes and domiciliary care).
- As delegated in the Scheme of Reservation & Delegation, Local Primary care commissioning – building the capacity of local Primary Care Networks and supporting their clinical leadership role.
- Local Clinical Leadership including clinical pathway redesign and helping shape the commissioning of acute services
- Monitoring the quality of local health and care services – including support to care homes, e.g. infection prevention and control.
- Forging strong working relationships with the wider local system including HealthWatch, the Voluntary Sector, and other local public services.
- Monitor Place based delivery of key enabling strategies.

In addition, there are formal place-based joint working arrangements between the NHS and Local Authorities which will also be part of the Integrated Care Board delegated functions; they include:

- Participation in Health & Wellbeing Boards to develop Joint Strategic Needs Assessments and Joint Health & Wellbeing Strategies
- Joint initiatives to promote health, prevent disease and reduce inequalities
- Joint commissioning and leadership of local services:
    - Continuing Health Care
    - Personal Health Budgets
    - Community mental health, learning disability and autism
    - Children and young people's services (including transitions, Special Educational Needs and Disabilities, Looked After Children)
- Service integration initiatives and jointly funded work through, e.g. the Better Care Fund and Section 75.
- Fulfilling the NHS's statutory health advisory role in adults' and children's safeguarding.
- The provision of updates to local Scrutiny Committees and Lead Members on local health and care services.

** Some of these functions may have a policy or plan developed at a geography above Place for ICB consistency but the function would be delivered and nuanced at Place*

North East
North Cumbria
Health & Care
Partnership

North East and North Cumbria Integrated Care Partnership (ICP)

Terms of Reference and Membership for the Strategic ICP and Area ICPs

Background

1. The North East and North Cumbria Integrated Care Partnership (herein referred to as the Strategic ICP) is a joint committee established by the North East and North Cumbria Integrated Care Board and the soon to be fourteen upper tier local authorities in the North East and North Cumbria as equal partners:

2. The local authorities of the North East and North Cumbria ICP are:
   - County Durham
   - Cumberland
   - Darlington
   - Gateshead
   - Hartlepool
   - Middlesbrough
   - Newcastle upon Tyne
   - North Tyneside
   - Northumberland
   - Redcar and Cleveland
   - South Tyneside
   - Stockton-on-Tees
   - Sunderland
   - Westmorland and Furness

3. Together, the North East and North Cumbria Integrated Care Board (ICB) and the North East and North Cumbria Integrated Care Partnership (Strategic ICP) forms the new statutory North East and North Cumbria Integrated Care System (ICS).

4. While acknowledging the diversity of organisations and partners in our integrated care system there are a number of responsibilities placed on the ICB and local authorities as statutory co-owners and equal partners to formally engage with stakeholders and establish an effective and broad-based ICP. These requirements have guided the establishment of an inclusive ICP for the North East and North Cumbria that builds on existing partnership structures to galvanise the partnership behind some common aims and set the culture of the system that we all work in.

Purpose

5. The Strategic ICP will facilitate joint action to improve health and care outcomes and work together to influence the wider determinants of health as well as the broader social and economic development of the North East and North Cumbria

6. Our ICP will create the space for partners to develop joint strategies that better serve local populations, based on population health management approaches. They will enable partners to plan for the future and develop strategies for using available resources creatively to address the longer-term challenges which cannot be addressed by a single sector or organisation alone.

7. National guidance states that ICPs will highlight where coordination is needed on health and care issues and challenge partners to deliver the action required. These include, but are not limited to:
   - helping people live more independent, healthier lives for longer
   - taking a holistic view of people's interactions with services across the system and the different pathways within it
   - addressing inequalities in health and wellbeing outcomes, experiences and access to health services
   - improving the wider social determinants that drive these inequalities, including employment, housing, education, environment, and reducing offending
   - improving the life chances and health outcomes of babies, children and young people
   - improving people's overall wellbeing and preventing ill-health

8. In meeting these challenges, the Strategic ICP has a specific responsibility for developing the **North East and North Cumbria Integrated Care Strategy** for the whole population. This strategy will build on the Joint Local Health and Wellbeing Strategies from all of the Health and Wellbeing Boards in our ICS area, use the best available evidence and data, covering health and social care (both children's and adult's social care), and seek to address the wider determinants of health and wellbeing. The strategy will be built bottom-up from local assessments of needs and assets and the strategy will be focused on improving health and care outcomes, reducing inequalities, ensuring inclusion, and addressing the consequences of the pandemic for our communities.

9. While the Strategic ICP has no formal delegated powers from its constituent organisations, it will provide leadership, oversight, and support for system-wide activities, playing a key role in ensuring joint accountability to our population. The Strategic ICP will also continue to evolve in the way it works in response to the changing priorities of the partnership.

Responsibilities of the Strategic ICP

10. The Strategic ICP's responsibilities are to:
    - Develop and approve an Integrated Care Strategy for the population of North East and North Cumbria – which the ICB and local authorities will be required by law to have regard to the ICP's strategy when making decisions, and commissioning and delivering services.
    - Ensure the Integrated Care Strategy:
      - is focused on reducing health inequalities
      - uses the best available evidence and information
      - takes account of local challenges, assets and resources
      - expands the range of organisations and partners involved in strategy development and delivery,
      - is underpinned by insights gained from our communities,
      - benefits from strong clinical and professional input and advice.
      - Focuses on those issues where ICP partners need to take joint action in relation to managing collective issues and challenges
    - Design and oversee a joint accountability framework to ensure the delivery of the Integrated Care Strategy.

11. In addition to these responsibilities, the Strategic ICP will:
    - Consider recommendations from partners and reach agreement on priority work programmes and workstreams that would benefit from a cross-partnership approach
    - Commission specific advice from established groups, including but not limited to the multi-agency Healthier and Fairer Advisory Group, to obtain subject matter expertise, in setting the direction of the Strategic ICP.
    - Provide active support to the development of four Area ICPs across the North East and North Cumbria, enabling local partnership arrangements, engagement and co-production, bringing together Local Authorities, voluntary and community groups, and other key partners.
    - Facilitate and support cross-area working and sharing of best practice where this would benefit the population or provide efficiencies in our approach.
    - Ensure that the ICP has a greater focus on population health improvement, integration of health and care services around the needs of residents, and a focus on care provided in primary and community settings.

12. For the avoidance of doubt, it is not a function of the Strategic ICP to duplicate the statutory functions of its constituent organisations. The Strategic ICP will not perform a health scrutiny function and will itself be subject to scrutiny by the Health Scrutiny Committees as appropriate of the fourteen local authorities in the ICS area.

Membership

13. The statutory membership of the Strategic ICP will comprise the Chair and Chief Executive of the Integrated Care Board and an elected member and senior officer from each of the fourteen local authorities. Subject to the agreement of the Strategic ICP, an additional initial range of members will be as set out in Appendix 1.

14. In addition to the membership outlined in Appendix 1, the Strategic ICP may appoint such additional persons as it sees fit, either as co-opted voting members or as observers who shall be entitled to participate in discussion at its meetings but shall not be entitled to vote.

15. At the discretion of the Chair, additional ICB directors and other representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues.

Deputies

16. If a member is unable to attend a meeting of the Strategic ICP, they will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and understanding of the issues to be considered to represent their organisation effectively. Deputies will be eligible to vote if required. The Chair of the Strategic ICP must be informed in advance of the relevant meeting of the identity of a substitute

Chairing

17. Until a substantive chair of the ICP is appointed in 2023, meetings will be convened and chaired by the chair of the ICB on an interim basis.

Frequency of Strategic ICP Meetings

18. The Strategic ICP will meet at least biannually to instigate and then sign off the Integrated Care Strategy development process. As a formal joint committee of the ICB and the local authorities the Strategic ICP will be required to meet in public, and its meetings will be recorded and made available on the ICB website.

Operating Model and Area ICPs

19. Whilst there is a legislative basis for Integrated Care Partnerships, and extensive national guidance on the formation of Integrated Care Systems, there is, in addition, considerable flexibility for the Integrated Care Partnership's members to determine its operating model.

20. Therefore, the statutory members of the ICP have agreed a "one plus four" model, with one Strategic ICP (with a core membership of the ICB and all the local authorities in the ICS) which will be built up from the four existing and well-established partnership forums within North East and North Cumbria. These are based on geographical groupings that created valuable forums to think through how we better coordinate care and create new opportunities for wider access to services. NHS chairs and local authority leaders, as well as their chief executives and senior officers, have already been meeting together informally in this way for several years, building the relationships and trust that are helping to deliver increasing levels of integration and joint planning.

21. Therefore, our Area ICPs will be based on these existing geographies within our ICS:
    - **North**: Gateshead, Newcastle upon Tyne, North Tyneside, and Northumberland.
    - **Central**: County Durham, South Tyneside, and Sunderland.
    - **Tees Valley**: Darlington, Hartlepool, Middlesbrough, Redcar & Cleveland, and Stockton-on-Tees.
    - **North Cumbria**: Cumberland, and Westmorland & Furness (given part of the latter authority is within the North East and North Cumbria ICS area). It was agreed to establish this as a separate Area ICP given the unique challenges of geographical isolation and service fragility within North Cumbria, and their need to collaborate on these challenges with the neighbouring ICP for Lancashire and South Cumbria, as well as its neighbours to the east.

Complimentary role of the Strategic ICP and Area ICPs

22. The Strategic ICP will:
    - oversee and approve the ICS-wide Integrated Care Strategy, built up from an analysis of need from the four Area ICPs led by the Joint Strategy Development Group.
    - promote a multi-agency approach to improving population health and wellbeing and tackling the wider social and economic determinants of health for our population of over 3 million people
    - consider and suggest ways forward to tackle health inequalities, and improve experiences and access to health services at this same population level
    - champion initiatives involving the contribution of the NHS and wider health and care organisations to large scale social and economic development

23. The Area ICPs will:
    - Develop and strengthen relationships between professional, clinical, political and community leaders
    - Analyse needs from each of the constituent places within that Area (based on the HWBB-led Joint Strategic Needs Assessment process) to feed into the Integrated Care Strategy setting process
    - Agree how to deliver the priorities set out in the Integrated Care Strategy within their Area
    - Provide a regular forum for system partners to share intelligence, identify common challenges, agree joint objectives and share learning
    - Ensure the evolving needs of their local population are well understood

24. The membership of the Area ICPs will be diverse and drawn from a range of organisations as set out in Appendix 2 – including the Integrated Care Board, local

authorities, foundation trusts, primary care networks, the voluntary sector and HealthWatch, and other partners.

Chairing of Area ICPs

25. This will be for local determination between Area ICP partners, but typically this will be undertaken by a non-executive chair, such as the chair of a local Health and Wellbeing Board.

Relationship of ICPs to place through Health and Wellbeing Boards

26. In recognition of the importance of place, Department of Health Social Care guidance issued on 22 November 2022 recognises the important ongoing role of Health and Wellbeing Boards (HWBs), and expects as a minimum that all partners – the HWBs, ICBs and ICPs – will adopt a set of principles in developing relationships, including:
    - building from the bottom up
    - following the principles of subsidiarity
    - having clear governance, with clarity at all times on which statutory duties are being discharged
    - ensuring that leadership is collaborative
    - avoiding duplication of existing governance mechanisms
    - being led by a focus on population health and health inequalities

27. ICP need to have regard for and build on the work of HWBs to maximise the value of place-based collaboration and integration, and reduce the risk of duplication. They should ensure that action at system-wide level adds value to the action at place level, and they are all aligned in understanding what is best for their population.

28. ICB and ICP strategies and priorities should not detract from or undermine the local collaboration at place level. In an effective health and care system the ICP should build upon the existing work by HWBs and any place-based partnerships to integrate services. Working together at system level is helpful for issues that benefit from being tackled at scale.

29. HWBs will remain legally distinct from Integrated Care Partnerships but the latter's strategic priorities should be informed by local population health data as expressed through Joint Strategic Needs Assessments, and Joint Local Health and Wellbeing Strategies (JLHWS). The JLHWS sets out the vision, priorities and action agreed by the HWB to meet the needs identified within the JSNA and to improve the health, care and wellbeing of local communities and reduce health inequalities. The JLHWS is for the footprint of the local authority (with children's and adult social care and public health responsibilities).

30. HWBs will need to consider the integrated care strategies when preparing their own strategy (JLHWS) to ensure that they are complementary. Conversely, HWBs should be active participants in the development of the integrated care strategy as this may also be useful for HWBs to consider in their development of their strategy. When the HWB receives an integrated care strategy from the ICP, it does not need to refresh JLHWS if it considers that the existing JLHWS is sufficient

31. The integrated care strategy should build on and complement JLHWSs, identifying where needs could be better addressed at the system level. It should also bring learning from across the system to drive improvement and innovation. Our Area ICPs will

therefore facilitate opportunities to share innovation and expertise in how to deliver integrated approaches in the context of local circumstances – but they should not seek to overrule or replace existing place-based plans.

Frequency of Area ICP Meetings

32. Meetings of the Area ICP will be held be held on a quarterly basis as a minimum. As these are not formal joint committees of public bodies their meetings are not required to be made public, but Area ICPs can hold meetings in public if they wish, and their minutes will be published on the ICB website.

Reporting arrangements

33. Area ICPs will provide regular updates to the Strategic ICP via the minutes from each meeting. These minutes will be agreed by the Chair and circulated to representatives for approval and ratification (with the exception of any elements of any minutes need to be redacted due to conflicts of interest or withheld for reasons of commercial or personnel confidentiality).

Administrative Support

34. The ICB's Corporate Governance, Communications and Involvement team will provide a secretariat to the Strategic and Area ICPs to ensure the effective administration of the partnership, including the publication of meeting details on the ICB's website and the recording of meetings. The agenda and papers for meetings of the Strategic ICP and Area ICPs will be distributed no less than five working days in advance of the meeting unless agreed with the chair.

Conflicts of Interest

35. It is imperative that members ensure complete transparency in any discussions and/or subsequent recommendations by declaring any interests, both actual and/or perceived. The matter must always be resolved in favour of the public interest rather than the individual member or related organisation.

36. Members of the ICP are responsible for declaring any conflicts of interest in relation to the agenda items of the Partnership's meetings. Where any representative has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair shall use their discretion to decide, having regard to the nature of the potential or actual conflict of interest, whether or not that representative may participate in that part, or any other parts of the meeting, in which the relevant matter is discussed. Each representative must abide by all policies of the organisation he/she represents in relation to conflicts of interest.

Conduct of the ICPs

37. Each representative and those in attendance at ICP meetings will abide by the 'Principles of Public Life' and the NHS Code of Conduct, and the Standards for members of NHS boards and governing bodies, Principles of the Citizen's Charter and the Code of Practice on Access to Government Information together with all other applicable guidance, statutory guidance and/or requirements applying from time to time.

Date of review

38. The Partnership will review its own effectiveness, membership and terms of reference annually, however an initial review will take place after a period of six months following its establishment. Recommendations for amendment of the terms of reference will be submitted to the Board for approval.

Approved by the members of the Strategic ICP:
December 2022

Appendix 1:

Strategic ICP Membership

Members from statutory partner organisations:

Integrated Care Board
- Chair: Professor Sir Liam Donaldson
- Chief Executive: Samantha Allen

County Durham
- Cllr Chris Hood, Lead Member for Adults Services
- Jane Robinson, Corporate Director, Adult and Health Services

Cumbria (interim position pending the council reorganisation in 2023)
- Cllr Martin Harris, Lead Member for Adults (Cumberland)
- Cllr Patricia Bell, Lead Member (Westmorland & Furness)
- Colin Cox, Director of Public Health

Darlington
- Cllr Kevin Nicholson, Cabinet Member for Health & Housing
- James Stroyan, Group Director of People

Gateshead
- Cllr Lynne Caffrey, Chair of the Health and Wellbeing Board
- Alice Wiseman, Director of Public Health

Hartlepool
- Cllr Shane Moore, Leader of the Council
- Craig Blundred, Director of Public Health

Middlesbrough
- Cllr David Coupe, Chair of the Health and Wellbeing Board
- Erik Scollay, Director of Adults Services

Newcastle upon Tyne
- Cllr Karen Kilgour, Deputy Leader of the Council
- Matt Wilton, Assistant Chief Executive

North Tyneside
- Cllr Karen Clark, Chair of the Health and Wellbeing Board and the Cabinet Member for Public Health
- Wendy Burke, Director of Public Health

Northumberland
- Cllr Wendy Pattison, lead member for Adult Wellbeing
- Liz Morgan, Director of Public Health

Redcar & Cleveland
- Mary Lanigan, Leader of the Council
- Patrick Rice, Corporate Director Adults and Communities

South Tyneside
- Cllr Anne Hetherington, Lead Member for adults, health and independence
- Tom Hall, Director of Public Health

Stockton-on-Tees
- Cllr Bob Cook, Leader of the Council & Chair of the Health and Wellbeing Board
- Ann Workman, Director Adults & Health Services

Sunderland
- Cllr Kelly Chequer, Healthy City Portfolio Holder
- Gerry Taylor, Director of Public Health

Members from non-statutory partner organisations:

ICS VCSE Partnership
- Jane Hartley, Social Prescribing and Health Partnerships Strategic Manager (and ICB Participant)
- Lisa Taylor, Health and Wellbeing Programme Director

ICS HealthWatch Network
- Christopher Akers-Belcher, Chief Executive, Healthwatch Hartlepool
- Paul Jones, Lead Officer for Healthwatch North Tyneside

Housing Sector
- Tracy Harrison, Chief Executive of the Northern Housing Consortium
- Chris Smith, Chief Executive of Thirteen Housing Group

Social Care Provider Sector
- (Member TBC)

Regional Hospice Network
- Steph Edusei, Chief Executive of St Oswald's Hospice

University Sector
- Professor Jane Robinson, Pro-Vice-Chancellor, Newcastle University

Police and Fire & Rescue Services
- (Members TBC)

At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues.

Appendix 2:

Area ICP Membership
This will be for local determination, but it is expected that each Area ICP will have members drawn from the following organisations and sectors:

- **NHS North East and North Cumbria Integrated Care Board**
- **Foundation Trusts (Acute, Mental Health and Ambulance)**
- **Local Authorities (e.g., Health and Wellbeing Board Chairs and Directors of Adult's Services, Children's Services & Public Health)**
- **Primary Care Networks**
- **Healthwatch**
- **Housing Sector**
- **Police and Fire & Rescue Services**
- **University and Education sector**
- **VCSE providers and local infrastructure organisations**

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North East and North Cumbria

Integrated Care Board

ICB Place [Sub] Committee Terms of Reference

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1. Establishment

The xxx Place Committee is established as a Subcommittee of the North East and North Cumbria Integrated Care Board (the ICB) Executive Committee in accordance with the ICB's Constitution, Functions and Decisions Map, and Scheme of Reservation and Delegation (SoRD).

2. Terms of Reference:

Definition of terms: The terms of deference are defined by the ICB.

Amendment: The terms of reference may be amended in accordance with the provisions in the ICB's Constitution and SoRD.

Publication: The terms of reference are published in the ICB's Governance Handbook which is accessible here: https://northeastnorthcumbria.nhs.uk/about-us/corporate-information/governance/.

3. Purpose

The purpose of the ICB Place Committee (the Committee) 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.

4. Roles and responsibilities

This section describes the Committee's duties, authority, accountability and reporting.

4.1 Duties (on behalf of the ICB - and local authority where agreed)

The Place Committee's duty is to:

- Approve on behalf of the ICB the arrangements for the provision of delegated health services in (xxx place).
- Operate within agreed financial limits
- Agree and implement a place plan on behalf of the place partners
- Working with partners to develop 'Place' capabilities and capacity

4.2 Develop 'Place' capabilities and capacity

- Agree ideal future state in relation to local priorities and integrated working and delivery
- Conduct a self-assessment to determine areas of development
- Co-create a development roadmap
- Support joint development programmes across all key partners at place

4.3 Agree a place plan including:

- Plan: Agree the Place plan to meet the health and healthcare needs of the population within (xxx place), having regard to (and informing) the NENC Integrated Care Strategy, health and wellbeing strategies, joint strategic needs assessment (JSNA) and the joint five year-forward plan

- Resources: allocate resources to deliver the plan in (xxx place), determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital)
- People: agree implementation in place of people priorities
- Data and digital: Work with partners across the NHS and local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care
- Estates and procurement: agree joint work on estates, procurement, supply chain and commercial strategies to maximise value for money in place and support wider goals of development and sustainability (this may be carried out across more than one place, for example the One Public Estate programme).
- Risk: Develop arrangements for risk sharing and /or risk pooling with other organisations (for example pooled budget arrangements under section 75 of the NHS Act 2006), for approval by the ICB executive committee and local authority(s). (Section 75 agreements can be agreed with one or more local authority areas).

4.4 Approve the arrangements for the provision of health, care and wellbeing services in (place) including:

- Contracts: put contracts and agreements in place to secure delivery of its plan by providers (complying with NHS Provider Selection Regime)
- Collaboration: Embed collaboration and service integration as the basis for delivery within the place plan
- Pathway transformation: Convene and support providers (working both at scale and at place) to innovate, learn from best practice and lead major service transformation programmes to achieve agreed outcomes
- Primary care development: Support the development of primary care – including general practice, pharmacy, optometry and dentistry – as the foundation of place-based out-of-hospital care, including investment in primary care networks and their management support, data and digital capabilities, workforce development and estates.

4.5 Propose future governance arrangements including:

- Collective accountability: Arrangements to support collective accountability between partner organisations for place-based health and care system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations
- Operating model: implement an operating structure, which works effectively with the ICB, local authorities and other partners' operating models
- Assurance:
  - Oversee the implementation of the assurance framework for (xxx place), including review of quality and performance against ICB and national priorities and targets, reporting outcomes to the ICB

– Ensure compliance with delegated functions and provide reports to the ICB on the discharge of delegated functions

5. Authority

The committee is authorised to:	
Investigate	Investigate any activity within its terms of reference.
Seek information	Seek any information it requires within its remit, from any employee or member of the ICB.
Commission	Commission reports required to help fulfil its obligations.
Obtain advice	Obtain independent professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the Committee must follow any relevant procedures put in place for obtaining professional advice.
Create sub-groups	Create, with agreement of the Committee, task and finish sub-groups for specific programmes of work. Determine the terms of reference of task and finish sub-groups, in accordance with the ICB constitution, Standing Orders and Scheme of Reservation and Delegation – but no decisions may be delegated to these groups.

6. Delegation by Scheme of Reservation and Delegation (SoRD)

Decisions Delegated by the Scheme of Reservation & Delegation
Place committees – decisions and associated budgets aligned to Place include: • Services commissioned and delivered in the community / out of hospital system • PCN support/development and primary care (general practice) commissioning (with the exception of nationally negotiated GP contract) • Influencing pharmacy, optometry and dental service planning and delivery • Continuing healthcare (includes CHC, FNC, joint packages, children's CHC) • Better Care Fund arrangements with the Local Authority / authorities or other integrated agreements in place prior to the establishment of the ICB • Prescribing including local contracts for medicines optimisation activities • Community based mental health, LD and autism (including section 117 packages of care) • Local safeguarding arrangements

7. Accountability and reporting

ICB Place Committees are accountable to the ICB Executive Committee. It may also be required to report to other governance bodies (e.g., the ICB Board), on how it discharges its delegated responsibilities.

Accountabilities	Description
Draft minutes and reports	The Committee receives scheduled assurance reports, as required, in line with its responsibilities. The Secretary formally records the minutes of each meeting. The Chair of the Committee reports to the ICB Executive Committee after each meeting and provides a report on assurances received, escalating any concerns, where necessary.
Monitor attendance	Attendance is monitored and profiled as part of the agenda at each Committee meeting. Members should aim to attend 100% of meetings and must attend at least 75% of meetings and read all papers beforehand.
Draft annual work plans	The Committee produces an annual work plan in consultation with the ICB Executive Committee.
Conduct annual self-assessment	The Committee undertakes an annual self-assessment of its performance against the annual plan and terms of reference. Any resulting proposed changes to the terms of reference are submitted for approval by the Board. The Committee utilises a continuous improvement approach in its delegation. Members review the effectiveness of the meeting at each sitting.
Annual Report	The Committee provides the Board (via ICB Executive Committee) with an annual report, timed to support finalisation of the ICB accounts and governance statement. The report includes: • The governance cycle • A summary of the business conducted • Frequency of meetings, membership attendance, and quoracy • The committee's self-assessment

8. Committee meetings

This section sets out meeting:

- Composition and quoracy
- Frequency and formats
- Procedures

8.1 Composition and quoracy

This section sets out the meeting composition and quoracy requirements.

Composition/ quoracy	Description of expectations
Chair	Appointed for their specific knowledge skills and experience and suitability (Note: does not need to be a member of the ICB but must be a full member of the ICB Place Committee).
Deputy Chair	Committee members may appoint a Vice Chair from amongst the members.
Absence of Chair or Vice Chair	In the absence of the Chair, or Vice Chair, the remaining members present elects one of their number Chair the meeting.
Membership	As the Committee is a ICB decision making forum, ICB members will form the majority of the Committee. The Committee may appoint representatives of statutory and non-statutory partners to participate in the Committee or attend meetings to take part in discussions without being members. Members/Attendees: (*Example list – for local agreement)*. • ICB members – (e.g., Executive Area Director, Director of Place, Medical Director, Director of Nursing, Finance Director, Place Clinical Leaders) • NHS Partners – e.g. Foundation Trusts, Primary Care • LA officers – e.g., DASS, DCS, DPH • ICS VCSE alliance representative(s) • Healthwatch • Other (e.g., education, housing, police, fire, private care home representatives) **EDI and PPI:** When determining the membership of the Committee, consideration will be given to diversity and equality and patient and public involvement. **ICS:** Membership may be from across the Integrated Care System. However, the balance of decision making must sit with the ICB. **Conflicts**: Consideration must be given to material conflicts in the appointment of members.

Composition/ quoracy	Description of expectations
Attendees and procedure for absence	Only members have the right to attend meetings. Other attendees: Members may elect to co-opt additional attendees, where it is in the interests of the activities to do so. **Procedure for absence:** Where a member or any attendee of the Committee is unable to attend a meeting, a suitable alternative may be agreed with the Chair. The Chair may ask any or all of those who normally attend to withdraw to facilitate open and frank discussion of particular matters.
Quoracy and Procedure for Inquoracy	**Threshold:** A minimum of half the membership and where the ICB members present exceeds the other members present. Must include: • Executive Area Director or ICB Director of Place (or nominated deputy) • ICB Medical Director or Director of Nursing (or nominated deputies) • ICB Director of Finance (or nominated deputy) • An ICB Clinical Lead **Absence:** Where members are unable to attend, they should agree this with the Chair. **Disqualification:** If any member of the Committee is disqualified from participating in an item on the agenda, due to a declared conflict of interest, that individual no longer counts towards the quorum. **Inquoracy:** If the quorum is not reached, the meeting may proceed if those attending agree, but no decisions may be taken.

8.2 Frequency and formats

This section on Committee meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The Committee will meet monthly. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair. The ICB Executive may ask the Place Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.
Public vs closed	Where this is warranted by the nature of the business arising, the agenda is divided into two parts. Part 1 is open to the whole committee, including invited attendees. Part 2 is a closed session for members only to discuss confidential information. External Audit, Internal Audit and Local Counter Fraud representatives will have full and unrestricted rights of access to the Committee.
Virtual meetings and extra-ordinary meetings	In accordance with the ICB Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

8.3 Procedures

Procedure	Description of rules and expectations:
Agenda	The Chair is responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR. Committee members are expected to identify agenda items for consideration to the Chair and any meeting papers using the prescribed format at least 5 working days before the meeting.
Conflicts of interest	**Declarations:** All committee members, and those in attendance, must declare any actual or potential conflicts of interest. This is recorded in the minutes. **Exclusions:** The Committee will follow and apply the ICB Standards of Business Conduct with regards to the management of conflicts of interest. This means that the Chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.

Decision-making	**Decisions:** Decisions are taken in according with the ICB's Standing Orders and are arrived at by consensus. Where decisions cannot be made by consensus the Committee will follow voting procedures as described in the ICB Standing Orders.
Conduct	The Committee's conducts its business in accordance with relevant codes of conduct / good governance practice, including the Nolan principles of public life, the relevant Standards of Business Conduct Policies, and other relevant policies / guidance on good and proper meeting conduct.

9. Secretariat and administration

This section describes the functions of the secretariat whose role is to support the Committee in the following ways:

Functions	Description
Distribute papers	Prepare and distribute the agenda and papers in accordance with the Standing Orders following their agreement by the Chair with the support of the relevant executive lead.
Monitor attendance	Monitor the attendance of those invited to each meeting and highlight to the Chair those that are not meeting the minimum attendance requirements.
Maintain records	Record conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and to identify new members where necessary.
Minute Taking	Take good quality minutes and agree them with the Chair. Keep a record of matters arising, action points and issues to be carried forward.
Support for Chair & Committee	Support the Chair in preparing reports for the ICB Executive Committee and Board when required. Take forward action points between meetings and monitor progress against those actions.
Provide updates	Update the Committee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for committee members

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Appendix 1: Approval History

Version	Date	Approved by	Status
V1.0	28/3/2023	Board (TBC)	First Issue

Appendix 2: Revision History

Version	Date	Reviewed by	Changes Required Y/N?	Summary of changes (include in Appendix 1 above)

Review date: March 2024
Contact: ICB Corporate Governance Team

Document control
The controlled copy of this document is maintained by the governance team in the Governance Handbook, here https://northeastnorthcumbria.nhs.uk/about-us/corporate-information/governance/

Any copies of this document held outside of the Governance Handbook, in whatever format (e.g., paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

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NHS
North East and North Cumbria

Integrated Care Board

Individual Funding Request Panel

Terms of Reference

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1. Constitution

1.1. The North East and North Cumbria Integrated Care Board (ICB) hereby resolve to establish an Individual Funding Request Panel (IFR Panel) which will report to the ICB Executive Committee.

1.2. Each IFR Panel is a sub-committee of the ICB Executive Committee and is decision making in line with the Scheme of Reservation and Delegation.

2. Principal Functions

2.1. 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.

3. Membership

3.1. Two IFR Panels are convened to cover the NENC ICB geography. These are the North Panel (covering the North and North Cumbria areas of the ICB) and the South Panel (covering the Central and South areas of the ICB). The IFR Panel shall collectively assess requests across the ICB as per Appendix 1.

3.2. Each Panel will have a membership which comprises:

- Chair (Independent Chair for the IFR Panel)
- ICB Decision Makers (DM) from the Panel (*five nominated from the places making up each Panel. At least three ICB Decision Makers to be in attendance for quoracy).*
- Local NECS IFR Administrator
- Specialist public health advisor from the respective areas (in attendance to offer advice and technical support).

Additional Specialist Advisors

The following are specialist advisors to the Panel and can be in attendance at Panel to offer advice and technical support as and when necessary.

- Contracting/Commissioning representative
- Medicines Management representative
- Mental Health and Learning Disabilities representative
- Any other specialist deemed appropriate for a given case.

4. Quorum

4.1. No business shall be transacted at a meeting unless at least a Chair (or nominated deputy) and at least three decision makers are available to attend

the IFR Panel. The IFR Admin must also be in attendance and will support the presentation of cases where required and take notes of each meeting.

4.2. If the Chair or a panel member has been disqualified from participating in the discussion on any matter and / or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and / or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. Consideration/decisions can be deferred to the next meeting or, in urgent circumstances, be considered via an extraordinary meeting if required.

4.3. Panels will generally be expected to reach consensus decisions on these matters, but in exceptional cases a majority vote of Panel members may be required in order to make a decision. The Chair of the meeting is independent and non-voting, therefore in the event consensus cannot be reached the DM not present will be asked to vote out with of the meeting.

5. Frequency of meetings

5.1. Meetings will be convened monthly, at a time to be agreed, with the ability to call an extra Panel in the event of a backlog of cases or a requirement for an urgent decision (as outlined in section 6) or stand down a Panel in the event of no cases. This will be reviewed in the light of the number of applications received and the development of protocols which define criteria for approving or rejecting requests.

5.2. Two Panels will be held per month, a North and a South Panel (as outlined in appendix one).

6. Urgent Requests

6.1. In the case of urgent clinical need or a risk to patient safety the DM is able to make a timely decision to avoid inappropriate delay.

6.2. If an urgent Panel decision is required outside of a scheduled meeting and the request cannot be heard by the neighbouring ICB panel or an exceptional Panel cannot be convened, the application information will be communicated to members of the Panel via secure e-mail.

6.3. The information is communicated to each of the Panel members via NHS net in line with the agreed process and a decision will be made within 2 working days of receipt.

6.4. The decision will be securely communicated to the referring clinician via the electronic system in place with confirmation by letter and the outcome communicated formally at the next available Funding Panel meeting. The IFR Administration Team will ensure the decision is retrospectively recorded in the following month's Panel minutes.

7. Reconsideration

7.1. A reconsideration request should be made within three months of original decision, via documented correspondence stating why the reconsideration request is being made and must include any new information / evidence.

7.2. On receipt of an application for reconsideration, the IFR Admin will screen the original application, the notes of the Panel decision, all correspondence, any new information and the reconsideration request.

7.3. Where a recommendation is made to the DM that valid grounds for reconsideration have not been established, applicants will be informed in writing.

7.4. Where it is evident that substantial new information has been made available over and above the contents of the original request, the DM will confirm as to whether the request should be reconsidered within the next IFR Panel or whether a decision can be reached out with the Panel.

8 Appeals

8.1. Where there are grounds for an appeal hearing, i.e. where there is evidence that the IFR Admin/DM/IFR Panel may not have acted in accordance with the agreed IFR process, considered the relevant evidence, considered material factors only or appropriately applied the criteria in making this decision, a recommendation will be made to the DM to send the case to the neighbouring panel.

8.2. Panel members who were present at the original IFR Panel hearing are not eligible to sit on the appeals panel, therefore an appeal hearing must be undertaken by the neighbouring IFR Panel for reconsideration in line with their agreed meeting schedule. One of the DMs from the original Panel area must make themselves available to attend this meeting for the case to be discussed. The DM will then be asked to leave the Panel meeting to enable Appeal Panel Members to make a decision.

8.3. The outcome of the appeal panel is the final decision and will be communicated by written correspondence within 5 working days of the appeals panel meeting. For all cases the IFR Admin as role of co-ordinator, will write on behalf of the ICB and IFR Panel, to the referring clinician, with the decision(s) and reason(s) for the decision(s) reached by the IFR Panel. It is expected that the referring clinician will then discuss the outcome of the IFR Panel with the patient(s) concerned.

9. Reporting

9.1. The minutes of the Panel shall be formally recorded and when approved submitted to the ICB Executive Committee held in private. The Executive Medical Director shall draw to the attention of the Executive Committee any issues that require disclosure.

9.2. Reports will regularly be presented to the IFR Panel detailing a review of numbers / types of cases / number of upheld appeals considered in order to share learning, analysis of trends and consistency in decision making.

10. Other Matters

10.1. The Panel shall be supported administratively by the IFR Admin, whose duties in this respect will include:

- Agreement of the agenda with the Chair and the collation and distribution of the papers within 5 working days in advance of the meeting
- Taking the minutes and keeping a record of matters arising and issues to be carried forward via an up-to-date action log
- Action log maintained and updated prior to the IFR Panel papers being circulated
- Circulating the minutes to all IFR Panel members within 5 working days of the meeting, confirmation of the minutes is required from at least 3 out of 5 IFR Panel members prior to the decision letter being sent to the referring clinician. IFR Panel members will aim to confirm acceptance within 5 days of circulation.
- Advising the IFR Panel on pertinent matters
- Maintain a register of all applications considered and the outcome of each (via the web-based system in place)
- In their role as co-ordinator, will write on behalf of the ICB and IFR Panel to the referring clinician with the decision(s) and rationale(s) for the decision(s) reached by the DM/IFR Panel
- A monthly dashboard be produced for ongoing open cases and KPI compliance.

10.2. An annual report will be provided to the NENC ICB Executive Committee within three months of the financial year end by the NECS IFR Service Lead.

11. Review of Terms of Reference

11.1. The ICB Executive Committee will review these Terms of Reference annually.

Version: **V1-0**
Approved by: **Board (tbc)**
Date: **28 March 2023**
Review date: **March 2024**

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Appendix 1 - Panel Arrangements

Panel	Places
North	Gateshead Newcastle North Cumbria North Tyneside Northumberland
South	County Durham Darlington Hartlepool Middlesbrough Redcar & Cleveland South Tyneside Stockton-on-Tees Sunderland

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Appendix 6

NHS
North East and
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Integrated Care Board

Medicines Subcommittee

Terms of Reference

Table of Contents

1. Establishment

The NHS North East and North Cumbria Medicines Subcommittee is a subcommittee of the Executive Committee as established by the ICB Board, in accordance with the NHS North East and North Cumbria's (hereafter referred to as the ICB) Scheme of Reservation and Delegation (SoRD) and Constitution.

2. Terms of reference:

Definition of terms: The terms of reference are defined by the ICB.

Amendment: The terms of reference may be amended in accordance with the provisions set out in the 'Establishing Subcommittees' standard operating procedure.

Publication: The terms of reference will be published in the ICB's Governance Handbook which is accessible here: https://northeastnorthcumbria.nhs.uk/about-us/corporate-information/governance/

3. Purpose

The purpose is 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 Integrated Care System (ICS).

The NENC Medicines Subcommittee aims to improve patient centred healthcare through optimising the use of medicines and driving a reduction in health inequalities across the NENC population.

4. Roles and responsibilities

This section describes the subcommittee's duties, authority, accountability and reporting.

4.1 Duties

The subcommittee's duties are as follows:

a. Support the NHS England vision to establish a strategic framework of policy, clinical leadership, and governance to ensure all aspects of medicines optimisation are integrated and coordinated at every level of the NE&NC healthcare system including at "place"

b. To improve patient outcomes relating to medicines and ensure the equitable, safe, sustainable, appropriate, functional, and efficient use of medicines across the ICS
c. To provide assurance in respect of medicines safety, value, quality, inequality, sustainability, standards across NENC
d. To support the implementation at strategic level of best practice around medicines including NICE guidelines and technology appraisals and to facilitate rapid and consistent implementation across the ICS in a manner which reduces health inequalities but which recognises local variations.
e. To ensure corrective action has been taken and managed where gaps are identified in relation to system level medicines risks and issues and escalate to the Executive Committee where necessary.
f. To ensure that robust medicines governance structures, systems and processes are in place across all providers of medicines and pharmacy services; and that these have been developed in line with national and regional commissioning expectations.
g. To define role and set terms of reference for subgroups of the Medicines Subcommittee and ensure integrated multidisciplinary membership.
h. To assign sub-group and functionality as appropriate and ensure integrated multidisciplinary membership
i. To enable local NHS stakeholders and clinicians to exert a population approach to the prioritisation, improvement and development of healthcare delivery related to medicines.

The scope of the subcommittee is all aspects of NHS physical and mental healthcare delivered across the ICB footprint regardless of setting.

The function of the subcommittee is to continually develop and promote the vision, values and culture of quality medicines use, ensuring that commissioned healthcare services meet national and local clinical standards, realising equitable access to medicines for the NENC population and in turn quality outcomes across NENC.

The Medicines Subcommittee will achieve this by:

- Taking a strategic view of medicines use and optimisation, co-ordinating cross-sector action and engagement with the public, patients, (in liaison with the ICB Involvement Team), commissioners, providers, and clinicians to improve outcomes, reduce harm, and encourage a long-term, patient-centred approach to medicines optimisation focusing on the effective investment in improving health and wellbeing, through a NENC collaborative approach.
- Setting high quality outcomes standards, and monitoring and reporting against these standards with the aim of improving outcomes, reducing unwarranted clinical variation, and reducing health inequalities across the population.

- Develop a population health management approach with better utilisation of digital systems, data, and analytics, through uniform implementation of agreed data collation and communication platforms, and utilising this to develop a broader population health approach to reducing health inequalities and improving outcomes.
- Monitoring system-wide investment on medicines and ensuring value is obtained.
- Developing and implementing robust system-wide medicines decision making processes for the NENC, (in accordance with the decisions delegated by the Scheme of Reservation and Delegation (see page 6) to manage entry, use and provision of medicines.
- Further integrating and collaboration with other ICB medicines optimisation committees/boards across the North East and Yorkshire via the North East and Yorkshire Regional Medicines Optimisation Committee (RMOC NEY), optimising the medicines optimisation agenda through the sharing of best practice.

5. Authority

The subcommittee is authorised to:	
Investigate	Investigate any activity within its terms of reference.
Seek information	Seek any information it requires within its remit, from any employee or member of the Board.
Investigate	Commission reports required to help fulfil its obligations from NECS. Commission reports required to help fulfil its obligations from Audit One or the ICB's external auditors, in consultation with the Executive Director of Finance. Commission other external reports required to help fulfil its obligations, subject to the financial limits of the most senior member of the subcommittee.
Obtain advice	Obtain independent professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the subcommittee must follow any procedures put in place by the ICB for obtaining professional advice.
Create Groups	Groups may be established by the subcommittee, but they have no formal status. They do not have any

The subcommittee is authorised to:	
	delegated authority from the Board. Their decision making is restricted to decisions and limits of individuals as set out in the ICB's Financial Limits and Financial Delegations. These may not be aggregated and therefore the limits are those of the most senior member present at any meeting of the group. Groups may be permanent or task and finish groups. The NENC Medicines Sub Committee may choose to establish/adopt other permanent or temporary sub-groups and short-life working groups to take forward specific programmes of work as considered necessary by members. They may also choose to delegate such tasks but not decision making to existing groups. The Northern Treatment Advisory Group (NTAG) and the Medicines Safety Subgroup will be permanent subgroups of the NENC Medicines Sub Committee.

6. Delegation by Scheme of Reservation and Delegation (SoRD)

Decisions delegated by the Scheme of Reservation and Delegation
To make decisions on all aspects of medicines use at system level subject to delegation from the Executive Committee (as approved by the Board through their approval of these terms of reference and the Scheme of Reservation and Delegation) and to report these decisions to the Executive Committee.

7. Accountability and reporting

The Subcommittee is accountable to its parent committee, the Executive Committee, and reports to its parent committee on how it discharges its responsibilities.

Accountabilities	Description
Draft minutes and reports	The Subcommittee receives scheduled assurance reports from its established groups. The secretary formally records the minutes of each meeting.

	The chair of the Subcommittee reports to its parent committee after each meeting and provides a report on assurances received, escalating any concerns, where necessary.
Monitor attendance	Attendance is monitored and profiled as part of the agenda at each subcommittee meeting. Members should aim to attend 100% of meetings and must attend at least 75% of meetings and read all papers beforehand.
Draft annual work plans	The Subcommittee produces an annual work plan in consultation with its parent committee.
Conduct annual self-assessment	The Subcommittee undertakes an annual self-assessment of its performance against the annual plan and terms of reference. Any resulting proposed changes to the terms of reference are submitted to the parent committee for agreement and action as the 'Establishing Subcommittees' standard operating procedure. The Subcommittee utilises a continuous improvement approach in its delegation. Members review the effectiveness of the meeting at each sitting.
Annual Report	The Subcommittee provides its parent committee with an annual report, timed to support finalisation of the accounts and the governance statement. The report includes: • The governance cycle • A summary of the business conducted • Frequency of meetings, membership attendance, and quoracy • The committee's self-assessment.

The Medicines Subcommittee is accountable to the Executive Committee. Any changes to these terms of reference must be recommended for approval by the Executive Committee to the Board.

Individual members of the subcommittee are responsible for progressing any actions relevant to their own areas and communicating decisions made through their own reporting structures to share information

Decisions from the subcommittee will be submitted after each meeting to the Executive Committee for approval as in line with the Scheme of Reservation and Delegation.

The subcommittee will receive the minutes of the Northern Treatment Advisory Group (NTAG) and the Medicines Safety Subgroup for assurance.

8. Committee meetings

This section sets out meeting:

- Composition and quoracy
- Frequency and formats
- Procedures

8.1 Composition and quoracy

This section sets out the meeting composition and quoracy requirements.

Composition/ quoracy	Description of expectations
Chair	Appointed for their specific knowledge skills and experience and suitability. (Note: does not need to be a member of the ICB board)
Deputy Chair	Subcommittee members may appoint a vice chair from amongst the members.
Absence of Chair or Vice Chair	In the absence of the chair, or vice chair, the remaining members present elects one of their number to Chair the meeting.
Membership	Membership will be multidisciplinary and will include all parts of the NENC pharmacy and medicines optimisation sectors. The membership will include the following or their nominated deputies as agreed with the Chair: Voting members: • ICB Director of Medicines and Pharmacy (chair) • ICB Medical Director representative (vice chair) • ICB Community Pharmacy Clinical Lead • Foundation Trust Chief Pharmacist representatives – Mental Health x 1, Acute x 1 and Ambulance x 1 • ICB Nursing Director • ICB Director of Finance • ICB Director of Place representative Non-voting members • System representative, NECS • Public Health Commissioning representative, NHS England • Public Health Pharmacist representative • Social Care representative • Strategic Clinical Networks representative

Composition/ quoracy	Description of expectations
	• Specialised Commissioning representative, NHS England (to include Health and Justice representation) • Regional Chief Pharmacist, NHS England • Chair of NTAG • Chair of Medicines Safety Subcommittee Chair • NICE associate • Lay representative Nominated deputies as agreed by the Chair will have the same voting rights as those that they are deputising for. **EDI:** When determining the membership of the subcommittee, consideration will be given to diversity and equality. **Involvement:** In determining membership consideration will be given to the need for a patient and public involvement member. **ICS:** Membership may be from across the Integrated Care System. However, the balance of decision making must sit with the ICB. **Conflicts**: Consideration must be given to material conflicts in the appointment of members.
Attendees and procedure for absence	Only members have the right to attend meetings. Other attendees: the chair may elect to co-opt additional attendees, where it is in the interests of the activities to do so. Other advisory specialists may be invited to attend where specific issues relating to their respective areas of responsibility are discussed (e.g., those submitting papers or pathways for approval) as agreed following discussion between the chair and committee secretary. The chair may ask any or all of those in attendance but who are not members to withdraw to facilitate open and frank discussion. **Procedure for absence:** Where a member or any regular attendee of the subcommittee is unable to attend a meeting, a suitable alternative may be agreed with the chair. The chair may ask any or all of those who normally attend to withdraw to facilitate open and frank discussion of particular matters.
Quoracy and Procedure for Inquoracy	**Threshold:**

Composition/ quoracy	Description of expectations
	A minimum of 50% of voting members (or their agreed nominated deputies) which must include at least: • ICB Director of Medicines and Pharmacy • ICB Medical Director • ICB Director of Finance, and • One Foundation Trust Chief Pharmacist **Absence:** Where members are unable to attend, they should agree this with the chair. **Disqualification:** If any member of the subcommittee is disqualified from participating in an item on the agenda, due to a declared conflict of interest, that individual no longer counts towards the quorum. **Inquoracy:** If the quorum is not reached, the meeting may proceed if those members attending agree, but no decisions may be taken.

Members, deputies and regular attendees must complete a 'declarations of interest' form on joining the group, on changes of job title or position, where declarations change or new declarations are to be made, and annually in April.

In addition, members and attendees are required to declare any relevant interests relating to the agenda on receipt of the papers, at the start of a meeting, or at any point during the meeting where a conflict (actual, potential or perceived) arises.

Members may be excluded from decision making (as determined by the Chair) where appropriate. If quoracy is affected as a result, the meeting may continue but no decisions will be made from the point the meeting becomes inquorate.

Declarations of Interest will also be required from all those submitting papers, formulary application, and guidelines to the Area Prescribing Committee.

8.2 Frequency and formats

This section on Subcommittee meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The Subcommittee will meet at least six times a year with a minimum of five meetings at appropriate times in the reporting cycle.

Frequency/ format	Description
	Additional meetings may be convened on an exceptional basis at the discretion of the subcommittee chair. The parent committee chair may ask the Subcommittee to convene further meetings to discuss particular issues on which they want the sub committee's advice.
Public vs closed	Meetings will be held in private. External Audit, Internal Audit and Local Counter Fraud representatives will have full and unrestricted rights of access to the Subcommittee.
Virtual meetings and extra-ordinary meetings	In accordance with the Standing Orders, the Subcommittee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

8.3 Procedures

Procedure	Description of rules and expectations:
Agenda	The chair is responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference. Members are expected to identify agenda items for consideration to the chair and any meeting papers using the prescribed format at least 5 working days before the meeting.
Conflicts of interest	**Declarations:** All members, and those in attendance must declare any actual, potential, or perceived conflicts of interest. This is recorded in the minutes. **Exclusions:** The Subcommittee will follow and apply the ICB's Standards of Business Conduct with regards to the management of conflicts of interest. This means that the chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.
Decision-making	**Decisions:** Decisions are taken in accordance with the Standing Orders and are arrived at by consensus.

Conduct	The Subcommittee's conducts its business in accordance with relevant codes of conduct / good governance practice, including the Nolan principles of public life, the ICB Standards of Business Conduct Policy, and other relevant policies / guidance on good and proper meeting conduct for NHS organisations

An agenda will be produced and circulated electronically together with accompanying papers at least 5 working days prior to the meeting.

Draft minutes, decision summary and updated action log will be circulated after the meeting to the members within 2 weeks and the minutes confirmed in the subsequent meeting.

Action points are taken forward between meetings and progress against those actions is monitored.

All appeals against decisions of the subcommittee must comply with the ICB Appeals Policy. The grounds on which an appeal can be made are outlined within the policy and must be sent to the Subcommittee secretary in the first instance. Appeals can only be made by NHS healthcare Professionals within the NENC ICS.

9. Secretariat and administration

This section describes the functions of the secretariat whose role is to support the Subcommittee in the following ways:

Functions	Description
Distribute papers	Prepare and distribute the agenda and papers in accordance with the Standing Orders following their agreement by the chair with the support of the relevant executive lead.
Monitor attendance	Monitor the attendance of those invited to each meeting and highlight to the chair those that are not meeting the minimum attendance requirements.
Maintain records	Record conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and to identify new members where necessary.
Minute Taking	Take good quality minutes and agree them with the chair. Keep a record of matters arising, action points and issues to be carried forward.

Functions	Description
Support for Chair & Committee	Support the chair in preparing and delivering reports to the parent committee. Take forward action points between meetings and monitor progress against those actions.
Provide updates	Update the Subcommittee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for subcommittee members

Communications between the subcommittee and stakeholders will generally be through the secretariat, except where it has been agreed that an individual member should act on the subcommittee's behalf

All media enquiries relating to outputs from the Medicines Subcommittee will be dealt with by the ICB's Communications Team in consultation with the Chair and the secretariat (after consultation from the membership if necessary).

The Medicines Subcommittee will not accept requests from the pharmaceutical industry to attend meetings or to present information to group members. Ways in which the group will engage with the industry are defined within the NENC ICS pharmaceutical engagement policy.

Appendix 1: Approval History

Version	Date	Approved by	Status
V0.5	14/3/2023	Executive Committee recommended to Board for Approval	Draft (until Board approval)
V1.0	28/3/2023	Board (TBC)	First Issue

Appendix 2: Review History

Version	Date	Reviewed by	Changes Required Y/N?	Summary of changes (once changes are approved Appendix 1 should be updated)

Review date: March 2024
Contact: ICB Corporate Governance Team

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Appendix 7

NHS
North East and
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Integrated Care Board

Quality and Safety Area Subcommittee

Terms of Reference

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Table of Contents

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1. Establishment

The Quality and Safety Area subcommittee, as established by the Board, is a subcommittee of the Quality and Safety Committee in accordance with the NHS North East and North Cumbria's (hereafter referred to as the ICB) Scheme of Reservation and Delegation (SoRD) and Constitution.

2. Terms of reference:

Definition of terms: The terms of reference are defined by the ICB.

Amendment: The terms of reference may be amended in accordance with the provisions set out in the 'Establishing Subcommittees' standard operating procedure.

Publication: The terms of reference will be published in the ICB's Governance Handbook which is accessible here: https://northeastnorthcumbria.nhs.uk/about-us/corporate-information/governance/

3. Purpose

The Subcommittee has 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 Subcommittee exists to scrutinise the robustness of and 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.

The Subcommittee will provide regular assurance updates to the Quality and Safety Committee in relation to activities and items within its remit.

4. Roles and responsibilities

This section describes the sub committee's duties, authority, accountability, and reporting.

4.1 Duties

It is expected that the subcommittee will carry out the following for the geographical area for which the subcommittee is responsible:

- Be assured that there are robust processes in place for the effective management of quality and safety

- Scrutinise structures in place to support quality, clinical effectiveness, and safety; planning, control and improvement programmes, to be assured that the structures operate effectively, and timely action is taken to address areas of concern. Escalate to the Quality and Safety Committee any significant/material performance issues for action.

- Oversee and monitor delivery of the ICB key statutory requirements in relation to quality; safety and clinical effectiveness

- Escalate quality and safety risks to the Quality and Safety Committee for consideration of inclusion in the risk register

- Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) directives, regulations, national standard, policies, reports, reviews and best practice as issued by the Department of Health and Social Care, NHS England and other regulatory bodies / external agencies (e.g., Care Quality Commission, National Institute for Clinical Excellence) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained

- Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the Board that these are disseminated and implemented across all sites

- Oversee and seek assurance on the effective and sustained delivery of the ICB quality improvement programmes

- Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by NHS and independent contractors

- Receive assurance, including through the Patient Safety Incident Response Framework, that the ICB identifies lessons learned from all relevant sources, including, serious untoward incidents requiring investigation, never events, safety alerts, complaints and claims and ensures that learning is disseminated and embedded

- Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and associated metrics, and that it learns from

Trusts' Learning From Deaths (LFD) reports (including coronial inquests and LFD reports)

- To be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities

- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children (in conjunction with the NENC Integrated Care System Safeguarding Health Executive Group: Children, Adults and Cared for Children sub committee)

- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control

- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services

- Have oversight of and approve the terms of reference and work programmes for any working groups reporting into the Subcommittee

- Approve arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.

5. Authority

The subcommittee is authorised to:	
Investigate	Investigate any activity within its terms of reference.
Seek information	Seek any information it requires within its remit, from any employee or member of the Board.
Commission	Commission reports required to help fulfil its obligations from NECS. Commission reports required to help fulfil its obligations from Audit One or the ICB's external auditors, in consultation with the Executive Director of Finance. Commission other external reports required to help fulfil its obligations, subject to the financial limits of the most senior member of the subcommittee.

The subcommittee is authorised to:	
Obtain advice	Obtain independent professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the sub committee must follow any procedures put in place by the ICB for obtaining professional advice.
Create Groups	Groups may be established by the subcommittee, but they have no formal status. They do not have any delegated authority from the Board. Their decision making is restricted to decisions and limits of individuals as set out in the ICB's financial limits and financial delegations. These may not be aggregated and therefore the limits are those of the most senior member present at any meeting of the group. Groups may be permanent or task and finish groups.

6. Accountability and reporting

The subcommittee is accountable to its parent committee and reports to its parent committee on how it discharges its responsibilities.

Accountabilities	Description
Draft minutes and reports	The secretary formally records the minutes of each meeting. The chair of the subcommittee reports to its parent committee after each meeting and provides a report on assurances received, escalating any concerns, where necessary.
Monitor attendance	Attendance is monitored and profiled as part of the agenda at each subcommittee meeting. Members should aim to attend 100% of meetings and must attend at least 75% of meetings and read all papers beforehand.
Draft annual work plans	The subcommittee produces an annual work plan in consultation with its parent committee.
Conduct annual self-assessment	The subcommittee undertakes an annual self-assessment of its performance against the annual plan and terms of reference. Any resulting proposed changes to the terms of reference are submitted to the parent committee for agreement and action as the 'Establishing Subcommittees' standard operating procedure.

	The subcommittee utilises a continuous improvement approach in its delegation. Members review the effectiveness of the meeting at each sitting.

7. Committee meetings

This section sets out meeting:

- Composition and quoracy
- Frequency and formats
- Procedures

7.1 Composition and quoracy

This section sets out the meeting composition and quoracy requirements.

Composition/ quoracy	Description of expectations
Chair	Director of Nursing (Area)
Deputy Chair	Subcommittee members may appoint a vice chair from amongst the members.
Absence of Chair or Vice Chair	In the absence of the chair, or vice chair, the remaining members present elects one of their number to Chair the meeting.
Membership	The membership will include the following or their deputies as agreed with the Chair: • Director of Nursing (Area) • Medical Director (Area) • Directors of Place (within given Area) • [other members to be agreed in each area] Deputies as agreed by the Chair have the same voting rights as those that they are deputising for. **EDI:** When determining the membership of the group, consideration will be given to diversity and equality. **Involvement:** In determining membership consideration will be given to the need for a patient and public involvement member.

Composition/ quoracy	Description of expectations
	ICS: Membership may be from across the Integrated Care System. However, the balance of membership must sit with the ICB. **Conflicts**: Consideration must be given to material conflicts in the appointment of members.
Attendees and procedure for absence	Only members have the right to attend meetings. Other attendees: The chair may elect to co-opt additional attendees, where it is in the interests of the activities to do so. **Procedure for absence:** Where a member or any regular attendee of the sub committee is unable to attend a meeting, a suitable alternative may be agreed with the chair. The chair may ask any or all of those who normally attend to withdraw to facilitate open and frank discussion of particular matters.
Quoracy and Procedure for Inquoracy	**Threshold:** A minimum of half the membership and where the ICB members present exceeds the other members present. **Absence:** Where members are unable to attend, they should agree this with the chair. **Disqualification:** If any member of the sub committee is disqualified from participating in an item on the agenda, due to a declared conflict of interest, that individual no longer counts towards the quorum. **Inquoracy:** If the quorum is not reached, the meeting may proceed if those members attending agree, but no decisions may be taken.

7.2 Frequency and formats

This section on Sub Committee meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The sub committee will meet bi-monthly.

Frequency/ format	Description
	Additional meetings may be convened on an exceptional basis at the discretion of the sub committee chair. The parent committee chair may ask the sub committee to convene further meetings to discuss particular issues on which they want the sub committee's advice.
Public vs closed	Meetings will be held in private. External Audit, Internal Audit and Local Counter Fraud representatives will have full and unrestricted rights of access to the sub committee.
Virtual meetings and extra-ordinary meetings	In accordance with the Standing Orders, the sub committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

7.3 Procedures

Procedure	Description of rules and expectations:
Agenda	The chair is responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference. Members are expected to identify agenda items for consideration to the chair and any meeting papers using the prescribed format at least 5 working days before the meeting.
Conflicts of interest	**Declarations:** All members and those in attendance must declare any actual, potential, or perceived conflicts of interest. This is recorded in the minutes. **Exclusions:** The subcommittee will follow and apply the ICB's Standards of Business Conduct with regards to the management of conflicts of interest. This means that the chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.
Decision-making	**Decisions:** Decisions are taken in accordance with the Standing Orders and are arrived at by consensus.
Conduct	The subcommittee's conducts its business in accordance with relevant codes of conduct / good governance practice, including the Nolan principles of public life, the ICB

	Standards of Business Conduct Policy, and other relevant policies / guidance on good and proper meeting conduct for NHS organisations

8. Secretariat and administration

This section describes the functions of the secretariat whose role is to support the subcommittee in the following ways:

Functions	Description
Distribute papers	Prepare and distribute the agenda and papers in accordance with the Standing Orders following their agreement by the chair with the support of the relevant executive lead.
Monitor attendance	Monitor the attendance of those invited to each meeting and highlight to the chair those that are not meeting the minimum attendance requirements.
Maintain records	Record conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and to identify new members where necessary.
Minute Taking	Take good quality minutes and agree them with the chair. Keep a record of matters arising, action points and issues to be carried forward.
Support for Chair & Committee	Support the chair in preparing and delivering reports to the parent committee. Take forward action points between meetings and monitor progress against those actions.
Provide updates	Update the subcommittee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for sub committee members

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Appendix 1: Approval History

Version	Date	Approved by	Status
V1.0	28/3/2023	Board TBC	First Issue

Appendix 2: Review History

Version	Date	Reviewed by	Changes Required Y/N?	Summary of changes

Review date: March 2024
Contact: ICB Corporate Governance Team

Document control
The controlled copy of this document is maintained by the governance team in the Governance Handbook, here https://northeastnorthcumbria.nhs.uk/about-us/corporate-information/governance/

Any copies of this document held outside of the Governance Handbook, in whatever format (e.g., paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

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Appendix 8

NHS
North East and
North Cumbria

Integrated Care Board

Safeguarding Health Executive Group:

Children, Adults and Cared for Children Subcommittee

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1. Establishment

The Safeguarding Health Executive Group: Children, Adults and Care for Children Subcommittee (the subcommittee) is established by the Board as a subcommittee of the Quality and Safety Committee, in accordance with the NHS North East and North Cumbria ICB's (hereafter referred to as the ICB) Scheme of Reservation and Delegation (SoRD) and Constitution.

2. Terms of Reference:

Definition of terms: The terms of reference are defined by the ICB.

Amendment: The terms of reference may be amended in accordance with the provisions set out in the Establishing Subcommittees Standard Operating Procedure.

Publication: The terms of reference will be published in the ICB's Governance Handbook which is accessible here: https://northeastnorthcumbria.nhs.uk/about-us/corporate-information/governance/

3. Purpose

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

4. Roles and responsibilities

This section describes the subcommittee's duties, authority, accountability and reporting.

These terms of reference describe the role and responsibilities of the Subcommittee. The functions of the subcommittee do not in any respect or change current ICB and or provider statutory responsibilities. It is also noted that these terms of reference will remain under review as required and in response to Acts or draft legislation where but there is currently no statutory guidance yet published.

4.1 Duties

The subcommittee's duties are as follows:

- To make formal recommendations to the Safeguarding Partnerships /Adult Boards as per the health governance structure on future

commissioning arrangements for safeguarding, including any proposed changes to delegated decision making

- To make formal recommendations to the Safeguarding Partnerships/Adult Boards, ICB Quality and Safety Committee and Board and Integrated Care Partnership (ICP) as appropriate and local organisations on future provision and delivery of safeguarding services
- Provide a single strategic oversight body providing assurance to the Safeguarding Partnerships/Adult Boards, ICB and ICP and local organisations on quality, outcomes, finance, and performance.
- Be an active voice and partner in shaping the proposal and implementation of an overall strategic programme of work to deliver the ambitions, priorities, and plans for safeguarding (endorsed with Safeguarding Partnerships/Adult Boards).
- To provide health executive leadership for safeguarding, facilitating and promoting joint working and best practice within and across the whole North East North Cumbria Integrated Care System
- To enable Subcommittee members to provide a strategic link back to the ICB Quality and Safety Committee and Board, ICP and local organisations ensuring that the programme has a strong balance between strategic leadership and local system delivery
- To provide assurance to the Safeguarding Partnerships/Adult Boards, ICB Quality and Safety Committee and Board, ICP and local organisations as appropriate on the discharging of statutory duties in-line with the legislative requirements
- To make formal recommendations to the ICB Quality and Safety Committee, Board, ICP and local organisations as appropriate on any proposed investments/disinvestments in safeguarding arrangements
- To seek assurance on safeguarding compliance and delivery and hold the Senior Safeguarding Leadership Group and Collaborative Forums to account on delivering the strategy and priorities agreed by the ICB and Partnership Boards.

In addition, it will be the responsibility of each local organisation and ICB representative to ensure that information and reporting on progress and outcomes is disseminated in line with the agreed arrangements and the ICB governance framework. All parties will ensure relevant wider stakeholder engagement is in place.

4.2 Roles

The role of the members of the Subcommittee is to:

- Provide strategic leadership to the programme being open and transparent in the pursuit for system improvement

- To ensure that there is a coordinated programme to progress commissioning for improved quality and outcomes.

5. Authority

The subcommittee is authorised to:	
Investigate	Investigate any activity within its terms of reference.
Seek information	Seek any information it requires within its remit, from any employee or member of the Board.
Investigate	Commission reports required to help fulfil its obligations from NECS. Commission reports required to help fulfil its obligations from Audit One or the ICB's external auditors, in consultation with the Executive Director of Finance. Commission other external reports required to help fulfil its obligations, subject to the financial limits of the most senior member of the sub committee.
Obtain advice	Obtain independent professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the sub committee must follow any procedures put in place by the ICB for obtaining professional advice.
Create Groups	Groups may be established by the sub committee, but they have no formal status. They do not have any delegated authority from the Board. Their decision making is restricted to decisions and limits of individuals as set out in the ICB's Financial Limits and Financial Delegations. These may not be aggregated and therefore the limits are those of the most senior member present at any meeting of the group. Groups may be permanent or task and finish groups.

6. Accountability and reporting

The subcommittee is accountable to its parent committee and reports to its parent committee on how it discharges its responsibilities.

Accountabilities	Description
Draft minutes and reports	The subcommittee receives scheduled assurance reports from its established groups. The secretary formally records the minutes of each meeting. The chair of the subcommittee reports to its parent committee after each meeting and provides a report on assurances received, escalating any concerns, where necessary.
Monitor attendance	Attendance is monitored and profiled as part of the agenda at each subcommittee meeting. Members should aim to attend 100% of meetings and must attend at least 75% of meetings and read all papers beforehand.
Draft annual work plans	The subcommittee produces an annual work plan in consultation with its parent committee.
Conduct annual self-assessment	The subcommittee undertakes an annual self-assessment of its performance against the annual plan and terms of reference. Any resulting proposed changes to the terms of reference are submitted to the parent committee for agreement and action as the 'Establishing Sub Committees' SoP. The subcommittee utilises a continuous improvement approach in its delegation. Members review the effectiveness of the meeting at each sitting.
Annual Report	The subcommittee provides its parent committee with an annual report, timed to support finalisation of the accounts and the governance statement. The report includes: • The governance cycle • A summary of the business conducted, • Frequency of meetings, membership attendance, and quoracy • The committee's self-assessment

7. Committee meetings

This section sets out meeting:

- Composition and quoracy
- Frequency and formats
- Procedures

7.1 Composition and quoracy

This section sets out the meeting composition and quoracy requirements.

Composition/ quoracy	Description of expectations
Chair	ICB Executive Chief Nurse
Deputy Chair	Subcommittee members may appoint a vice chair from amongst the members.
Absence of Chair or Vice Chair	In the absence of the chair, or vice chair, the remaining members present elects one of their number to Chair the meeting.
Membership	Members: • ICB Executive Chief Nurse • ICB Strategic Safeguarding Lead /ICB Director of Nursing (North) • ICB Director of Nursing (South) • NHS England Regional Lead • Nominated Designated Nurse (Children) • Nominated Designated Nurse (Adults) • Nominated Designated Doctor • Nominated Cared for Children lead • Nominated Head/Director of Midwifery • Acute/Community Provider Executive Directors of Nursing • NEAS Director of Nursing and Quality • NWAS NEAS Director of Nursing and Quality • Mental Health Provider Executive Director of Nursing • Named GP Safeguarding Lead **EDI:** When determining the membership of the subcommittee, consideration will be given to diversity and equality. **Involvement:** In determining membership consideration will be given to the need for a patient and public involvement member. **ICS:** Membership may be from across the Integrated Care System. However, the balance of decision making must sit with the ICB. **Conflicts**: Consideration must be given to material conflicts in the appointment of members.
Attendees and procedure for absence	Only members have the right to attend meetings. Other attendees: The chair may elect to co-opt additional attendees, where it is in the interests of the activities to do so.

Composition/ quoracy	Description of expectations
	Procedure for absence: Where a member or any regular attendee of the subcommittee is unable to attend a meeting, a suitable alternative may be agreed with the chair. The chair may ask any or all of those who normally attend to withdraw to facilitate open and frank discussion of particular matters.
Quoracy and Procedure for Inquoracy	**Threshold:** A minimum of half the membership and where the ICB members present exceeds the other members present. **Absence:** Where members are unable to attend, they should agree this with the chair. **Disqualification:** If any member of the subcommittee is disqualified from participating in an item on the agenda, due to a declared conflict of interest, that individual no longer counts towards the quorum. **Inquoracy:** If the quorum is not reached, the meeting may proceed if those members attending agree, but no decisions may be taken.

7.2 Frequency and formats

This section on Sub Committee meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The subcommittee will meet bi-monthly Additional meetings may be convened on an exceptional basis at the discretion of the subcommittee chair. The parent committee chair may ask the subcommittee to convene further meetings to discuss particular issues on which they want the sub committee's advice.
Public vs closed	Where this is warranted by the nature of the business arising, the agenda may be divided into two parts. Part 1 is open to the whole subcommittee, including invited attendees. Part 2 is a closed session for members only to discuss confidential information.

Frequency/ format	Description
	External Audit, Internal Audit and Local Counter Fraud representatives will have full and unrestricted rights of access to the subcommittee.
Virtual meetings and extra-ordinary meetings	In accordance with the Standing Orders, the subcommittee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

7.3 Procedures

Procedure	Description of rules and expectations:
Agenda	The chair is responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference. Members are expected to identify agenda items for consideration to the chair and any meeting papers using the prescribed format at least 5 working days before the meeting.
Conflicts of interest	**Declarations:** All members and those in attendance must declare any actual, potential, or perceived conflicts of interest. This is recorded in the minutes. **Exclusions:** The subcommittee will follow and apply the ICB's Standards of Business Conduct with regards to the management of conflicts of interest. This means that the chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.
Decision-making	**Decisions:** Decisions are taken in accordance with the Standing Orders and are arrived at by consensus.
Conduct	The sub committee's conducts its business in accordance with relevant codes of conduct / good governance practice, including the Nolan principles of public life, the ICB Standards of Business Conduct Policy, and other relevant policies / guidance on good and proper meeting conduct for NHS organisations

8. Secretariat and administration

This section describes the functions of the secretariat whose role is to support the subcommittee in the following ways:

Functions	Description
Distribute papers	Prepare and distribute the agenda and papers in accordance with the Standing Orders following their agreement by the chair with the support of the relevant executive lead.
Monitor attendance	Monitor the attendance of those invited to each meeting and highlight to the chair those that are not meeting the minimum attendance requirements.
Maintain records	Record conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and to identify new members where necessary.
Minute Taking	Take good quality minutes and agree them with the chair. Keep a record of matters arising, action points and issues to be carried forward.
Support for Chair & Committee	Support the chair in preparing and delivering reports to the parent committee. Take forward action points between meetings and monitor progress against those actions.
Provide updates	Update the subcommittee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for subcommittee members

Appendix 1: Approval History

Version	Date	Approved by	Status
V1.0	28/3/2023	Board TBC	First Issue

Appendix 2: Review History

Version	Date	Reviewed by	Changes Required Y/N?	Summary of changes

Review date: March 2024
Contact: Louise Mason-Lodge, ICB Director of Nursing

Document control

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Appendix 9

North East and North Cumbria

Integrated Care Board

Antimicrobial Resistance (AMR) and Healthcare Associated Infection (HCAI) Sub committee

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1. Establishment

The Antimicrobial Resistance (AMR) and Healthcare Associated Infection (HCAI) Subcommittee is a subcommittee of the Quality and Safety Committee as established by the Board, in accordance with the NHS North East and North Cumbria's (hereafter referred to as the ICB) Scheme of Reservation and Delegation (SoRD) and Constitution.

2. Terms of reference:

Definition of terms: The terms of reference are defined by the ICB.

Amendment: The terms of reference may be amended in accordance with the provisions set out in this SOP (Establishing Sub Committees).

Publication: The terms of reference will be published in the ICB's Governance Handbook which is accessible here: https://northeastnorthcumbria.nhs.uk/about-us/corporate-information/governance/

3. Purpose

The purpose is of the subcommittee is to support the Quality and Safety Committee to discharge its duties relating to is to bring 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 Antimicrobial Resistance/ Health care Associated Infections (AMR/ HCAI), particularly Gram-negative blood stream infections (GNBSI), Clostridium difficile and Methicilin-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.

4. Roles and responsibilities

This section describes the sub committee's duties, authority, accountability and reporting.

4.1 Duties

The subcommittee's duties are as follows:

a. Delivering the NENC ICS Infection Prevention and Control strategy 2021-2024 which reflects and is aligned to the UK's five-year action plan

b. Delivering a standard quality assurance framework, based on the Health and Social Care Act 2008 Code of Practice and the National Institute for

Health and Care Excellence Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use - Baseline Assessment Tool, across all health and social care organisations

c. Facilitating the harmonisation of local AMR / HCAI plans and delivery frameworks across NENC to ensure coordination of efforts by primary, secondary and social care

d. Aligning improvement efforts across public health, primary and secondary health care, and social care demonstrating clear system leadership and linked to the ICS

e. Ensuring that robust management systems are in place and that effective infection prevention and control (IPC) processes are applied consistently across all NENC organisations in line with national evidence-based policy, guidance, and regulation

f. Prior to approval contribute to the development of new systems to provide antibiotics by Patient Group Directions

g. Engaging with the Academic Health Sciences Network (AHSN) to support unmet needs and innovation influencing future evaluation and audit

h. Ensuring escalation of quality concerns regarding AMR/HCAI through Quality and Safety Committee or Medicines Subcommittee as appropriate and supporting ongoing delivery of the quality monitoring and quality improvement functions as part of the developing ICB governance arrangements

i. Ensuring organisational cultures, human factors, change, and behaviour theories are considered throughout

j. Working in partnership with social care and the care sector

k. Supporting the ICB Senior Responsible Officer (SRO) for Infection Prevention and Control and Antimicrobial Resistance IPC and AMR.

<u>Objectives and Key Result Areas:</u>

l. Along with the Medicines Subcommittee, lead the development of an ICS AMR/ HCAI strategy for approval by the Quality and Safety Committee

m. Agreeing actions to support the delivery of the strategy

n. Evaluating the impact of the agreed actions through surveillance and audit

o. Oversight of the delivery and assurance of the national Education and Training Framework

p. Development of standardised meaningful performance indicators

q. Drafting communications and engagement programmes for issue by the ICB Communications Team to ensure consistent delivery of HCAI/IPC communications messaging across the NENC ICS

r. Monitoring and reviewing relevant data to ensure early identification of quality concerns

s. Focus on quality improvement across the whole system

t. Disseminate learning nationally, regionally and locally ensuring learning is shared and the implications for future practice are considered

u. Foster greater collaboration and partnership working to deliver the AMR / HCAI ambition across NENC

v. Recommend commissioning specifications and contracts ensuring reference to emerging AMR/HCAI knowledge for decision by the Executive Committee

w. Recommend strategic guidance to the ICB and ICS via the optimising health and/or prevention ICS workstreams and through the Quality and Safety Committee

x. Ensure the development of robust mechanisms for surveillance and monitoring of AMR/HCAI

y. Maintain collaborative interfaces and partnership working regarding AMR/HCAI across health and social care, including the independent sector

z. Maintain a high profile in AMR/HCAI achievement to facilitate increasing public confidence

5. Authority

The subcommittee is authorised to:	
Investigate	Investigate any activity within its terms of reference.
Seek information	Seek any information it requires within its remit, from any employee or member of the Board.
Investigate	Commission reports required to help fulfil its obligations from NECS. Commission reports required to help fulfil its obligations from Audit One or the ICB's external auditors, in consultation with the Executive Director of Finance. Commission other external reports required to help fulfil its obligations, subject to the financial limits of the most senior member of the sub committee.
Obtain advice	Obtain independent professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the sub committee must follow any procedures put in place by the ICB for obtaining professional advice.
Create Groups	Groups may be established by the subcommittee, but they have no formal status. They do not have any delegated authority from the Board. Their decision making is restricted to decisions and limits of individuals as set out in the ICB's Financial Limits and Financial Delegations. These may not be aggregated and therefore the limits are those of the most senior member present at any meeting of the group. Groups may be permanent or task and finish groups.

6. Accountability and reporting

The subcommittee is accountable to its parent committee and reports to its parent committee on how it discharges its responsibilities.

Accountabilities	Description
Draft minutes and reports	The subcommittee receives scheduled assurance reports from its established groups. The secretary formally records the minutes of each meeting. The chair of the subcommittee reports to its parent committee after each meeting and provides a report on assurances received, escalating any concerns, where necessary.
Monitor attendance	Attendance is monitored and profiled as part of the agenda at each subcommittee meeting. Members should aim to attend 100% of meetings and must attend at least 75% of meetings and read all papers beforehand.
Draft annual work plans	The sub committee produces an annual work plan in consultation with its parent committee.
Conduct annual self-assessment	The subcommittee undertakes an annual self-assessment of its performance against the annual plan and terms of reference. Any resulting proposed changes to the terms of reference are submitted to the parent committee for agreement and action as the Establishing Sub Committees Standard Operating Procedure. The subcommittee utilises a continuous improvement approach in its delegation. Members review the effectiveness of the meeting at each sitting.
Annual Report	The subcommittee provides its parent committee with an annual report, timed to support finalisation of the accounts and the governance statement. The report includes: • The governance cycle • A summary of the business conducted, • Frequency of meetings, membership attendance, and quoracy • The committee's self-assessment

7. Committee meetings

This section sets out meeting:

- Composition and quoracy
- Frequency and formats
- Procedures

7.1 Composition and quoracy

This section sets out the meeting composition and quoracy requirements.

Composition/ quoracy	Description of expectations
Chair	Appointed for their specific knowledge skills and experience and suitability. (Note: does not need to be a member of the ICB board)
Deputy Chair	Sub committee members may appoint a vice chair from amongst the members.
Absence of Chair or Vice Chair	In the absence of the chair, or vice chair, the remaining members present elects one of their number to Chair the meeting.
Membership	The membership will include the following or their deputies as agreed with the Chair: • ICB Senior Responsible Officer for AMR/IPC (Chair) • Chairs of the Sub Committee working groups • Representative from Nursing and Quality team –NENC • NHSE Representative, Specialised Commissioning Health and Justice • Place based representation - commissioners and provider trusts including Mental Health and Ambulance Trust Representative • Representative Microbiologist • UK Health Security Agency Consultant in Health Protection Representative of ICB / NECS Medicines team • Representative Director of Public Health • Representative Director of Adult Social Services • Representative from Health Education England (North East) • Representative from local authority commissioner group • Representative from Academic Health Science Network) AHSN • Representative from NENC IPC Nurse Forum • NHSE regional IPC lead • NHSE AMR Prescribing lead

Composition/ quoracy	Description of expectations
	Deputies as agreed by the Chair have the same voting rights as those that they are deputising for. **EDI:** When determining the membership of the sub committee, consideration will be given to diversity and equality. **Involvement:** In determining membership consideration will be given to the need for a patient and public involvement member. **ICS:** Membership may be from across the Integrated Care System. However, the balance of decision making must sit with the ICB. **Conflicts**: Consideration must be given to material conflicts in the appointment of members.
Attendees and procedure for absence	Only members have the right to attend meetings. Each member will attend or send a senior appropriate delegate to each of the meeting to ensure that the agenda and programmes of work move forward within agreed timescales. Each member will ensure that there is a system in place to share information from their organisation and/or professional group and cascade information within their organisation/professional group Other attendees: The chair may elect to co-opt additional attendees, where it is in the interests of the activities to do so. **Procedure for absence:** Where a member or any regular attendee of the sub committee is unable to attend a meeting, a suitable alternative may be agreed with the chair. The chair may ask any or all of those who normally attend to withdraw to facilitate open and frank discussion of particular matters.
Quoracy and Procedure for Inquoracy	**Threshold:** A minimum of half the membership which must include an ICB member. **Absence:** Where members are unable to attend, they should agree this with the chair.

Composition/ quoracy	Description of expectations
	Disqualification: If any member of the sub committee is disqualified from participating in an item on the agenda, due to a declared conflict of interest, that individual no longer counts towards the quorum. **Inquoracy:** If the quorum is not reached, the meeting may proceed if those members attending agree, but no decisions may be taken.

7.2 Frequency and formats

This section on Subcommittee meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The subcommittee will meet monthly, and at least 10 times in a calendar year. Additional meetings may be convened on an exceptional basis at the discretion of the subcommittee chair. The parent committee chair may ask the subcommittee to convene further meetings to discuss particular issues on which they want the sub committee's advice.
Public vs closed	Meetings will be held in private. External Audit, Internal Audit and Local Counter Fraud representatives will have full and unrestricted rights of access to the subcommittee.
Virtual meetings and extra-ordinary meetings	In accordance with the Standing Orders, the subcommittee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

7.3 Procedures

Procedure	Description of rules and expectations:
Agenda	The chair is responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

	Members are expected to identify agenda items for consideration to the chair and any meeting papers using the prescribed format at least 5 working days before the meeting.
Conflicts of interest	**Declarations:** All members and those in attendance must declare any actual, potential, or perceived conflicts of interest. This is recorded in the minutes. **Exclusions:** The sub committee will follow and apply the ICB's Standards of Business Conduct with regards to the management of conflicts of interest. This means that the chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.
Decision-making	**Decisions:** Decisions are taken in accordance with the Standing Orders and are arrived at by consensus.
Conduct	The sub committee's conducts its business in accordance with relevant codes of conduct / good governance practice, including the Nolan principles of public life, the ICB Standards of Business Conduct Policy, and other relevant policies / guidance on good and proper meeting conduct for NHS organisations

8. Secretariat and administration

This section describes the functions of the secretariat whose role is to support the subcommittee in the following ways. The secretariat will be provided by NHS England and in addition to the functions listed in the table below will provide:

- Facilities and technology to support the effective operation of the Board
- Co-ordinate meeting agendas and papers,
- Provide a record of the discussions and agreed actions and maintaining suitable records.

Functions	Description
Distribute papers	Prepare and distribute the agenda and papers in accordance with the Standing Orders following their agreement by the chair with the support of the relevant executive lead.
Monitor attendance	Monitor the attendance of those invited to each meeting and highlight to the chair those that are not meeting the minimum attendance requirements.
Maintain records	Record conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and to identify new members where necessary.
Minute Taking	Take good quality minutes and agree them with the chair. Keep a record of matters arising, action points and issues to be carried forward.
Support for Chair & Committee	Support the chair in preparing and delivering reports to the parent committee. Take forward action points between meetings and monitor progress against those actions.
Provide updates	Update the sub committee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for sub committee members

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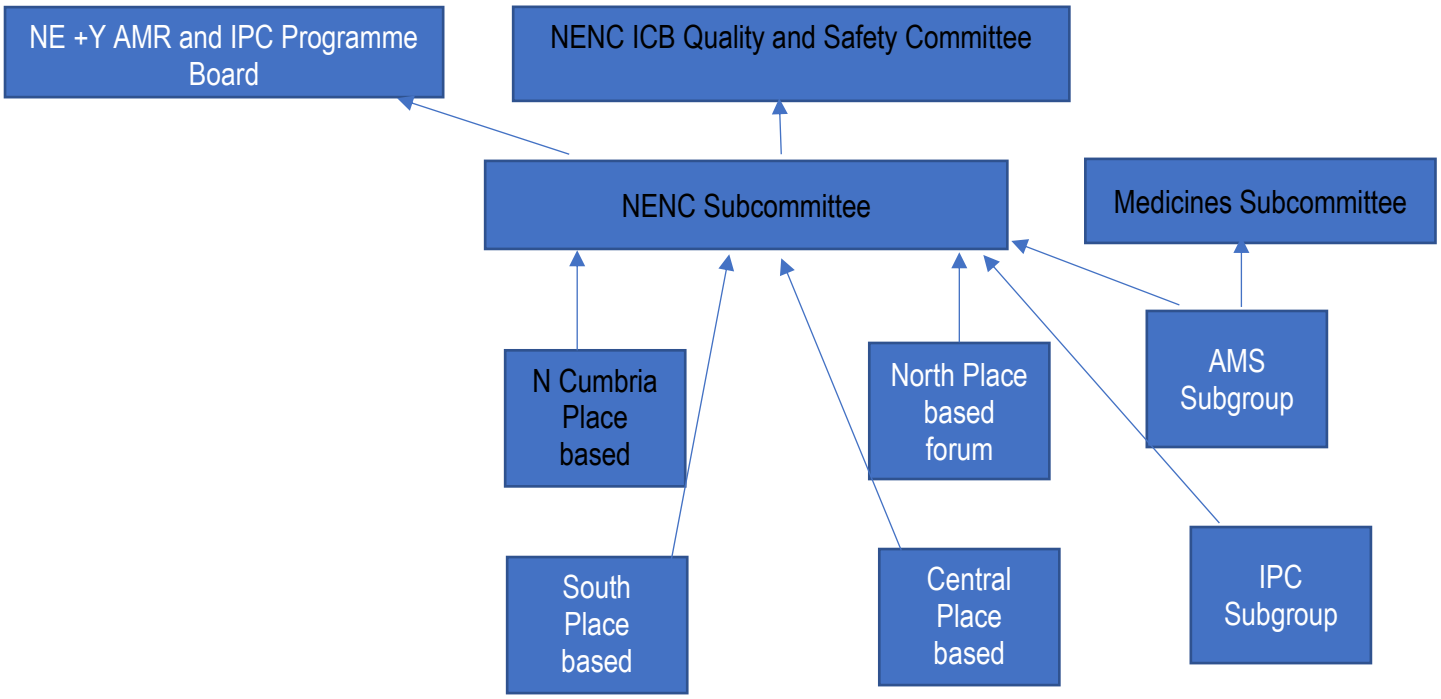
Governance mechanisms 2023:



For future editing, please note that this has been created in Paint 3D

Appendix 1: Approval History

Version	Date	Approved by	Status
V1.0	28/3/2023	Board TBC	First Issue

Appendix 2: Review History

Version	Date	Reviewed by	Changes Required Y/N?	Summary of changes

Review date:
Contact: Chris Piercy, Director of Nursing NENC ICB, SRO AMR IPC

Document control
The controlled copy of this document is maintained by the governance team in the Governance Handbook, here https://northeastnorthcumbria.nhs.uk/about-us/corporate-information/governance/

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Appendix 10

NHS
North East and
North Cumbria

Integrated Care Board

Primary Care Strategy and Delivery Subcommittee

Terms of Reference

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1. Establishment

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), and, the Health and Care Act 2022, NHS England has delegated to ICBs the exercise of the functions specified in the Delegation Agreement.

The Primary Care Strategy and Delivery Sub Group is a sub committee of the Executive Committee as established by the Board, in accordance with the NHS North East and North Cumbria's (hereafter referred to as the ICB) Scheme of Reservation and Delegation (SoRD) and Constitution. The governance arrangements are depicted at Appendix 1.

2. Terms of reference:

Definition of terms: The terms of reference are defined by the ICB.

Amendment: The terms of reference may be amended in accordance with the provisions set out in this SOP (Establishing Sub Committees).

Publication: The terms of reference will be published in the ICB's Governance Handbook which is accessible here: https://northeastnorthcumbria.nhs.uk/about-us/corporate-information/governance/

3. Purpose

The purpose is of the subcommittee is to support the Executive Committee to discharge its duties relating to primary care.

4. Roles and responsibilities

This section describes the sub committee's duties, authority, accountability and reporting.

4.1 Duties

The scope of the sub committee's duties is as follows:

Primary Medical Services
All decisions except those delegated by the Board to Place Sub Committees or individuals

Pharmacy
All decisions except those delegated by the Board to the Pharmaceutical Service Regulations (sub) Committee (PSRC).

Ophthalmology
All commissioning and contracting decisions

Dentistry

All commissioning and contracting decisions

The duties of the Primary Care Strategy and Delivery Subcommittee are listed below:

ALL PRIMARY CARE SERVICES

Reference	Delegation
1	Occupational health contract commissioning and management
2	Escalation of disputes
3	Forward plans for all functions
4	Enabler plans for all functions including estates, workforce and digital
5	Local professional network proposals (for decision)
6	Decisions in respect of Quality Assurance Frameworks
7	Commissioning needs analysis and commissioning of ad-hoc primary care services
8	Decisions in respect of investigations (commencement and outcome excluding Primary Medical Care Services)
9	Clinical Waste contract commissioning and management

OPTOMETRY

Reference	Delegation
1	Primary Care Audits - Assurance Framework outcome
2	Optometry National & Local Enhanced Services commissioning and contracting
3	New optometry contracts
4	Variations decisions affecting existing contracts

DENTISTRY

Reference	Delegation
1	Commissioning needs analysis for dental services
2	Primary Care Audits - Assurance Framework
3	Dental National & Local Enhanced Services commissioning and contracting
4	New dental contracts
5	Variations decisions affecting existing contracts

PHARMACY

Reference	Delegation
1	Primary Care Audits- Community Pharmaceutical Assurance Framework (CPAF)
2	Community Pharmacy National & Local Enhanced Services commissioning and contracting
3	Pharmacy Integration Fund decisions

PRIMARY MEDICAL SERVICES

Reference	Delegation
1	Decision to procure a new Primary Medical Services contract[1]
2	Decision to award (following procurement) of a new Primary Medical Services contract[1]
3	Interface and management of assurance to ICB Executive - ICB wide strategy development and delivery oversight
4	Govern and manage assurance of delegated commissioning from Place to ensure the ICB meets its duties in relation to delegation
5	Strategic oversight of Place operational planning, delivery and management in respect of Primary Medical Services
6	Interface and management of assurance to NHS E N&Y region
7	Clinical waste contract oversight (General Practice)
8	National funding scheme development and oversight
9	Quality and Outcomes Framework (QOF) annual sign off of scheme and approval of payments
10	Manage the design (where applicable) and commissioning of any regional services, including re-commissioning these services annually where appropriate
11	Decision making and budget management regarding primary care estates strategies and overarching revenue consequences
12	Decision making and budget management regarding primary care GPIT
13	Revenue decisions relating to premises (affecting more than one Place)
14	Decisions escalated from Place where it exceeds financial limits and risk

Notes

[1] For contracts up to 5 years see Appendix 2a of SORD.

General Note

Any matter in relation to the primary medical delegated functions which is novel, contentious or repercussive must be referred to the ICB Chief Executive or Executive Director of Finance or ICB Chair (see Appendix 2a of SORD)

5. Authority

The subcommittee is authorised to:	
Investigate	Investigate any activity within its terms of reference.
Seek information	Seek any information it requires within its remit, from any employee or member of the Board.
Investigate	Commission reports required to help fulfil its obligations from NECS. Commission reports required to help fulfil its obligations from Audit One or the ICB's external auditors, in consultation with the Executive Director of Finance. Commission other external reports required to help fulfil its obligations, subject to the financial limits of the most senior member of the sub committee.
Obtain advice	Obtain independent professional advice and secure the attendance of advisors with relevant expertise to fulfil its functions. In doing so, the sub committee must follow any procedures put in place by the ICB for obtaining professional advice.
Create Groups	Groups may be established by the sub committee, but they have no formal status. They do not have any delegated authority from the Board. Their decision making is restricted to decisions and limits of individuals as set out in the ICB's Financial Limits and Financial Delegations. These may not be aggregated and therefore the limits are those of the most senior member present at any meeting of the group. Groups may be permanent or task and finish groups.

6. Accountability and reporting

The subcommittee is accountable to the Executive Committee and reports to the Executive Committee on how it discharges its responsibilities.

Accountabilities	Description
Draft minutes and reports	The subcommittee receives scheduled assurance reports from its established groups. The secretary formally records the minutes of each meeting. The chair of the subcommittee reports to its parent committee after each meeting and provides a report on assurances received, escalating any concerns, where necessary.
Monitor attendance	Attendance is monitored and profiled as part of the agenda at each subcommittee meeting. Members should aim to attend 100% of meetings and must attend at least 75% of meetings and read all papers beforehand.
Draft annual work plans	The subcommittee produces an annual work plan in consultation with its parent committee.
Conduct annual self-assessment	The subcommittee undertakes an annual self-assessment of its performance against the annual plan and terms of reference. Any resulting proposed changes to the terms of reference are submitted to the parent committee for agreement and action as the 'Establishing Subcommittees' standard operating procedure. The subcommittee utilises a continuous improvement approach in its delegation. Members review the effectiveness of the meeting at each sitting.
Annual Report	The subcommittee provides the Executive Committee with an annual report, timed to support finalisation of the accounts and the governance statement. The report includes: • The governance cycle • A summary of the business conducted, • Frequency of meetings, membership attendance, and quoracy • The committee's self-assessment

7. Committee meetings

This section sets out meeting:

- Composition and quoracy
- Frequency and formats
- Procedures

7.1 Composition and quoracy

This section sets out the meeting composition and quoracy requirements.

Composition/ quoracy	Description of expectations
Chair	Appointed for their specific knowledge skills and experience and suitability. (Note: does not need to be a member of the ICB board)
Deputy Chair	Sub committee members may appoint a vice chair from amongst the members.
Absence of Chair or Vice Chair	In the absence of the chair, or vice chair, the remaining members present elects one of their number to Chair the meeting.
Membership	Core Members: Executive Area Director (s) (Chair) Finance Director Medical Director Director of Medicines and Pharmacy Director of Place (1 x North and 1 x South) – representatives will be on a rolling 12-month basis Director of Transformation (Primary Care) Head of Primary Care Head of Primary Care Transformation Non-core members – attending for specific items/sections of the Committee as appropriate Senior Primary Care Manager (Pharmacy and Optometry) Senior Primary Care Manager (Dental) Senior Primary Care Manager (GP Commissioning and Transformation) Representative of Nursing and Clinical Quality Representative of Estates and Premises Representative of Primary Care Digital Representative of Workforce Deputies may be agreed with the Chair, and where agreed deputies will have the same voting rights as members. **EDI:** When determining the membership of the sub committee, consideration will be given to diversity and equality.

Composition/ quoracy	Description of expectations
	Involvement: In determining membership consideration will be given to the need for a patient and public involvement member. **ICS:** Membership may be from across the Integrated Care System. However, the balance of decision making must sit with the ICB. **Conflicts**: Consideration must be given to material conflicts in the appointment of members.
Attendees and procedure for absence	Only core members have the right to attend meetings. Non-core members: The chair may elect to co-opt additional attendees, where it is in the interests of the activities to do so. **Procedure for absence:** Where a member or any regular attendee of the sub committee is unable to attend a meeting, a suitable alternative may be agreed with the chair. The chair may ask any or all of those who normally attend to withdraw to facilitate open and frank discussion of particular matters.
Quoracy and Procedure for Inquoracy	**Threshold:** Either Chair or Deputy Chair to be present plus a minimum of half the membership **Absence:** Where members are unable to attend, they should agree this with the chair. **Disqualification:** If any member of the sub committee is disqualified from participating in an item on the agenda, due to a declared conflict of interest, that individual no longer counts towards the quorum. **Inquoracy:** If the quorum is not reached, the meeting may proceed if those members attending agree, but no decisions may be taken.

7.2 Frequency and formats

This section on Sub Committee meetings describes the meeting frequency and formats.

Frequency/ format	Description
Meeting frequency	The subcommittee will meet monthly and must meet a minimum of 10 times per year. Additional meetings may be convened on an exceptional basis at the discretion of the subcommittee chair. The parent committee chair may ask the subcommittee to convene further meetings to discuss particular issues on which they want the subcommittee's advice.

Frequency/ format	Description
Public vs closed	Meetings will be held in private. External Audit, Internal Audit and Local Counter Fraud representatives will have full and unrestricted rights of access to the subcommittee.
Virtual meetings and extra-ordinary meetings	In accordance with the Standing Orders, the subcommittee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

7.3 Procedures

Procedure	Description of rules and expectations:
Agenda	The chair is responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference. Members are expected to identify agenda items for consideration to the chair and any meeting papers using the prescribed format at least 5 working days before the meeting.
Conflicts of interest	**Declarations:** All members and those in attendance must declare any actual, potential, or perceived conflicts of interest. This is recorded in the minutes. **Exclusions:** The sub committee will follow and apply the ICB's Standards of Business Conduct with regards to the management of conflicts of interest. This means that the chair will consider the exclusion of members and / or attendees from discussion and / or decision-making if individuals have a relevant material or perceived interest in a matter under consideration.
Decision-making	**Decisions:** Decisions are taken in accordance with the Standing Orders and are arrived at by consensus.
Conduct	The sub committee's conducts its business in accordance with relevant codes of conduct / good governance practice, including the Nolan principles of public life, the ICB Standards of Business Conduct Policy, and other relevant policies / guidance on good and proper meeting conduct for NHS organisations

8. Secretariat and administration

This section describes the functions of the secretariat whose role is to support the sub committee in the following ways:

Functions	Description
Distribute papers	Prepare and distribute the agenda and papers in accordance with the Standing Orders following their agreement by the chair with the support of the relevant executive lead.
Monitor attendance	Monitor the attendance of those invited to each meeting and highlight to the chair those that are not meeting the minimum attendance requirements.
Maintain records	Record conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and to identify new members where necessary.
Minute Taking	Take good quality minutes and agree them with the chair. Keep a record of matters arising, action points and issues to be carried forward.
Support for Chair & Committee	Support the chair in preparing and delivering reports to the parent committee. Take forward action points between meetings and monitor progress against those actions.
Provide updates	Update the sub committee on pertinent issues/ areas of interest/ policy developments.
Governance advice	Provide easy access to governance advice for sub committee members

Appendix 1: Approval History

Version	Date	Approved by	Status
V1.0	28/3/2023	Board (TBC)	First Issue

Appendix 2: Review History

Version	Date	Reviewed by	Changes Required Y/N?	Summary of changes

Review date: 01 October 2023 (annually thereafter)
Contact: ICB Corporate Governance Team

Document control
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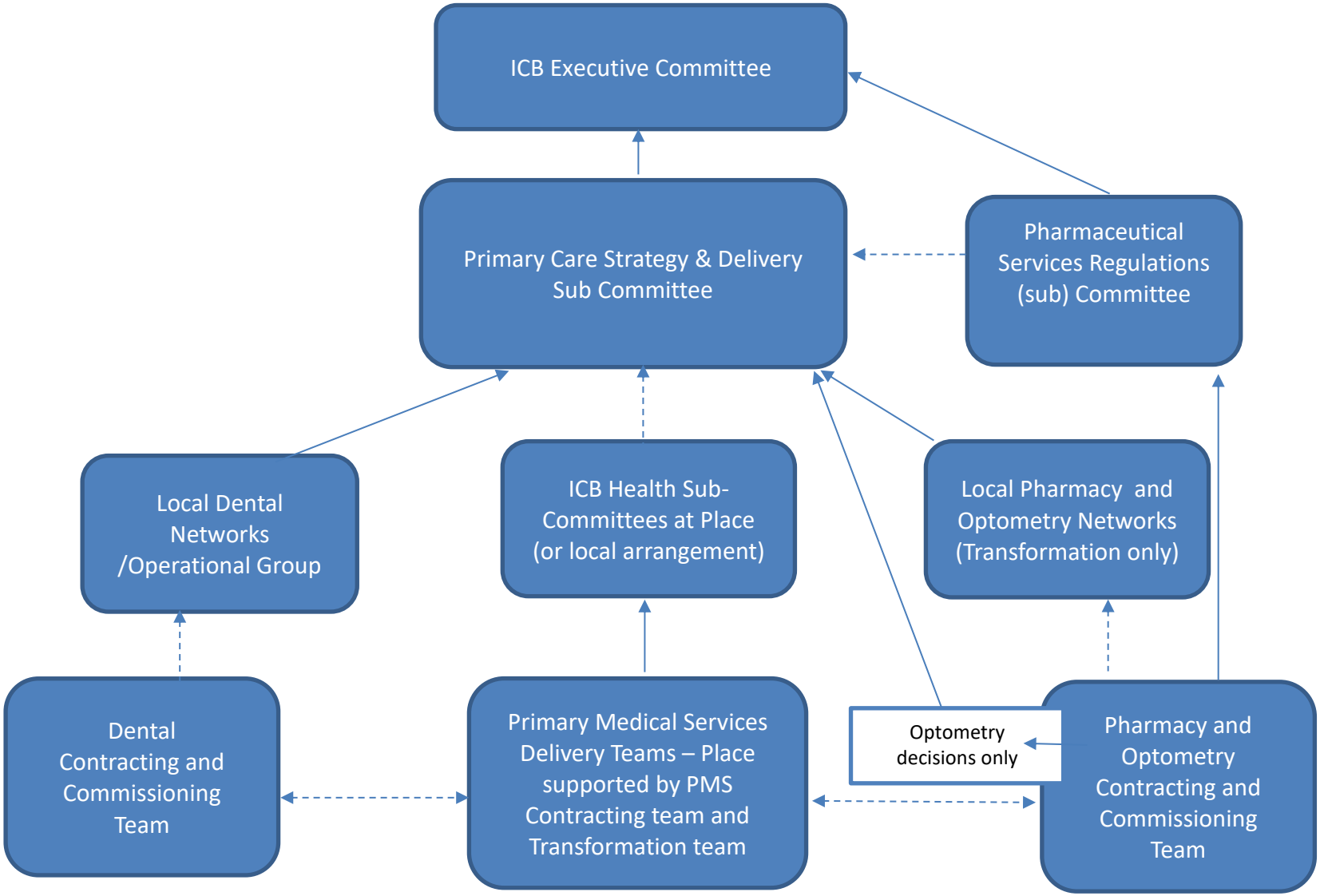
Annex 1 – Governance and Decision Making



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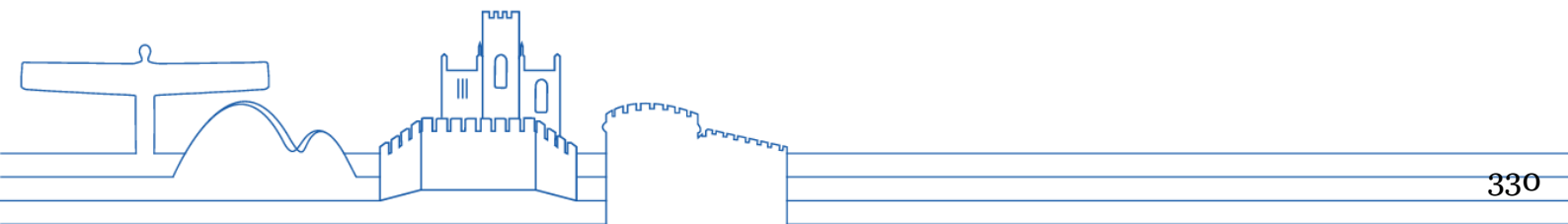
Appendix 11

North East and North Cumbria

Integrated Care Board

Pharmaceutical Services Regulations [Sub] Committee Terms of reference



1. Constitution

NHS England has established local committees to be known as Pharmaceutical Services Regulations Committees (PSRCs). Each PSRC is authorised by NHS England to undertake any activity within these terms of reference (ToRs).

ICBs are required to establish committees that are the equivalent of NHS England's PSRCs as part of the delegation arrangements for ICBs to undertake the commissioning of community pharmacy services on behalf of NHS England. Where such a subcommittee is established and is properly constituted in line with the Regulations, it is authorised by NHS England to undertake any activity within these ToRs.

For the purpose of this document, 'the committee' or 'committee' is either the PSRC or the ICB equivalent.

NHS England has delegated decision-making to each committee in relation to the maters under the Regulations listed in the Pharmacy Manual where the decision-maker is listed as the committee.

2. Authority

The PSRC is a formal Subcommittee of the ICB Executive Committee. The Board has delegated authority to the Subcommittee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The PSRC holds only those powers as delegated in these terms of reference (as defined by the Pharmacy Manual (Version 2, 10 February 2023) and approved by the ICB Board.

The PSRC will determine all matters within its ToRs and is authorised by the ICB to obtain such outside legal or other independent professional advise and to co-opt persons with the relevant experience and expertise if it considers this necessary. Co-opted persons will not have voting rights and if required by the Chair will leave the meeting whilst the decision is made.

3. Purpose of the Committee

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').

4. Membership and Attendance

The PSRC members shall be appointed by the Board in accordance with the ICB Constitution and in line NHS (Pharmaceutical and Local Pharmaceutical Services) Regulation 2013.

In line with the above requirements the Board will appoint the following to be the membership of the PSRC:

- Head of Primary Care (or their suitable, nominated deputy) who will Chair the meeting (Chair)
- Executive Area Director (Senior Responsible Officer (SRO)) who will chair the meeting in the absence of the Head of Primary Care (Vice-Chair)
- Up to two PSRC Lay Members 'NHSE Expert volunteers'

All members of the PSRC must have a good knowledge and understanding of the Regulations to reduce the likelihood of a successful appeal against decisions made. It is essential that members build up expertise in the Regulations and therefore consistency of attendance is expected. Subject to the provision of this paragraph deputies may be appointed.

The following persons will be co-opted to each PSRC but will not be voting members:

- Pharmacy Contract Manager (or equivalent post in the ICB)
- Pharmacy Professional Advisor (or equivalent post in the ICB)

Persons ineligible to be voting or co-opted members of a PSRC are listed in Regulation 62 and in paragraph 26(1) of Schedule 2 to the Regulations. All voting and co-opted members must sign a declaration to confirm that they are not barred by virtue of this regulation or paragraph. The Chair can require any co-opted member to leave the meeting before discussion of a matter and not return until the relevant decision has been made. The minutes will record the absences of the relevant voting or co-opted member or members.

Persons barred from taking part in decision-making on applications for inclusion in a pharmaceutical list or a dispensing doctor

- A person who is included in a pharmaceutical list or is an employee of such a person
- A person who assists in the provision of pharmaceutical services under Chapter 1 or Part 7 of the NHS Act 2006
- A person who is an LPS chemist, or a person who provides or assists in the provision of LPS
- A person who is a provider of primary medical services
- A person who is a member of a provider or primary medical service that is a partnership, or a shareholder in a provider of primary medical services that is a company limited by shares
- A person who is employed or engaged by a primary medical services provider
- A person who is employed or engaged by an alternative provider medical services contractor in any capacity relating to the provision of primary medical services

No Member may take part in a decision if, in the opinion of the remaining voting members, the circumstances set out in paragraph 26(2) of Schedule 2 to the Regulations apply (reasonable suspicion of bias).

Chair and Vice-Chair

The Chair will be the Head of Primary Care (or their suitable, nominated deputy) and the Executive Area Director (Senior Responsible Officer (SRO) or their suitable nominated deputy) will chair the meeting in the absence of the Head of Primary Care. If the Chair is not present, then the Vice Chair will chair the meeting.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToRs and in line with the general principles for decision making outlined in the Pharmacy Manual (Version 2, 10 February 2023).

The PSRC shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

If a Chair has a conflict of interest, then the Vice-Chair or, if necessary, another Member of the PSRC will be responsible for deciding the appropriate course of action.

The Chair may agree other nominated individuals to attend regularly or for specific agenda items but, at the request of the Chair, will leave the meeting while decisions are made.

5. Meetings, Quoracy and Decisions

The PSRC will meet in private.

The PSRC shall meet monthly (or earlier if needed in order to discuss a case urgently). The arrangements and notice for calling meetings are set out in the ICB's standing orders. Additional meetings may be convened urgently, to discuss urgent cases, on an exceptional basis at the discretion of the Subcommittee Chair. Where a meeting is not required it will be documented in line with local procedures.

In accordance with the ICB's Standing Orders, the Subcommittee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

The Subcommittee will report at least every month to the Primary Care Strategy and Delivery Subcommittee on the decisions taken and the outcome of any appeals on those decisions. ICB committees will also be required to report to NHS England in line with the assurance framework or on request.

Quoracy

No business shall be transacted at a meeting unless at least two of the voting members are present one of which must be an officer from the ICB.

In the event that a meeting of the PSRC is not quorate, the Chair can decide that the meeting will progress, but where decisions are required, they will be deferred to the next meeting when the PSRC is quorate.

Decision making and voting

Decisions will be taken in according with the ICB's Standing Orders. The PSRC will ordinarily reach conclusions by consensus of voting Members. When this is not possible each voting Member will have one vote and in the event of a tied vote the Chair will have the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. Responsibilities of the Committee

The responsibilities of the PSRC are defined Under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and will be authorised by the ICB Board. It is expected that PSRC will:

a. Determine those application and notifications received under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the 2013 Regulations)

b. Take overall responsibility for resolving issues of non-compliance with the terms of service as set out in the 2013 Regulations by pharmacy and dispensing appliance contractors;

c. Make decisions on whether an essential small pharmacy local pharmaceutical services (EPSLPS) contract is to be terminated in line with the provisions of the contract

d. HWBs are responsible for identifying current or future needs for, or improvements or better access to, a pharmaceutical service or pharmaceutical services in general via the pharmaceutical needs assessment (PNA). The PSRC is required to review the PNAs in its area and to record the actions taken to address identified needs, improvements or better access whether this is via the market entry process or through local commissioning processes.

Delegated authority is given to the nominated Pharmacy Contract Manager (PCM) or ICB equivalent to determine those applications and notifications delegated in the regulations. Where necessary the nominated PCM may escalate an application of notification to the PSRC. If, due to annual or sick leave, the nominated PCM is unable to determine an application or notification with the regulatory timescale it is to be determined by the PSRC.

7. Behaviours and Conduct

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the PSRC shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

8. Accountability and Reporting

The PSRC is accountable to the ICB through the Executive Committee. The minutes of meetings shall be formally recorded and submitted to the Primary Care Strategy and Delivery Subcommittee and then onward to the Executive Committee, in private or public as appropriate.

The Chair of the PSRC shall report to the Primary Care Strategy and Delivery Subcommittee after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The PRSC, through its reports and minutes to the Executive Committee and via the Primary Care Strategy and Delivery Subcommittee, will advise the on the adequacy of assurances available and contribute to the ICB's Annual Governance Statement.

The PSRC will receive scheduled assurance reports from its delegated groups. Any delegated groups or sub-committees would need to be agreed by the ICB Board.

9. Declarations of Interest

All members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Sub-committee Chair.

10. Secretariat and Administration

The PSRC shall be supported with a secretariat function which will ensure that:

I. The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead

II. Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements

III. Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept

IV. The Chair is supported to prepare and deliver reports to the Primary Care Strategy and Delivery Sub-committee

V. The Sub-committee is updated on pertinent issues/ areas of interest/ policy developments

VI. Action points are taken forward between meetings and progress against those actions is monitored.

11. Review

The PSRC will review its effectiveness at least annually and complete an annual report submitted to the Primary Care Strategy and Delivery Subcommittee and Executive Committee.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Executive Committee and, if required, the Board for approval.

The PSRC will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Version: 1-0
Date of approval: Board 28 March 2023 TBC
Date of review:

Regulatory provision	Decision-maker
Regulations 13, 14 and 21A – determination of application (current need)	Subcommittee
Regulations 15, 16 and 21A – determination of application (future need)	Subcommittee
Regulations 17, 19 and 21A – determination of application (current improvement/better access)	Subcommittee
Regulations 18 and 19 – determination of application (unforeseen benefits)	Subcommittee
Regulations 20, 21 and 21A – determination of application (future improvement/better access)	Subcommittee
Regulation 23 – determination of application (application from NHS chemist in respect of providing directed services)	Subcommittee
Regulation 24 – determination of application (relocation involving no significant change)	Subcommittee
Regulation 25 – determination of application (distance selling pharmacies)	Subcommittee
Regulation 26(1) – determination of application (change of ownership)	Officer or Subcommittee
Regulation 26(2) – determination of application (relocation involving no significant change/change of ownership)	Subcommittee
Regulation 26A – determination of preliminary matters including refusal of application for reasons set out in Regulation 26A(5)(b)	Officer
Regulation 26A – determination of application (consolidation onto an existing site)	Subcommittee
Regulation 27 – determination of application (for temporary listing arising out of suspension)	Subcommittee
Regulation 28 – determination of application (exercising right of return to the pharmaceutical list)	Officer or Subcommittee
Regulation 29 – determination of application (temporary arrangements during emergencies/because of circumstances beyond the control of NHS chemists)	Officer or Subcommittee
Regulation 30 – refusal on language requirement for some NHS pharmacists	Subcommittee or Performers List Decision Panel (PLDP)
Regulatory provision	**Decision-maker**
Regulation 31 – refusal: same or adjacent premises	Subcommittee
Regulation 32 – deferrals arising out of LPS designations	Officer or Subcommittee

Regulation 33 – determination of suitability of an applicant to be included in a pharmaceutical list on fitness grounds	Subcommittee or PLDP
Regulation 34 – determination of deferral of application to be included in a pharmaceutical list on fitness grounds	Subcommittee or PLDP
Regulation 35 – determination of conditional inclusion of an applicant to be included in a pharmaceutical list on fitness grounds	Subcommittee or PLDP
Regulation 36 – determination of whether an area is a controlled locality (or is part of a controlled locality), as a result of a local medical committee or local pharmaceutical committee request for such a determination or because NHS England is satisfied that such a determination is required (and make arrangements for any controlled locality to be clearly delineated on a published map)	Sub Committee
Regulation 37 – process for determining controlled localities: preliminary matters	Subcommittee
Regulation 40 – applications for new pharmacy premises in controlled localities: refusals because of preliminary matters	Subcommittee
Regulations 41 and 42 – determination of whether premises are (or a best estimate is) in a reserved location (and make arrangements for any reserved location to be clearly delineated on a published map)	Sub Committee
Regulation 44 – prejudice test in respect of routine applications for new pharmacy premises in a part of a controlled locality that is not a reserved location	Subcommittee
Regulation 48(2) - determination of patient application ('serious difficulty' applications)	Officer or Subcommittee
Regulation 48(5) to (9) – making of arrangements with a dispensing doctor to dispense to a particular patient or patients	Subcommittee
Regulation 50 – consideration of 'gradualisation' (ie the postponement of the discontinuation of services by dispensing doctors) for an application in relation to premises in, or within 1.6km of, a controlled locality	Subcommittee
Regulations 51 to 60 – determination of doctor application (outline consent and premises approval) including the taking effect of decisions, relocations, gradual introduction of premises approval, temporary provisions in cases of relocations or additional premises	Subcommittee

Regulatory provision	Decision-maker
where premises approval has not taken effect, practice amalgamations, and lapse of outline consent and premises approval	
Regulation 61 – temporary arrangements during emergencies or circumstances beyond the control of a dispensing doctor	Officer or Subcommittee
Regulation 65(5) to (7) – direction to increase core opening hours	Officer or Subcommittee
Regulation 67 – agreement of a shorter notice period for withdrawal from a pharmaceutical list	Subcommittee
Regulation 69 – determination of whether there has been a breach of terms of service	Subcommittee
Regulation 70 – determination of whether to issue a breach notice with or without an accompanying withholding of payments in connection with a breach of terms of service. Determination of whether to rescind a breach notice	Subcommittee
Regulation 71 – determination of whether to issue a remedial notice with or without an accompanying withholding of payments in connection with a breach of terms of service. Determination of whether to rescind a remedial notice	Subcommittee
Regulation 72 – determination of whether to withhold remuneration	Subcommittee
Regulation 73 – determination of whether to remove premises or a chemist from the pharmaceutical list (following remedial or breach notice)	Subcommittee
Regulation 74 – determination of whether to remove premises or a chemist from the pharmaceutical list (death, incapacity or cessation of service)	Subcommittee
Regulation 79 – determination of review of fitness conditions originally imposed on the grant of an application	Subcommittee or PLDP
Regulation 80 – determination of removal of a contractor for breach of fitness conditions	Subcommittee or PLDP
Regulation 81 and 82 – determination of removal or contingent removal	Subcommittee or PLDP
Regulation 83 – suspensions in fitness cases	Subcommittee or PLDP
Regulation 84 – reviewing suspensions and contingent removal conditions	Subcommittee or PLDP
Regulation 85 – general power to revoke suspensions in appropriate circumstances	Subcommittee or PLDP

Regulation 94 – overpayments	Subcommittee
Regulation 99 – designation of an LPS area	Subcommittee
Regulation 100 – review of designation of an LPS area	Subcommittee
Regulation 101 – cancellation of an LPS area	Subcommittee
Regulatory provision	**Decision-maker**
Regulation 104 – selection of an LPS proposal for development and decision to adopt proposal	Subcommittee
Regulation 108 – right of return for LPS contractor	Subcommittee
Schedule 2, paragraph 1(10) – whether a best estimate is acceptable	Officer or Subcommittee
Schedule 2, paragraph 11(1) – determination of whether there is missing information	Officer
Schedule 2, paragraph 11(2)(b) – determination of review of reasonableness of request for missing information	Officer or Subcommittee
Schedule 2, paragraph 14 – whether to defer consideration of application	Officer or Subcommittee
Schedule 2, paragraph 19 – determination of who is to be provided with notice of a notifiable application	Officer
Schedule 2, paragraph 21(4) – determination of whether the full disclosure principle applies to information contained within a notifiable application	Subcommittee
Schedule 2, paragraph 22(2) – whether oral representations are to be provided and who may be additional presenters as defined in Schedule 2, paragraph 25(2)	Officer or Subcommittee
Schedule 2, paragraph 25 – decision to hold an oral hearing to determine an application	Subcommittee
Schedule 2, paragraph 28 – determination of who is to be notified of decisions on routine and excepted applications	Officer or Subcommittee
Schedule 3, paragraph 30 – determination of who is to have a third party right of appeal against decisions on routine and excepted applications	Officer or Subcommittee
Schedule 2, paragraph 31 – consideration of a notification of address following a 'best estimate' routine application. Where this may lead to a refusal under regulation 31, the matter should be escalated to the committee	Officer or Subcommittee
Schedule 2, paragraph 32 – determination of whether to accept a change to premises	Officer or Subcommittee
Schedule 2, paragraph 33 – determination as to whether the future circumstances have arisen	Officer
Schedule 2, paragraph 34 – decisions as to whether notices of commencement are valid, and whether a shorter notice period can be given	Officer
Schedule 2, paragraph 34A – decisions as to whether notices of consolidation are valid, and whether a shorter notice period can be given	Officer

Schedule 2, paragraph 34(4)(c)(i) and 34A(4)(b)(i) – extension of latest date for receipt of notice of commencement or consolidation	Officer or Subcommittee
Regulatory provision	**Decision-maker**
Schedule 2, paragraph 35 – notice requiring the commencement of pharmaceutical services	Officer or Subcommittee
Schedule 4, paragraph 23(1)/Schedule 5, paragraph 13(1) – consideration of a request to temporarily suspend the provision of services (fixed period)	Subcommittee
Schedule 4, paragraphs 23–25/Schedule 5, paragraphs 13–15 – decision to direct a contractor to open at certain times on certain days	Subcommittee
Schedule 4, paragraph 23(10)/Schedule 5, paragraph 9 – review of reason for temporary suspension within the control of the contractor	Subcommittee
Schedule 4, paragraph 26/Schedule 5, paragraph 16 – determination of core opening hours instigated by the contractor	Subcommittee
Schedule 4, paragraph 27/Schedule 5, paragraph 17 – temporary opening hours and closures during an emergency requiring the flexible provision or pharmaceutical services	Officer or Subcommittee
Schedule 4, paragraph 27B – flexible provision of relevant immunisation services during a pandemic	Officer
Schedule 4, paragraph 28A – premises requirements in respect of consultation rooms – decisions that a pharmacy premises is too small	Officer or Subcommittee
Schedule 5, paragraph 13(6) – arranging for amendments to be made to the relevant pharmaceutical list following notification of a change of supplementary opening hours (where change is not intended to come into effect sooner than three months after receipt of notification of change)	Officer or Subcommittee
Decisions relating to compliance with the dispensing doctor terms of service	Subcommittee
Approval of responses to an appeal against, or challenge to, decisions of the committee	Officer or Subcommittee
Approval of responses to an appeal against, or challenge to, decisions of the officer	Officer or Subcommittee
Determination of further action where community pharmacy assurance framework identifies concerns	Officer or Subcommittee
Determination of further action where the contractor fails or refuses to agree a date and time for a visit	Officer or Subcommittee

Determination of action where any of the following are identified: • patient safety issues • the commissioner is at risk of material financial loss, and/or • possible fraudulent or criminal activity.	Officer or Subcommittee
Regulatory provision	**Decision-maker**
Determination of action where the contractor fails to complete the required actions or fails to respond to a visit report	Officer or Subcommittee
Determination of action where the contractor exceeds the maximum number of appliance use reviews that may be done in any one year	Officer

Item: 9.2.1

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

NORTH EAST AND NORTH CUMBRIA ICB BOARD MEETING 28 March 2023	
Report Title:	**Highlight report and minutes from the Executive Committee meetings held on 10 January and 14 February 2023**

Purpose of report

To provide the Board with an overview of the discissions and decisions at the Executive Committee meetings in January and February 2023.

Key points

The key points from the meetings include the following:

- Ophthalmology
- Cancer Care
- NICE Compliance
- Community Diagnostics Programme
- Next Step on Place Based Working
- Newcastle – Special Schools
- County Durham – Acute Respiratory Infection (ARI) Hubs
- Tees Valley – Children and Young People (CYP)
- South Tees Integrated Urgent Care
- Primary Care Operating Framework
- Community Pharmacy Services in North East and North Cumbria – review of pilot schemes and proposed next steps

The confirmed minutes from the meetings held on 10 January and 14 February 2023 are attached at Appendix 1 and Appendix 2 respectively.

The Board is also asked to note an amendment made to the Executive Committee minutes for the meeting held on 15 November 2022. The minutes did not reflect the nominated deputy arrangements for the Executive Director of Finance for that meeting and should have recorded

the Director of Finance (Central) as present as the nominated deputy. This change has been made to the minutes and the Board is asked to note this amendment. Due to this being a minor amendment only, the minutes have not been attached.

Risks and issues

The Committee discussed the ICB risk register, noting the existing risks and the mitigating actions being put in place to address these, and following a discussion, identified the following risks and issues:

- A risk to be added to the risk register in relation to financial risks for the Community Diagnostics Programme.

Assurances

The Committee also received a number of items for assurance and these included:

- NHS England Clinical Network Staff Transfer to NENC ICB - update on the current position of the staff transfer to the ICB
- ICB programme plan highlight report – current ICB programme plan and progress against key deliverables
- Research and Evidence 2022/23 - assurance regarding the ICBs statutory duties in relation to research and evidence, namely 1) promote research on matters relevant to the health service, 2) promote the use in the health service of evidence obtained from research, and 3) take responsibility for Excess Treatment Costs (ETCs)
- NICE Compliance Report - compliance of the ICB with NICE technology appraised treatments and future plans to improve equitable commissioning of these medicines
- A finance update report – an overview of the current financial position
- An integrated delivery report – a high level overview of the key metrics across the system and internal to the ICB, covering access, experience, outcomes, people and finance
- A risk management report – an overview of the ICB's current risk register and movement of risks
- Data Security and Protection Toolkit – a baseline assessment.

Recommendation/Action Required

The Board is asked to:

- Receive the highlight report and confirmed minutes for the Executive Committee meetings held on 10 January and 14 February 2023 for information and assurance
- Formally note the amendment to the Executive Committee minutes for the meeting held on 15 November 2022.

Acronyms and abbreviations explained

CYP - Children and Young People
ICB – Integrated Care Board
NENC – North East and North Cumbria
ETCs - Excess Treatment Costs
NICE - National Institute for Health and Care Excellence
NuTH - Newcastle upon Tyne Hospital NHS Foundation Trust
PCNs - Primary Care Networks
NHSE - NHS England
SALT - Speech and Language Services
BSIL - Best start in life

Item: 9.2.1

Sponsor/approving director	Samantha Allen, Chief Executive
Reviewed by	Deborah Cornell, Director of Corporate Governance and Involvement
Report author	Jane Leighton, Corporate Governance Manager and Business Manager to the Chair

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

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

Key implications	
Are additional resources required?	Identified as part of the committee minutes.
Has there been/does there need to be appropriate clinical involvement?	Yes, as part of the Executive Committee membership.
Has there been/does there need to be any patient and public involvement?	Not applicable as highlight report only.
Has there been/does there need to be partner and/or other stakeholder engagement?	Not applicable as highlight report only.

Item: 9.2.1

Executive Committee Highlight Report

Introduction

The principal purpose of the Executive Committee is to support the Board by:

- Overseeing the day-to-day operational management and performance of the Integrated Care Board (ICB) in support of the Chief Executive in the delivery of her duties and responsibilities to the Board
- Provide a forum to inform ICB strategies and plans and in particular, the Committee will undertake any commissioning and planning activity on behalf of the Board, helping to secure continuous improvement of the quality of services
- Implementation of the approved ICB strategies and plans.

The Committee will contribute to the overall delivery of the ICB objectives by delivering its remit as set out in its terms of reference.

Summary report

The Executive Committee, chaired by Samantha Allen, Chief Executive, met on 10 January and 14 February 2023.

The key points to bring to Board's attention from each meeting are set out below.

10 January 2023

- **Ophthalmology (also applies to Northumberland, Newcastle and Gateshead):** the long waiting list and waiting times for ophthalmology provision was raised. Considerable investment had been made into the service at Newcastle upon Tyne Hospital NHS Foundation Trust (NuTH) and, while it remained one of the key areas for Referral to Treatment breaches, the number of people waiting for cataract operations had reduced and were now below pre-pandemic level.
- **Cancer Care:** key ambitions for this work were early cancer diagnosis, the need to reduce health inequalities and positive patient experience and personalised care. The need for a Primary Care Network (PCN) Cancer Early Diagnosis Facilitator role was recognised to work with PCNS and general practices across County Durham to support understanding and early cancer diagnosis. A social marketing campaign was underway and would run until April 2023 to raise awareness of signs and symptoms with the public in hard-to-reach communities in three key tumour group areas (head and neck, lung, urology).
- **NICE Compliance:** a detailed position was noted in relation to NICE technology appraised treatments and future plans to improve equitable commissioning of these medicines.
- **Community Diagnostics Programme:** an update was received on the development of Community Diagnostic Centres in the region and the additional diagnostic capacity created. It was noted that Community Diagnostic Centre's would provide a broad range of elective diagnostics away from acute facilities, many in a ‘one stop shop’ setting.
- **Next Step on Place Based Working:** next steps on the proposed recommendations in relation to place-based governance arrangements were considered in each of the thirteen local authority areas within the ICS area, based on the latest government guidance and in line with the place-based functions and resources identified.

14 February 2023

- **Newcastle – Special Schools:** information had been received from NHS England (NHSE) indicated that clinical interventions in schools must now be commissioned and funded by ICBs.

NHSE is leading a national task and finish group to develop governance and training support for ICBs.

- **County Durham – Acute Respiratory Infection (ARI) Hubs:** – three locally commissioned ARI hubs were in the process of opening and had been mobilised at pace to help tackle the immediate pressures on emergency departments and primary care. In Durham, the hubs would create up to 6000 additional appointments in primary care up to 31 March 2023.
- **Tees Valley – Children and Young People (CYP):** work is underway in Tees Valley on jointly identified system priorities for CYP, for example CYP Speech and Language Services (SALT); commissioning for CYP with complex needs; CYP emotional health and well-being; the best start in life (BSIL) including integrated working.
- **South Tees Integrated Urgent Care:** an update on progression of the South Tees Integrated Urgent Care project, outlining the development and engagement of a robust proposal for the future configuration and standardisation of urgent care services across the Tees Valley area. The project aimed to ensure patients are directed to the right care, minimising disruption and frustration, improving efficiency and quality of outcomes and reducing waiting times.
- **Primary Care Operating Framework:** an update on the proposed framework for the commissioning of primary care services following the proposed delegation of pharmacy, optometry and dentistry services from NHSE to the ICB from April 2023. The operating framework would be aligned to the ICB's overall governance framework to enable clarity of decision-making, oversight, and assurance that all functions would be delivered appropriately.
- **Community Pharmacy Services in North East and North Cumbria – review of pilot schemes and proposed next steps:** two pilot community pharmacy services had been commissioned across North East and North Cumbria. The pilot 'Think Pharmacy First' minor ailments scheme, available through community pharmacies, provides patients with advice and access to medicines where appropriate, supporting integration of the urgent care system and self-care.

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North East and North Cumbria Integrated Care Board

Executive Committee

Minutes of the meeting held on Tuesday 10 January 2023, 10:25hrs in the Joseph Swan Suite, Pemberton House, Colima Avenue, Sunderland

Present:
Samantha Allen, Chief Executive (Chair)
Nicola Bailey, Interim Executive Director of Place Based Delivery (North and North Cumbria)
David Chandler, Interim Executive Director of Finance
Graham Evans, Executive Chief Digital and Information Officer
Dave Gallagher, Executive Director of Place Based Delivery (Tees Valley and Central)
Annie Laverty, Executive Chief People Officer
Jacqueline Myers, Executive Director of Strategy and System Oversight
Neil O'Brien, Executive Medical Director
David Purdue, Executive Chief Nurse
Claire Riley, Executive Director of Corporate Governance, Communications and Involvement
Julia Young, Director of Nursing (on behalf of David Purdue, Executive Chief Nurse)
Aejaz Zahid, Executive Director of Innovation

In attendance:
Deborah Cornell, Director of Governance and Involvement
Shona Haining, Head of Research and Evidence (NECS)
Gemma Matthews, Executive Assistant (notes)
Peter Rooney, Director of Strategy and Planning

EC/2023/122	**Agenda Item 1 Welcome and introductions** The Chair welcomed all those present to the meeting.
EC/2023/123	**Agenda Item 2 Apologies for absence** Apologies for absence were received from David Purdue, Executive Chief Nurse who was represented by Julia Young, Director of Nursing, for this meeting only.
EC/2023/124	**Agenda Item 3 Declarations of interest** There were no declarations of interest made at this point in the meeting.

EC/2023/125	**Agenda Item 4 Minutes of the previous meeting held on 13 December 2022** **RESOLVED:** **The Executive Committee AGREED that the minutes from the meeting held on 13 December 2022 were a true and accurate record.**
EC/2023/126	**Agenda Item 5 Matters arising from the minutes and action log** Item number 3 (minute reference EC/2022/12) NICE Compliance Report This was on the agenda for consideration at Agenda Item 8.4. Item closed. Item number 12 (minute reference EC/2022/44) Central & Tees Valley Place Based Delivery Report (Social Impact Bonds) The Interim Executive Director of Finance confirmed that this was a complex issue but that work continued. A further update would be provided in February 2023. Item number 13 (minute reference EC/2022/47) Winter Plan The Executive Director of Corporate Governance, Communications and Involvement confirmed that a regular, weekly, update would be included in the Network Bulletin going forward. Item complete. Item number 22 (minute reference EC/2022/73) North & North Cumbria Place Based Delivery Report (Winter Plan Fund) Confirmation received from the Interim Executive Director of Finance that a process was in place for tracking the spend although more work on the local proposals was required. Item complete. Item number 25 (minute reference EC/2022/77) ICS Winter Plan for System Resilience The Executive Director of Strategy and System Oversight confirmed that progress had been made but that more work was needed to agree support to the programme. Agreed to close the action as this would be absorbed into the wider arrangement for the ICB and the ICB structure going forward. Item complete. Item number 26 (minute reference EC/2022/81) Ongoing support to NENC ICB COVID-19 Vaccination Programme (Vaccination Committee) The Director of Governance and Involvement advised that a full Committee Structure would be presented to the committee at a future meeting and that the Vaccination Committee would be included in that. Item number 27 (minute reference EC/2022/83) Finance Update (Running Costs and Budgets) The Interim Executive Director of Finance advised that an update on the running costs would be circulated, including granular detail, once the work with executive directors on their respective budgets was complete. Item complete.

	<u>Item number 29 (minute reference EC/2022/86) Delegation of Specialised Service Commissioning to ICBs</u> The Chair confirmed that the concerns relating to due diligence work in specialised commissioning had been raised with the regional team. Item complete. <u>Item number 30 (minute reference EC/2022/87) NHSE Clinical Network Staff Transfer to the NENC ICB</u> It was noted that the timescale on this particular work had slipped. Further update expected at the meeting in February 2023. <u>Item number 32 (minute reference CEC/2022/110) Operational Resilience Update (Data Analysis)</u> The Executive Director of Strategy and System Oversight confirmed that a report had been prepared but that agreement was needed as to which day of the week would be best to issue the report. Item complete.
EC/2023/127	**Agenda Item 5.1 NHS England Clinical Network Staff Transfer to NENC ICB Update (Verbal)** The Director of Nursing provided a verbal update on the current position of the staff transfer to the ICB. Work was ongoing to move staff, via TUPE transfer, whilst considering any potential efficiencies, for example with the alignment of the maternity network and LMNS. It was noted that the first step would be the staff within the Cancer Network as a pilot and then reviewing the process before continuing with the other services. The committee was assured that the process was on track and that the ICB was working alongside NHS England. Following discussion, it was agreed that the Executive Chief People Officer would link in with this process to ensure that transferring staff would be appropriately supported. **<u>RESOLVED:</u>** **The Executive Committee NOTED the update.**
EC/2023/128	**Agenda Item 6 Notification of urgent items of any other business** No items of any urgent business had been received.
EC/2023/129	**Agenda Item 7.1 North and North Cumbria Place Based Delivery Report** The Interim Executive Director of Place Based Delivery (North and North Cumbria) provided a brief summary of the items which the committee was asked to particularly note from the report:

	• **Ophthalmology (also applies to Northumberland, Newcastle and Gateshead)** – a long waiting list and waiting times for ophthalmology provision remained at high levels despite considerable investment into the service at Newcastle Upon Tyne Hospitals NHS Foundation Trust (NuTH). However, during the past 12 months there had been a rise in independent sector provision opening facilities for cataract operations. Due to the impact of private providers in to Northumbria for ophthalmology and audiology services, a review was ongoing with finance colleagues to ascertain any potential impact on ICB contracts. Although acknowledged as a short term issue due to these services being under ERF currently, from 1 April 2023 all would fall under PPR which would need to be considered at that time. ACTION: That the Interim Executive Director of Place Based Delivery (North and North Cumbria) link with the Executive Director of Strategy and System Oversight to start the piece of work in relation to ophthalmology and audiology from 1 April 2023 onwards. • **Primary Care (Gateshead)** – following the death of a GP in Gateshead, it was thought that his son would take over the contract at the practice but he has since indicated he would not take over the contract. Two practices had shown interest in the emergency and permanent contract element with Community Based Health (CBC) also offering support if needed. • **Update on Local Place Partnership Development (Northumberland)** – work remained ongoing to progress the development of Northumberland's place-based partnership arrangements. Governance around the preparation of the Terms of Reference and who was responsible for writing those was to be clarified. **RESOLVED:** **The Executive Committee NOTED the content of the report.**
EC/2023/130	**Agenda Item 7.1 Central and Tees Valley Place Based Delivery Report** The Executive Director of Place Based Delivery (Tees Valley and Central) asked the committee to note the following: • **Cancer Care –** the committee was referred to paragraphs 49 – 52 which provided an update on the cancer pathways, particularly noting that North Tees had moved in and out of Tier 2 for Cancer in a short space of time having made some improvements. The Executive Director of Corporate Governance, Communications and

	Involvement asked that the consideration be given to the voluntary sector and correlating the funding as the report suggested that funding was being given to two organisations for the same thing. It was acknowledged that this may not be the case but that a piece of work to establish clarity would be beneficial. **RESOLVED:** **The Executive Committee NOTED the content of the report.**
EC/2023/131	**Agenda Item 8.1 Winter Planning Update (including 9 winter metrics)** The Executive Director of Strategy and System Oversight introduced the report which outlined key deliverables for Winter Operating Resilience for urgent and emergency care and progress against actions and against both local and national metrics for delivery. Key points to noted included:- • UEC Strategic Board oversees winter resilience for the ICB and reports on a monthly basis to both this committee and the ICB Board; • 2023/24 Planning Guidance published on 23 December 2022 with implications for UEC; • The monthly UEC Board Assurance Framework (BAF) reports progress to NHS England on 63 actions for winter – almost all actions now partially or fully completed; and • National Funding for Acute Respiratory Hubs not released with business cases due on 6 January 2023. During discussion it was asked if there were any areas which needed to be added to the list or any metrics which needed to be deprioritised. It was agreed that there was an opportunity to consider around 15 to 20 areas in the new year and to present a further work programme for consideration. There was also an opportunity to link in the workforce metrics. It was noted that daily performance would not be provided by the UEC Network. In relation to 111 call handling, NEAS had been asked if out of area calls would be diverted to them if all the "Speak To's" were sent somewhere else. **RESOLVED:** **That the new planning guidance in relation to UEC and associated services; and performance against national and local metrics be NOTED.**
EC/2023/132	**Agenda Item 8.2 ICB Programme Plan Highlight Report** The Executive Director of Strategy and System Oversight introduced the report which provided visibility of the current ICB programme plan and provided assurance on progress against key deliverables.

	It was confirmed that the fundamental actions for effective running of the ICB were progressing well. Those rated 'amber' were being worked through and would include timelines for completion. The Chair request a 'director by director' update on those areas at the next meeting **ACTION:** **That all directors provide an update of those actions which remain amber at the next meeting.** **RESOLVED:** **That the report and contents of the ICB Programme Plan be NOTED and that the change request as described in Section 3 of the report be AGREED.**
EC/2023/133	**Agenda Item 8.3 Research and Evidence Report 2022/23 (H1)** The Executive Director of Innovation introduced the report which supported the statutory duties of the ICB in relation to research and evidence. The committee was reminded that these duties were:- 1. To promote research on matters relevant to the health service; 2. To promote the use in the health service of evidence obtained from research; and 3. To take responsibility for Excess Treatment Costs (ETCs). The Head of Research and Evidence (NECS) was welcomed to the meeting and explained the key points from the report. The committee noted that this was a 'new look' report and asked to review the content, style and assurance provided therein. It was agreed that the report and requirements should run through the strategic and long term goals of the ICB to map out any gaps and be included in the five year delivery plan to further identify any potential gaps. It was confirmed that the research support costs for excess treatment costs were funded through the Clinical Research Network. The excess was reported at around £250k and it was agreed that the Interim Executive Director of Finance be linked into discuss further as this may be something which needed consideration at the Performance, Finance and Investment Committee. **RESOLVED:** **That the report and content be NOTED.**
EC/2023/134	**Agenda Item 8.4 NICE Compliance Report** The Executive Medical Director introduced the report which provided the committee with a detailed position on compliance of the ICB with NICE

	technology appraised treatments and future plans to improve equitable commissioning of these medicines. It was proposed that a new process be introduced to seek assurance from localities that treatment could be provided in line with NICE. Any barrier to implementation would be discussed by the medicines committee and its sub-committees to identify possible solutions or escalate through the ICB as appropriate. Consideration would need to be given to the cost implications and to remind foundation trust colleagues of the conditions around the current block contracts. The committee supported the proposal as presented. The Interim Executive Director of Finance and the Executive Director of Strategy and System Oversight would incorporate this into discussions regarding the planning position. **ACTION:** **1) The Executive Medical Director to write to all Foundation Trusts with the proposal agreed.** **RESOLVED:** **That the proposal as presented within the report be SUPPORTED.**
EC/2023/135	**Agenda Item 8.5 2023/24 Operational Planning Guidance (presentation)** The Director of Strategy and Planning gave a presentation on the National Planning Guidance for 2023/24. The slides covered the following areas:- • National Planning Guidance – financial allocations/guidance; operational plan 2023/24; joint forward plan guidance; contract and NHS payment scheme consultation; and CQUIN; • Operational Plan priorities; • Emergency Care and Maternity Objectives; • Community and Primary Care Objectives; • Diagnostics, Elective and Cancer Objectives; • Mental Health & Learning Disability Objectives; • Prevention, Resources & Workforce Objectives; • Joint Forward Plan 2023/24 – 2028/29; • National Timescales; • Financial Framework and Allocations; and • North East and North Cumbria Approach It was agreed that the aim for this document should be to be as concise as possible with focus on pragmatic actions, detailing what will be done, by when and by who. The document needed to be accessible to the public,

	staff and services and to understand what the role is. The committee agreed that there was a genuine opportunity to produce something of great value. **RESOLVED:** **That the presentation and update be NOTED.**
EC/2023/136	**Agenda Item 9.1 Finance Update** The Interim Executive Director of Finance introduced the report which provided an update on the financial performance for the ICB and ICS in 2022/23 for the period to 30 November 2022 (Month 8). The ICB was reporting a forecast deficit of £5.6m prior to the expected receipt of additional funding of £11.2m to cover costs associated with Primary Care Additional Roles Reimbursement Scheme (ARRS). Once received, the ICB would report a forecast surplus of £5.7m against a planned surplus of £2.6m. It was reported that the ICS had highlighted a £40m risk to reach balance. NHS England have agreed to give £20m in non-recurrent funding to assist the ICS in reaching breakeven. During consideration of the report, the committee agreed that a better understanding of the issues around prescribing would be helpful. It was expected that costs around medicines would continue to increase. **RESOLVED:** **That the year to date and forecast financial position for 2023/23; and the financial risks across the system be NOTED.**
EC/2023/137	**Agenda Item 9.2 Community Diagnostics Programme Update** The Executive Director of Strategy and System Oversight introduced the report which provided an update on the development of community diagnostic centre (CDC) capacity within the ICS. The committee noted that the revenue costs were agreed until March 2025. The revenue to-date was noted at £50m with the possibility of no future provision for ongoing revenue costs. This position was acknowledged and the suggest of a mechanism in future to consider that further. It was agreed that this would be added to the risk register as part of the finance risks. **ACTION:** **The Director of Governance and Involvement to add this to the risk register under finance risks.**

	RESOLVED: **That the progress to-date be NOTED and the future plans for CDC development within the ICS be SUPPORTED.**
EC/2023/138	**Agenda Item 10.1 Integrated Delivery Report** The Executive Director of Strategy and System Oversight introduced the report which provided an overview of quality and performance across the ICS. The report was structured around the 2022/23 planning priorities and linked to the NHS Oversight Framework (NHSOF) which applied to all ICSs, trusts and foundation trusts, providing oversight of the delivery of the NHS Long Term Plan (LTP). The key changes, as noted in the report, were highlighted including the changes to CQC ratings; the reopening of maternity services in Sunderland; Contract Performance Notices (CPNs); ongoing issues around handover delays; and the move into tier 2 for County Durham and Darlington. It was also confirmed that North Cumbria remained in the tier process but had stepped down from tier 1 to tier 2. Confirmation was received that the Quality and Safety Committee do look at themes and issues and do undertaken in depth reviews when themes emerge. There was an ongoing review of cardiothoracic services at NuTH as there had been a total of six incident reported, although some were 'never events'. All SOF and Oversight meetings had been booked in the diary and would be complete by the end of Quarter 2, following which a rolling plan would be implemented. **RESOLVED:** **That the report and update be NOTED.**
EC/2023/139	**Agenda Item 11.1 Commissioning** No update was required for this item.
EC/2023/140	**Agenda Item 12.1 Strategy & Partnerships** No update was required for this item.
EC/2023/141	**Agenda Item 13.1 Risk Management Report** The Executive Director of Corporate Governance, Communications and Involvement presented the report which provided an updated position on

	the risk facing the ICB for the period 28 November 2022 to 20 December 2022. The committee accepted the report as presented. **RESOLVED:** **That the report and the profile of the risks as at 20 December 2022 be NOTED.**
EC/2023/142	**Agenda Item 13.2 Next Step on Place Based Working** The Executive Director of Corporate Governance, Communications and Involvement presented the report which proposed recommendations for place-based governance arrangements in each of the thirteen local authority areas within the ICS. The recommendations were based on the latest government guidance and in line with place-based functions and resources identified in the functions and decisions map annex to the ICB Constitution and Scheme of Reservation and Delegation (SORD). Work had been undertaken with the Good Governance Institute to develop and Accelerating Place Development Checklist and a standard Terms of Reference for ICB Place Committees and Joint Committee which were noted within the appendices to the report. It was noted that Gateshead had requested to be a committee of the ICB and not a joint committee. It was also noted that discussions were ongoing with the Care Home Association and a suggestion made that they also become part of the ICP. Although this particular report was focussed around place based working, it would be helpful to consider widening the remit of the broader ICP. **RESOLVED:** **That the report and contents be NOTED.**
EC/2023/143	**Agenda Item 13.3 Medicines Committee Recommendations** The Executive Medical Director introduced the report which sought approval from the Executive Committee for the medicines recommendations from the December Medicines Committee meeting. The Director of Governance and Involvement recommended that the Medicines Sub-Committee be established as a sub-committee to the Executive Committee. **RESOLVED:** **1) That the medicines decisions made at the Medicines Committee in December 2022, as detailed, be APPROVED;** **2) That the medicines decisions made by the three localities, as**

	detailed, be APPROVED; **3) That the open publication of the draft minutes of the Medicines Committee and sub-committee meetings, on the Medicine's Committee website, be APPROVED; and** **4) That the proposal to establish the Medicines Committee as a sub-committee of the Executive Committee be APPROVED.**
EC/2023/144	**Agenda Item 14.1 Business Continuity and EPRR On-call Policies** The Executive Director of Strategy and System Oversight introduced the report which provided revised Business Continuity and EPRR On-Call Policies. The policies would be reviewed within the first six months of ICB establishment. The following policies were reviewed and revised as part of this review:- • ICBP03 Incident Response Plan • ICBP0114 Emergency Preparedness Resilience and Response Policy • ICBP015 Emergency Preparedness, Resilience and Response On-Call Policy **RESOLVED:** **That the Business Continuity and EPRR On-Call policies be APPROVED.**
EC/2023/145	**Agenda Item 14.2 Continuing Healthcare and Safeguarding Policies** The Director of Nursing introduced the report which provided reviewed and revised Continuing Healthcare and Safeguarding Policies for consideration. **RESOLVED:** **That the Continuing Healthcare (CHC) and Safeguarding Policies, as noted within the report, be APPROVED for review and update.**
EC/2023/146	**Agenda Item 14.3 Policy for the Development and Authorisation of Patient Group Directives (PGDs)** The Executive Medical Director introduced the report which provided a summary of the process followed to update the NENC ICB Patient Group Directives (PGD) Policy. **RESOLVED:** **That the review of the ICB PGD Policy be NOTED.**
EC/2023/147	**Agenda Item 14.4 Investment Business Case Policy** The Executive Director of Strategy and System Oversight introduced the report which presented the Investment Business Case Policy to the committee for approval.

	The suggestion for general training for ICB colleagues around this was supported. **<u>RESOLVED:</u>** **That the Investment Business Case Policy be APPROVED.**
EC/2023/148	**Agenda Item 15.1 Any Other Business** **Industrial Action** It was noted that the relevant arrangements had been implemented for the forthcoming industrial action. All organisations had been involved at Place and access to services had been made with learning from the last action considered. **Senior ICB Staff Meeting (11 January 2023)** The agenda for the meeting would include:- • Chief Executive Update; • Discharge Update (Executive Chief Nurse); • Pressures Update (Executive Director of Strategy and System Oversight); and • National Planning Guidance (Executive Director of Strategy and System Oversight and Interim Executive Director of Finance).
EC/2023/149	**Agenda Item 16 CLOSE** The meeting was closed at 12.30pm
	Date and Time of Next Meeting Tuesday 14 February 2023 9.00am

Signed: **Sam Allen**

Position: **Chief Executive (Chair)**

Date: **14 February 2023**

NHS
North East and North Cumbria

North East and North Cumbria Integrated Care Board

Executive Committee

Minutes of the meeting held on Tuesday 14 February 2023, 10:35hrs in the Joseph Swan Suite, Pemberton House, Colima Avenue, Sunderland

Present:
Samantha Allen, Chief Executive (Chair)
Nicola Bailey, Interim Executive Area Director (North and North Cumbria)
Craig Blair, Director of Place (Middlesbrough and Redcar & Cleveland)
David Chandler, Interim Executive Director of Finance
Joseph Chandy, Director of Transformation (Primary Care)
Graham Evans, Executive Chief Digital and Information Officer
Leanne Furnell, Director of Workforce
Jacqueline Myers, Executive Chief of Strategy and Operations
Neil O'Brien, Executive Medical Director
David Purdue, Executive Chief Nurse
Claire Riley, Executive Director of Corporate Governance, Communications and Involvement

In attendance:
Andrea Brown, Executive Assistant (minutes)
Deborah Cornell, Director of Corporate Governance and Involvement
Neil MacKnight, Head of Quality,Primary Care Transformation (item 8.4 only
Ewan Maule, Director of Medicines and Pharmacy (items 8.5 and 11.1 only)
Hamid Motraghi, Director of Health Equity, and Inclusion (item 12.1 only)
Pamela Phelps, Senior Head of Commissioning Primary Care (item 8.3 only)
Joanne Smith, Research Manager, NECS (item 11.1 only)

EC/2023/150	**Agenda Item 1 Welcome and introductions** The Chair welcomed all those present to the meeting.
EC/2023/151	**Agenda Item 2 Apologies for absence** Apologies for absence were received from Dave Gallagher, Executive Area Director (Tees Valley and Central) who was represented by Craig Blair, Director of Place (Middlesbrough and Redcar & Cleveland); Annie Laverty, Executive Chief People Officer, who was represented by Leanne Furnell, Director of Workforce; Jacqueline Myers, Executive Chief of Strategy and Operations, who was represented by Joseph Chandy, Director of Transformation (Primary Care); and Aejaz Zahid (Executive Director of

	Innovation).
EC/2023/152	**Agenda Item 3 Declarations of interest** The Executive Medical Director and the Director of Transformation (Primary Care) both made a declaration of interest during Agenda Item 7.1 Executive Area Directors Update – County Durham Local Improvement and Integration Scheme (LIAISE) 2023/24 and within Agenda Item 8.4 – COVID-19 Vaccine Gateway Criteria for Inclusion in Local Incentive Schemes (LIS). The Chair noted the declarations and agreed that both the Executive Medical Director and the Director of Transformation (Primary Care) could take part in the discussion but not the decision-making.
EC/2023/153	**Agenda Item 4 Minutes of the previous meeting held on 10 January 2023** **RESOLVED:** **The Committee AGREED that the minutes from the meeting held on 10 January 2023 were a true and accurate record.**
EC/2023/154	**Agenda Item 5 Matters arising from the minutes and action log** Item number 12 (minute reference EC/2022/44) Central & Tees Valley Place Based Delivery Report (Social Impact Bonds) The Interim Executive Director of Finance confirmed that this remained a complex issue and advised that the timescale had slipped slightly. It was agreed that a further update would be provided in May 2023. Item number 30 (minute reference EC/2022/87) NHSE Clinical Network Staff Transfer to the NENC ICB The Interim Executive Director of Finance confirmed that a further update could be expected at the meeting in March 2023. The Executive Medical Director noted that six vacancies were being held in a team of 16 despite having budgets for two years. Item number 31 (minute reference EC/2022/103 NECS – Strategy Partnership and Delivery Plan The Executive Director of Corporate Governance, Communications and Involvement confirmed that a summary had been included in the Pulse and on the ICB website to promote the work of NECS. The bulletin had also been issued. Item complete. Item number 33 (minute reference EC/2022/111) Any Other Business – Hospital Discharge £500m The Executive Chief Nurse advised that a taskforce had been established as requested. It was agreed that a terms of reference and reporting line would need to be agreed. The Executive Chief Nurse to discuss further with the Director of Corporate Governance and Involvement. Ongoing.

	Item number 34 (minute reference EC/2022/112) Finance Update The Interim Executive Director of Finance advised that a meeting had taken place with each director and that a half day session would no longer be required. Item complete. Item number 36 (minute reference EC/2023/129) Place Based Delivery Report (North and North Cumbria) – Ophthalmology & Audiology The Interim Executive Area Director (North and North Cumbria) advised that this had been picked up through the contract review but would provide more detail before the next meeting. Item number 37 (minute reference EC/2023/137) Community Diagnostics Programme Update The Director of Corporate Governance and Involvement confirmed that the potential risk for no future revenue for the Community Diagnostics Programme had been added to the risk register as requested. Item complete. **RESOLVED:** **The Committee NOTED the updates for the matters arising and action log.**
EC/2023/155	**Agenda Item 6 Notification of urgent items of any other business** No items of any urgent business had been received.
EC/2023/156	**Agenda Item 7.1 Executive Area Directors Update Report January 2023 (North and North Cumbria)** The Interim Executive Area Director (North and North Cumbria) provided a summary of the items which the Committee was asked to particularly note from the report: • **North Cumbria – Potential Practice Mergers** – two practices within the west of county and two practices in Carlisle had approached North Cumbria Place to request consideration of merging four practices into two practices. The Deputy Director of Systems and Integrated Care Communities Development (North Cumbria) was currently working with North Cumbria Primary Care and NHS England (NHSE) to ensure all relevant process were following, including patient engagement. • **North Cumbria – ICB Chief Executive Visit** – the visit of the Chief Executive to North Cumbria to meet with a variety of staff across different organisations and areas in addition to primary care network colleagues, patient participation groups and other local stakeholders, had been well received. • **North Cumbria – Health and Wellbeing Board** – having undertaken a review of the scrutiny committee membership, supported by the North

	Cumbria Place Based team, the Cumbria Health and Wellbeing Board had indicated an expectation that there would be two health and wellbeing boards in place across North Cumbria from April 2023 following the establishment of the two new councils. • North Tyneside – Place Based Governance – development of place-based governance arrangements with key stakeholders in North Tyneside was underway with a review of the existing groups to determine which of those should continue and which should be refreshed or disestablished. Confidence remained that a robust ICB subcommittee at place would be operational in North Tyneside from April 2023. • Gateshead – Gateshead Cares System Board – a large review of the care partnership in Gateshead was underway. Planning was also underway for a health and care system event on 10 March 2023 to revisit ambitions and priorities with a view to developing timelines around future working arrangements. • Northumberland – Integrated Working – following the appointment of Dr Helen Paterson into the role of Chief Executive at Northumberland County Council (NCC), the wider executive team had now been appointed. An away day was in the planning stages across NCC and the ICB to consider and develop shared priorities and strategies. • Newcastle – Collaborative Newcastle Awards Shortlisting – the Collaborative Newcastle's 'Learning to Lead Together' programme had been shortlisted in the category 'People Development Programme of the Year – Public Sector' at the Learning and Performance Institute awards ceremony. • Newcastle – Special Schools – information received from NHSE indicated that clinical interventions in schools must now be commissioned and funded by ICBs which was linked to the changes in the high needs funding block within the Local Authority. Newcastle had developed (with partners) a proposed new model of provision of nursing support into special schools which had been endorsed by NHSE and discussed with ICB executive directors. • Newcastle – Spirometry – the current service in Newcastle was not meeting NICE guidance (with some exceptions), therefore potential models and costs were being explored to ensure that full compliance could be reached. An investment business case proposal would be brought to the Executive Committee for consideration once all information had been gathered. **RESOLVED:** **The Committee RECEIVED the report for assurance and NOTED the**

	decisions log included within the report.
EC/2023/157	**Agenda Item 7.1 Executive Area Directors Update Report January 2023 (Central and Tees Valley)** The Director of Place (Middlesbrough and Redcar & Cleveland) asked the Committee to note the following: • **County Durham – Acute Respiratory Infection (ARI) hubs** – three locally commissioned ARI hubs were in the process of opening and had been mobilised at pace to help tackle the immediate pressures on emergency departments and primary care created by the extraordinary increase in respiratory infections over the winter. In Durham, the hubs would create up to 6000 additional appointments in primary care up to 31 March 2023. • **Sunderland – Place Based Working** – in January 2023 it was anticipated that Sunderland Joint Consultative Forum and the Sunderland Health and Care Alliance would commence three development sessions to progress the establishment of its place-based governance arrangements. It was reported that the work was going well but that there had been some challenge in some areas, particularly around Sunderland. • **Sunderland – All Together Better (ATB)** – ATB were working with partners to improve access to the out-of-hours GP service and improve links between the service and other urgent and emergency care services. A proposal had been made to relocate the GP Out of Hours (OOH) Service from its current base at Leechmere/Vocare House to a suitable location in the Urgent Treatment Centre at Sunderland Royal Hospital. No proposal to change the home visiting element of the service had been made. The Executive Medical Director noted that a paper was also expected to be brought to the Committee regarding the re-procurement of the OOH service in South Tyneside with a proposal to extend for an additional year. The advantage being that it would then be aligned to the re-procurement of the Sunderland OOH service. A request had been made to pause this work until the extension in Sunderland had been considered and agreed. • Sunderland – Mental Health (MH) Conveyance – the Care Quality Commission (CQC) had instructed a MH conveyance provider to suspend their service for a three month period with immediate effect to enable time for a number of quality improvements to be implemented. Work continued to understand the impact and address any quality concerns with commissioning teams working to secure short-term options to support secure MH transport.

	• **Tees Valley – Winter Funding** – across the Tees Valley, work had been undertaken with partners to identify a range of potential winter initiatives focussed on increased capacity within Same Day Emergency Care (SDEC) and the Urgent Treatment Centre although funding resources were limited and ICB support had been sought. • **Tees Valley – Children and Young People (CYP)** – a piece of work was underway across the five places within Tees Valley and respective directors of children's services to jointly identify system priorities for CYP including speech and language services; commissioning for CYP with complex needs; emotional health and wellbeing; best start in life including integrated working with maternity services and Children in our Care. **RESOLVED:** **The Committee RECEIVED the report for assurance and NOTED the decisions log for information.**
EC/2023/158	**Agenda Item 7.2 South Tees Integrated Urgent Care** The Director of Place (Middlesbrough and Redcar & Cleveland) introduced the report which provided details of the progression and delivery of the South Tees Integrated Urgent Care project. Through close collaborative working and engagement with clinical leads from across the urgent and emergency care system in the Tees Valley, a robust proposal had been developed for the future configuration and standardisation of urgent care services across Tees Valley. The Committee was supportive of the proposals presented and asked if consideration had been given to the use of mobile units. It was noted that a bid had been submitted for capital for a temporary facility at John Cook Hospital which could be explored. National guidelines for urgent treatment centre opening times were discussed and a review of access usage at certain times during the night would be helpful for learning across the patch. It was proposed to operate in Hartlepool until midnight following a review of access. Clarification of what decisions could be taken at Place, whilst complying with governance guidelines, to be identified to avoid any extended delays. ACTION: **The Chief Executive and Interim Executive Director of Finance to consider the capital available to support the next period of winter pressure and to identify what decisions could be taken at Place, whilst complying with governance, to avoid any extended delays.**

	RESOLVED: **The Committee:** **1) SUPPORTED the proposed phased strategic approach to implementation based on a 3-stage process, as outlined in the report;** **2) SUPPORTED the progression of developing an interim, short-term contract, in lieu of a contract extension, with the existing provider of GP OOH services in the South of Tees locality;** **3) SUPPORTED issuing notice to the GP OOH Provider and to request information in relation to the Transfer of Undertaking for the Protection of Employment Regulations (TUPE) support of the procurement exercise; and** **4) AGREED that the proposal to add a market engagement report and procurement evaluation strategy to the cycle of business for the Committee.**
EC/2023/159	**Agenda Item 8.1 Comprehensive Winter Planning and Operating Resilience Update** The Executive Medical Director introduced the report which outlined progress against the deliverables for winter operating resilience for urgent and emergency care, ICB progress against actions and progress against national and local metrics for delivery. The amount of work achieved over the last few months was highlighted along with a recognition that the service was working well. The key action plan areas for the board assurance framework had either all been implemented or were in the process of being implemented. It was noted particularly that the ambulance handover bids for the backstop of 59 minutes totalled £8,381,086 for full year costs, therefore the group agreed to assume that funding each bid for two months was appropriate giving a cost of £1,396,847. All foundation trusts were aware that this was non-recurrent funding. The Chair noted the progress made which was agreed as outstanding and commended the personal leadership of the Executive Medical Director. **RESOLVED:** **The Committee:** **1) NOTED the headlines of the new delivery plan for the recovery of urgent and emergency care;** **2) NOTED the significant performance improvement against the national metrics indicating some impact on the overall significant pressures across the system; and** **3) NOTED the approval of the Chief Executive and the Interim Executive Director of Finance for the winter funding part 2 bids for (in the main) implementation of the handover backstop of 59 minutes across all trusts in the ICB footprint (as detailed in**

	Appendix 1 of the report).
EC/2023/160	**Agenda Item 8.2 ICB Programme Plan Update** The Director of Transformation (Primary Care) introduced the report which provided the Committee with visibility of the current ICB programme and progress against key deliverables. The plan had been refined to reflect the 15 key priority areas which required executive oversight and included a rating of progress against each programme with commentary from director leads where appropriate with key headlines described in section 3 of the report. The Project Management Office (PMO) would continue to track progress with director leads and escalate risks and issues as appropriate to the committee. As detailed in the report, the Committee was advised that the plan currently had seven amber rating and one red rating to note in particular. The Chair asked that the 15 priority areas be reviewed again to consider pharmacy, optometry and dentistry, discharge, etc. and for the Executive Chief of Strategy and Operations to pick up the action. The Executive Director of Corporate Governance, Communications and Involvement also suggested that the priority areas were to be used to develop a conclusion briefing for staff to update on what has been delivered. **ACTION:** **1) The Executive Chief of Strategy and Operations to review the 15 priority areas giving consideration to additional or changing priorities; and** **2) The Executive Chief of Strategy and Operations to oversee the development of a conclusion briefing for staff to update on deliverables.** **RESOLVED:** **The Committee NOTED the content of the ICB Programme Plan.** *At 11.00am, the Senior Head of Commissioning (Primary Care) joined the meeting for the following item of business only.*
EC/2023/161	**Agenda Item 8.3 Primary Care Operating Framework** The conflict for the Director of Transformation (Primary Care) was again noted for this item. The Director of Transformation (Primary Care) introduced the report which outlined the proposed operating framework for primary care. The scope of

	the framework was based around general medical services and had been adapted in this final proposal to include pharmacy, optometry and dental (POD) services which would facilitate governance and functions for the ICB and the delegation of all primary care services from April 2023. The Senior Head of Commissioning (Primary Care) explained in more detail the proposed future way of working for commissioning and contracting functions of primary care within the ICB. The Committee was asked to consider the primary care operating framework to align with the ICB's overall governance framework and Scheme of Reservation and Delegation (SORD). A primary care structure was outlined in the report, including a Primary Care Strategy and Delivery Subcommittee and a Pharmaceutical Regulations Subcommittee, to enable clarity of decision making, oversight and assurance that all functions would be delivered in line with the ICB triple aims and delegation of primary care services, recognising the primacy of Place. The Executive Committee and Board would be presented with a series of reports at future meetings which would further outline the arrangements for the transfer of POD delegation. The report built on the work first initiated by the Primary Care Strategy Group looking at decision making and governance. The Primary Care Transformation Team had since taken this forward and engaged further with the place-based teams across the ICB before shaping the recommended framework. The Executive Area Directors, Directors of Place and the Director of Corporate Governance and Involvement had also been involved in the discussions. Work had also commenced with the Primary Care Collaborative where this proposal would be presented no later than week ending 17 February 2023. The proposed interface with partners was included within diagram 3 of the report. The Committee acknowledged the huge amount of work undertaken to get to this point and thanked the Senior Head of Commissioning Primary Care. It was suggested that there would need to be links with the Medicines Subcommittee with the primary care subcommittees and would require further discussion to agree how this would work. The Senior Head of Commissioning Primary Care to discuss further with the Director of Corporate Governance and Involvement. Confirmation was provided that the Executive Area Directors would be responsible for the primary care budget in the respective areas. The Committee agreed that it had been extremely helpful to receive the framework in such detail which was presented more like a handbook which could be clearly followed to know where decisions were made.

	The Director of Corporate Governance and Involvement noted that appendix 2b regarding approval of the Primary Care Strategy should be reserved to the Board rather than the Executive Committee and asked that this be amended, therefore *"Primary Medical Services – delegation to the Integrated Care Board"*. ACTION: The Executive Director of Corporate Governance, Communications and Involvement to link with the Director of Transformation (Primary Care) to give more detailed consideration to the collaborative element of the framework. **RESOLVED:** **The Committee:** **1) SUPPORTED the establishment of a Primary Care Strategy and Delivery Subcommittee;** **2) SUPPORTED the establishment of a Pharmaceutical Services Regulatory Subcommittee with further discussion with the Director of Corporate Governance and Involvement on where this will sit within the governance structure;** **3) NOTED the draft SORD Appendix 2 a-d (at Appendix 1 to the report), to inform the Primary Care Strategy and Delivery Subcommittee terms of reference which would be presented to the committee on 14 March 2023 for recommendation to the Board on 28 March 2023;** **4) APPROVED for the Senior Responsible Officer for Primary Care and the Director of Transformation (Primary Care) to develop, with the Governance Team, any updates to the SORD, for approval by the Board in March; and** **5) NOTED the amendments to the operational functions of primary medical services commissioning teams, at Place and across the ICB.**
EC/2023/162	**Agenda Item 8.4 COVID-19 Vaccine Gateway Criteria for Inclusion in Local Incentive Schemes (LIS)** The conflict of interest for the Executive Medical Director was again noted for this item. The Executive Medical Director introduced the report which described the request to primary care networks (PCNs) to deliver all nationally prescribed vaccinations in 2023/24 across the North East and North Cumbria footprint as per guidance from the Joint Committee for Vaccinations and Immunisations. The larger campaigns for 2023/24 included the autumn and spring vaccinations for COVID-19 and for seasonal flu. Should PCNs not sign up to future gateway criteria, this could lead to a lack of vaccination capacity and subsequent increase in COVID-19

	infection rates and related mortality. If this intention was deferred by 12 months, there would be a risk that the areas with this in place already would feel that this was inequitable. The lack of a coordinated approach to vaccination may lead to inequity of access to vaccination across the ICB footprint and a lack of PCN participation may result in the ICB incurring significant additional revenue expense in order to commission a separate vaccination service. Approval was sought from the Committee to set up a Task and Finish Group with the intent of producing and ICB proposal to increase vaccination take-up and coverage. If approved, there would be immediate engagement and implementation by primary care medical directors and place-based directors. **RESOLVED:** **The Committee APPROVED the establishment of a Task and Finish Group with the responsibility to produce an ICB proposal to increase vaccination take-up and coverage.** *At 11.30am, the Director of Medicines and Pharmacy joined the meeting (for items 8.5 and 11.1 only)*
EC/2023/163	**Agenda Item 8.5 COVID-19 Medicines Delivery Units in NENC – Proposal for Interim Solution (January 2023)** The Executive Medical Director introduced the report which proposed an interim approach to the provision of COVID-19 Medicines Decision Units (CMDU) covering the period 1 April 2023 to 31 June 2023 utilising current hospital-based services at an estimated cost of £325k with the option to extend for a further three months depending on clarification of patient pathway and procurement requirements. The Director of Medicines and Pharmacy further explained that the ICB, in line with the 'Commissioning Framework: COVID-19 Therapeutics for Non-Hospitalised Patients' from NHS England in December 2022, was required to implement ongoing provision for a defined cohort of 'high risk' patients to reduce the chances of serious illness/hospital admissions in the event of contracting COVID-19. The Executive Team had considered the issues at an informal session in January 2023 and expressed concern over the capacity and capability of primary care services to take on the responsibility from 1 April 2023. Due to time constraint in addition to uncertainly around the patient pathway and digital enablers, it was proposed that an interim solution be adopted to commission the current hospital-based services for a further three months. It was noted that this was a high-cost service and, although drugs were provided free at the minute, it was predicted that there would only be enough to run through to March 2024 before charges would be

	implemented. **RESOLVED:** **The Committee:** **1) APPROVED the proposal to commission an interim solution for the provision of CMDU in North East and North Cumbria for a three month period from 1 April 2023, utilising the current hospital based services, with the option to extend this for a further three months depending on the resolution of the risks highlighted above;** **2) AGREED for further work to be undertaken to assess the options to develop a proposal for an ongoing model in line with NHSE's commissioning framework from 1 July 2023 with, as a minimum, an update to be provided to the Committee in April 2023 with a full proposal presented to the meeting in May 2023.**
EC/2023/164	**Agenda Item 8.6 ICB Records Management Interim Solution Proposal** The Executive Chief Digital and Information Officer introduced the report which provide a proposed interim solution for records management to enable collaborative working across the ICB. The proposal included the creation of a new file structure with links to the legacy file structures with department folders. There was also a requirement for a shared file structure to support the migration of the pharmacy, optometry, dentistry, GP transformation, GP contracting and commissioning and other specialised commissioning files and data to be transferred between 1 April 2023 and 1 July 2023. The Director of Workforce noted that personal staff files for staff would need to be considered within that work as there was a requirement for those files to be kept locally. The NECS Human Resources (HR) Team stored the files for recruitment but the personnel files for staff needed to be kept locally. Should the proposal be approved, the following actions would be required: • Corporate Governance to pilot the new shared drive • Provide new file structure required • Provide list of folder owners and staff requiring access to each folder; and • Communicate new process to ICB staff of new structure and gradual data migration rules and steps. **RESOLVED:** **The Committee APPROVED the implementation of an ICB shared Y drive, except for HR folders.**
EC/2023/165	**Agenda Item 9.1 NENC ICB and ICS Finance Report (M10)**

	The Interim Executive Director of Finance introduced the report which provided an update on the financial performance of the ICB and the NENC Integrated Care System (ICS) in the financial year 2022/23 for the period to 31 December 2022. The full financial report for the period had been reviewed in detail by the Finance, Performance and Investment Committee at its meeting on 2 February 2023. As at 31 December 2022, the ICB reported a forecast deficit of £4.9m prior to expected receipt of additional funding from NHSE of £10.6m to cover costs associated with the Primary Care Additional Role Reimbursement Scheme (ARRS). Once received, the ICB would report a forecast surplus of £5.7m against a planned surplus of £2.6m. The additional £3m surplus would offset a forecast deficit across relevant NHS providers, allowing a balanced financial position to be maintained across the ICS. The ICS revenue position reported a forecast outturn of a surplus against plan of £20k. One NHS provider foundation trust (FT) had reported a deterioration in forecast outturn of £5.6m (from surplus to breakeven) earlier in the year. This forecast deficit had been offset by a combination of additional surplus in the ICB as reported above £3m and another FT improving its forecast outturn by £2.6m. The forecast underspend was expected on ICB running costs, due largely to the impact of vacancies in the current year. This remained a potential recurring risk area if the vacancies were filled. A potential forecast pressure of £10.66m was forecast on capital spending plans across the ICS in comparison to the confirmed ICS capital departmental expenditure limit allocation (CDEL). This forecast pressured continued to reduce as work continued to review relevant capital plans with individual provider trusts. Discussions also continued with NHSE in respect of additional capital funding allocation for the year. Work was progressing to develop financial plans across the ICS for 2023/24 in line with the relevant planning guidance and financial allocations published by NHSE. Further clarity was expected in some areas, including elective recovery, to fully understand the implications for the ICS. The 2022/23 financial position across the ICS included significant non-recurring benefits, both in respect of balance sheet movements and non-recurring delivery of efficiency programmes. The non-recurrent nature of these savings will present a significant financial challenge to develop a balanced plan for 2023/24. The Chair noted that there was an opportunity to link the finance team into the contracting work to review the list of 1200 contracts, with multiple providers, as this might highlight some potential opportunities for

	streamlining. **<u>RESOLVED:</u>** **The Committee:** **1) NOTED the latest year-to-date and forecast financial position for 2022/23 and was assured that overall performance was in line with plan; and** **2) NOTED that the number of financial risks across the system were still to be managed.**
EC/2023/166	**Agenda Item 10.1 Integrated Delivery Report** The Director of Transformation (Primary Care) introduced the report which provided an ICS overview of quality and performance, highlighting significant changes, areas of risk and mitigating actions. The report included key elements of the 2022/23 planning priorities, NHS oversight framework metrics, some commitments within the NHS Long Term Plan (LTP) and the NHS People Plan commitments. The performance elements of the report had been discussed in detail at the Finance, Performance and Investment Committee and the quality elements discussed at the Quality and Safety Committee. In South Tees, the final inspection report was expected in March 2023 following a well-led inspection by the Care Quality Commission between 10 and 12 January 2023. It was noted that the Director of Performance and Improvement was leading on the key projects and issues raised within the report. A meeting had been held with all the directors of nursing to discuss the format of the report and as a result of feedback, the report would be amended to reflect that feedback. The Chair advised that a meeting had taken place with the NHSE Regional Director for the North East and Yorkshire and North West regions (NHSE) and representatives of Newcastle-upon-Tyne Hospitals NHS Foundation Trust to discuss elective care. The main issue raised was the requirement to deliver 104 week waits by the end of March 2023 and explained that every trust across the country have been told they need to hit zero so could move into Tier 1. An agreement had been reached to move to weekly Tier 2 meetings which the ICB would co-lead to help the trust stay on track. **<u>RESOLVED:</u>** **The Committee NOTED the report presented and ACKNOWLEDGED the future change in format of the report.** *At 11.30am, the Research Manager (NECS) joined the meeting for the next item of business only. The Director of Medicines and Pharmacy was also in attendance for the next item of business.*

EC/2023/167	**Agenda Item 11.1 Community Pharmacy Services in North East and North Cumbria – review of pilot schemes and proposed next steps** The Director of Medicines and Pharmacy introduced the report which described two pilot community pharmacy services commissioned across the North East and North Cumbria and included the proposed next steps for future commissioning. Further details of the schemes were presented by the Research Manager from NECS who confirmed that Winter Access Funding (WAF) had been awarded in 2021/22 to support the pilot schemes across the patch until 31 March 2023. Think Pharmacy First had provided 17,371 consultations to patients from December 2021 – December 2022 inclusive, assessing urinary tract infections (UTIs). It was confirmed that the cost for resourcing was cost neutral across both schemes. The committee was impressed by the work involved and the ability to have patients using pharmacy services first which would enable these schemes to progress to the next level. Of the 650 community pharmacies in the North East and North Cumbria, 435 had signed up to the scheme. It was hoped that this number would rise as the data is reported and more pharmacies consider the benefits. ACTION: **The Director of Medicines and Pharmacy and Research Manager to provide a map of the region highlighting the locations of the pharmacies who have signed up to these schemes and those who had not.** **RESOLVED:** **The Committee SUPPORTED the recommendation to commission the Think Pharmacy First minor ailments scheme and the community pharmacy service for the assessment and treatment of UTIs, on a recurrent basis, across the North East and North Cumbria.** *At 11.50am, the Director of Medicines and Pharmacy and Research Manager (NECS) left meeting and did not return.* *At 12.30pm, the Director of Health Equity and Inclusion joined the meeting for the next item of business only.*
EC/2023/168	**Agenda Item 12.1 Interim Equality, Diversity and Inclusion Strategy 2023-2024** The Director of Health Equity and Inclusion introduced the report which presented the ICB interim Equality, Diversity and Inclusion (EDI) strategy 2023/24. The strategy set out the intention to create a foundation and a short-term plan to shape the future for EDI and the wider system for the

	next 12 months whilst a five-year strategy was co-created across the ICS/ICP. Reference was made to the EDI maturity matrix which had been developed following a board development session on 13 December 2022 after considering what a potential five year strategy could look like. The Committee noted the amount of work undertaken so far and the simplicity of the objectives set out within the report was welcomed. Despite the simplicity, it was clear what the measurable goals underpinning the strategy were. It was suggested that this could also be included within the oversight framework to support EDI within system leadership as this was one of the 'golden threads' that needed to run through the whole organisation. ACTION: **The Executive Chief of Strategy and Operations to consider inclusion of EDI when reviewing the 15 priority areas.** **RESOLVED:** **The Committee:** **1) AGREED and fully SUPPORTED the interim EDI Strategy for 2023-2024 and its associated objectives and actions; and** 2) **AGREED and SUPPORTED for a five-year EDI Plan from 2024-2029 to be developed.** *At 12.40pm, the Director of Health Equity and Inclusion left the meeting and did not return.*
EC/2023/169	**Agenda Item 13.1 Risk Management Report** The Executive Director of Corporate Governance, Communications and Involvement introduced the report which provided an updated position on the risks facing the organisation for the period 20 December 2022 to 27 January 2023. The report included the current position of 29 risks on the risk register and assurance provided that there had been no movement in the risk score during the reporting period. Two new risks had been identified as follows: • NENC/0034 – ongoing recurring financial pressures and commitments for the ICB arising from services initially commissioned with non-recurring funding allocations. This risk was scored at 12 A (high); and • NENC/0035 – the ICB and wider ICS may be unable to agree and deliver a robust, and credible, balanced financial plan for 2023/24 within confirmed funding envelopes due to underlying recurring

	pressures across the system. This risk was scored at 20 R (extreme). The Committee was referred to paragraph 4.3 within the report and approval sought for the proposal for the scalation of risks between place and corporate risk registers. Risks identified at place or area would be reviewed to determine whether they should be escalated to the corporate risk register when a score of 12 or more is reached. In addition, risk identified at multiple places should be considered for escalation regardless of score to determine whether this was a regional risk. An illustration of the proposed escalation of place risks was included in the report. The Director of Corporate Governance and Involvement proposed that risk register be presented to the Committee on a bi-monthly due to minimal change month on month and this was agreed. Some discussion took place around the accuracy of the risk register following which the Chair requested all executive directors review the register to ensure that items noted were accurate and to highlight any omissions. ACTION: 1) The Director of Corporate Governance and Involvement to amend the table to clearly show the responsibility for risk review, i.e., the lead committees should be reviewing their own risks; 2) All Executive Directors to review the Risk Register to ensure accuracy of risk in each area and to highlight any omissions. **RESOLVED:** **The Committee RECEIVED the report for assurance and APPROVED the process for the escalation of risks identified at Place, as set out in section 4.3 of the report.**
EC/2023/170	**Agenda Item 13.2 Data Security and Protection Toolkit – Baseline Assessment** The Executive Director of Corporate Governance, Communications and Involved presented the report which provided a brief update and overview of the Data Security and Protection (DSP) Toolkit process and timelines for 2022/23. *At 12.20pm, the Executive Medical Director left the meeting and did not return.* The committee noted that the baseline was to be submitted by 28 February 2023 with the final DSPT submission by 30 June 2023. An interim audit would commence on 27 February 2023 by AuditOne with the final audit planned for completion in May/June prior to the final submission date. It was also noted that the ICB had been classified as a category one

	organisation for the DSPT. The DSPT consisted of 36 assertions within 10 National Data Guardian standards, 34 of which were mandatory for ICBs. The ICB was required to provide 113 items of mandatory evidence to support the assertions. A project team had been established to undertake the self-assessment process, consisting of both ICB and NECS colleagues and managed by a senior governance lead, with oversight from the Director of Corporate Governance and Involvement. **RESOLVED:** **The Committee RECEIVED the report for assurance and NOTED the ongoing actions and progress towards the final submission date.**
EC/2023/171	**Agenda Item 13.3 Subcommittee Terms of Reference and Recommendations** The Director of Corporate Governance and Involvement advised that this report had been withdrawn from the agenda at short notice as it was highlighted that further work was still required on the terms of references. The report would be presented to the Committee at the meeting in March 2023 for formal approval.
EC/2023/172	**Agenda Item 14.1 NENC ICB Corporate Policy Six Month Review** The Executive Director for Corporate Governance, Communications and Involvement introduced the report providing detail of four policies which had been reviewed. The complaints policy had been highlighted by subject matter experts (authors) as requiring an update. The following policies had been reviewed by subject matter experts required no updates: • Access and Choice Policy • Counter Fraud, Bribery and Corruption Policy; and • Media Policy It was noted that the complaints policy and procedure was a live document which would require updating as a result of the primary care and associated functions delegation and transition. The revised policy was noted and agreed that this would evolve with the possibility of creating a sub-committee to feed into the Quality and Safety Committee in the future. **RESOLVED:** **The Committee APRROVED the updated Complaints Policy and NOTED the other policies as not requiring an update.**
EC/2023/173	**Agenda Item 15.1 Any Other Business**

	There were no items of any other business for consideration.
EC/2023/174	**Agenda Item 16 CLOSE** The meeting was closed at 12.45pm
	Date and Time of Next Meeting Tuesday 14 March 2023 10.30am

Signed: **Sam Allen**

Position: **Chief Executive (Chair)**

Date: **14 March 2023**

Item: 9.2.2

NHS
North East and North Cumbria

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

BOARD

28 March 2023

Report Title:	**Highlight report from the Quality and Safety Committee held on the 16 February 2023**

Purpose of report

To provide the Board with an overview of the discussions at the meeting of the Quality and Safety Committee held in February 2023.

Key points

The Committee considered a number of issues and supporting papers including:

- Storyteller Protocol
- Sub committee proposals and terms of reference for consideration
- Risk reporting and top risks
- Maternity, Clinical Negligence Scheme for Trusts
- Reflections on ICB development session with Bill Kirkup
- Flu update

Risks and issues

The Committee will continue to receive and review the corporate risks aligned to the quality and safety portfolio to provide assurance to the Board that the quality and safety risks contained within the corporate risk register reflect the current environment.

Assurances

The clinical quality exception report and other supporting reports provide the Committee with a range of data and assurance sources.

Recommendation/action required

The Board are asked to note the Quality and Safety Committee highlight report for February 2023.

Acronyms and abbreviations explained	
N/A	
Executive Committee Approval	N/A
Sponsor/approving executive director	Eileen Kaner, Chair of the Quality and Safety Committee and Non-Exec Director
Report author	Neil Hawkins, Head of Corporate Affairs

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

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

Key implications	
Are additional resources required?	None at this stage.
Has there been/does there need to be appropriate clinical involvement?	Appropriate clinical representation within the membership of the Committee. Terms of reference to include representation from Nursing Directors and Medical Directors.
Has there been/does there need to be any patient and public involvement?	N/A
Has there been/does there need to be partner and/or other stakeholder engagement?	N/A

Item: 9.2.2

Quality and Safety Committee highlight report – February 2023

Summary report

The Quality and Safety Committee, Chaired by Eileen Kaner, met on the 16 February 2023 and considered a number of issues and supporting papers including:

Storyteller protocol and involvement and experience update – the Committee was provided with an update on the proposed protocol to capture patient and carer's lived experiences of the ICB's commissioned services, as well as its initial implementation. Specific consideration has been given to the need to widen the scope, ensuring we are listening to staff perspectives and those able to represent communities across our geography (instead of purely individual patient sorties). To reflect this, the name of the process has been changed from patient stories to storyteller.
A section has also been enhanced around ensuring people follow individual organisation's complaints procedures. An initial communication plan has also been developed with the ICB communications team. To support this work, key messaging and communication materials are also being developed and pre-tested. There was some concern about whether the term story telling could be confused with whistle-blowing or perceived as trivializing experiences – hence the need to check this with members of the public.

Terms of reference – the Committee considered the current terms of reference and agreed that further discussions and work would be required to refine the membership of the Committee. The membership of the Committee has been reviewed in light of planned sub-committee arrangements and to ensure the size of the Committee allows for good discussion and decision making. The Committee recommends to the ICB Board the establishment of the below sub-committees:

- NENC Integrated Care System Safeguarding Health Executive Group: Children, Adults and Cared for Children Sub Committee
- Quality and safety sub-committee (Area) (x4) – four sub committees covering the four geographic areas within the ICB - North Cumbria; North Area (Northumberland, North Tyneside, Newcastle and Gateshead), Central Area (Sunderland, South Tyneside and County Durham) and Tees Valley Area (Darlington, Hartlepool, Redcar & Cleveland, Middlesbrough and Stockton).
- Antimicrobial Resistance (AMR) and Healthcare Associated Infection (HCAI) sub committee

The terms of reference for the sub-committees have been included in the updated Governance Handbook which is being presented to the Board for approval in March.

Risk register – The Committee received the risk register report containing risks within the ICB corporate risk register that align to the Quality and Safety Committee. Six new risks were noted and reviewed. One further new risk was proposed for consideration by the Committee concerning identifying suitable placements for patients with complex learning disabilities and meeting targets concerning a reduction in in-patient bed capacity. The Committee agreed the proposed risk should be added to the risk register but the scope of the risk widened. The NECS risk team will work with the Director of Nursing (North) to capture the new risk and arrange for it to be added to the risk register.

Directors of Nursing – top three risks – The Directors of Nursing ran through a brief presentation outlining the current top three risks within each of the four geographical areas within the ICB. Themes included: workforce capacity in health and social care; continuing health care

(CHC) capacity and the fragility of the domiciliary care market; significant pressures across health and social care system resulting in pressures on Emergency Depts and ambulance waits.

Maternity, Clinical Negligence Scheme for Trusts - The ICB has the responsibility to confirm the eight Maternity providers' self-declaration for the Clinical Negligence Scheme for Trusts. Four of the Trusts are declaring full compliance and four not. There was some concern about scope for subjectivity in reporting. The Committee considered a report which highlighted the key areas of non-compliance and the process the Local Maternity and Neonatal System is following to support the Trusts. A number of Trusts nationally have had to payback premiums due to false declarations to their Boards. The ICB held a session with all providers and used local intelligence and data to assure the Trusts declared an accurate position.

Reflections on ICB development session with Bill Kirkup – Hannah Bows (vice chair) led a brief discussion with some reflections from the ICB Board development session with Bill Kirkup, which took place earlier in the month. Many of the Committee members attended the session and all agreed it was a very moving presentation. Three key points/take-away messages from the session were flagged:

1. Data – how do we address the lack of outcome data (beyond live birth or not) to help identify issues early?
2. Information/feedback from service users – how do we find out what we don't know? We can't rely only on formal complaints. Many people may have difficult experiences but don't complain. How do we capture that?
3. Culture – how can we identify problems at an early stage and challenge poor attitudes or practice (across clinical disciplines or differing level of seniority)?

It was suggested that a deeper dive process was required to move from what is known from elsewhere, to establish specific actions to ensure respectful, safe maternity practice across all relevant providers and differing maternal population sub-groups in NENC.

Update briefing – 2022/23 flu vaccination and forward view 2023/24 – Dr Neil O'Brien, ICB Medical Director took the Committee through a brief presentation concerning the flu vaccination program for this year, including some of the achievements of note and challenges. Planning for 23/24 is underway with a focus on:

- Pregnant women
- 2 and 3 year-olds
- New data and behavioural insights – from ICB inequalities funding
- Pharmacy focus
- New contract for school age providers from 1 Sept 2023
- Data flows and intelligence improvements
- Formalised plan ready by end of July

Item: 9.2.3

NHS
North East and North Cumbria

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

BOARD MEETING 28 March 2023	
Report Title:	**Finance, Performance and Investment (FPI) Committee Highlight report**

Purpose of report

To provide Board members with an overview of items considered and discussed at the FPI committee

Key points

A summary of the highlights from the February and March 2023 FPI Committee meetings

Risks and issues

- Work is ongoing to develop operational and financial plans for 2023/24 however initial draft financial plans showed a significant deficit across the ICS. This reflects the underlying recurring financial position in 2022/23, which has been largely mitigated through non-recurring benefits and efficiencies, together with additional unfunded pressures expected in 2023/24. Whilst significant work is continuing to reduce the deficit, and updates will be provided to Board on 28 March, delivery of a balanced financial plan for 2023/24 will be a significant challenge.

- There continues to be a number of potential financial risks to manage in 2022/23 across the system, although work to review pressures and identify mitigations has resulted in unmitigated potential financial risk reducing significantly for 2022/23. Work continues across the system to manage this position with delivery of a balanced system position expected.

Assurances

For the Board to gain assurance that the FPI Committee is undertaking the relevant discussions and approvals in line with its Terms of Reference

Recommendation/action required

The Board is asked to:

- Note the contents of the committee highlight report;
- Receive the approved January and February minutes for information

Item: 9.2.3

Acronyms and abbreviations explained	
Sponsor/approving executive director	David Chandler, Interim Executive Director of Finance
Report author	Richard Henderson, Director of Corporate Finance Jen Lawson, General Manager

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

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

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

Item: 9.2.3

Finance, Performance and Investment (FPI) Committee Highlight Report

Introduction

The purpose of the FPI Committee is to provide oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable, system financial plan. The committee reviews and scrutinises the financial performance of both the ICB and NHS organisations within the ICB footprint, as well as having an overview of overall operational performance and investments.

Summary report

The FPI Committee, chaired by Jon Rush, Non-Executive Director, met on 2 February (approved minutes attached) and 2 March. The March minutes will not be approved until the next meeting scheduled for 6 April, hence why they are not circulated with this report.

As the Board received an update at its meeting on 24 January regarding the FPI Committee meeting held on 1 December and 5 January, this update will cover 2 February and 2 March 2023 meetings. The approved minutes from 5 January are also attached for information.

2 February 2023

The Committee were provided with an ICB financial performance update, which demonstrated at Month 9 that the ICS is on track to deliver the planned breakeven position, reporting a small surplus of £20k.

A performance position update was provided by the Executive Chief of Strategy & Operations.

Key areas highlighted were:

- Handover delays
- 12 hour delays in A&E from decision to admit
- Ambulance response times
- Elective care
- Cancer
- Mental health

A presentation by the Executive Chief of Strategy & Operations on Operational planning submission 2023/24 detailing the requirements, process and submission timescales.

The Interim Executive Director of Finance presented the Resource Allocation Group terms of reference for approval. The purpose of this group is to support the ICB to discharge its responsibilities regarding resource allocation and implement recommendations relating to findings from the Allocations Task & Finish Group

2 March 2023

An update was received on the latest financial performance of both the ICB and ICS for 2022/23. The Committee discussed the work that had been undertaken across the system to manage the significant potential financial risks and agree forecast outturn positions across the ICS to enable overall delivery of a balanced position.

A further update on the latest performance position was provided by the Executive Chief of Strategy & Operations. Key areas highlighted were;

- The improvement in ambulance handover delays achieved in January 2023 has largely been sustained into the first few weeks of February
- Patients waiting in A&E more than 12 hours following decision to treat has decreased significantly in January 2023 to 1583 following a significant increase to 2347 in December 2022
- Category 2 ambulance response times mean performance has since improved from 1:36:22 in December 2022 to 32:24 in January 2023.
  Although the number of patients waiting over 78 weeks for elective care 2022 compared to November levels, unvalidated weekly data shows a decrease in recent weeks across NENC to 990 (w/e 29 Jan), with a particular reduction at South Tees.
- The plan to reduce reliance on inpatient care (IP) care for adults with learning disabilities trajectories is off track overall as at 13/2/23, with a total of 168 patients in IP care, working towards no more than 71 adults in NENC by 2023/24, due to a spate of new admissions

The Committee reviewed the latest risk register position for assurance along with the Board Assurance Framework. The Committee considered risk appetite levels and agreed further discussion would take place as part of scheduled Committee development sessions.

Following a discussion around the Committee's responsibilities in respect of capital funding and estates strategy in particular, the terms of reference of the Committee were reviewed again to ensure they remain relevant and appropriate. Certain amendments to clarify responsibilities were proposed which will be presented back to Board for formal approval in due course.

An update was received by both the Executive Chief of Strategy & Operations and the Executive Director of Finance on the latest position in respect of draft operational and financial plans for 2023/24, and the actions being taken to review and update plans across the ICS ready for final submission in March 2023.

Recommendation

The Board is asked to:

- Note the contents of the committee highlight report;
- Receive the approved January and February minutes for information

NHS
North East and North Cumbria

North East and North Cumbria Integrated Care Board
Finance, Performance and Investment Committee

Minutes of the meeting held on Thursday 5 January 2023, 10:00hrs
Via MS Teams

Present:
Jon Rush, Chair
Ken Bremner, Chief Executive, South Tyneside and Sunderland NHS FT
David Chandler, Interim Executive Director of Finance
Dave Gallagher, Executive Director of Place Based Delivery
Eileen Kaner, Vice Chair
Jacqueline Myers, Executive Chief of Strategy and Operations
Rajesh Nadkarni, Executive Medical Director, CNTW
Neil O'Brien, Executive Medical Director

In attendance:
Richard Henderson, Director of Finance
David Stout, ICB Audit Committee Chair
Gillian Sheppard, Executive Assistant (minutes)

FPI/2023/01	**Welcome and introductions** The Chair welcomed everyone to the Finance, Performance and Investment Committee (FPIC) meeting.
FPI/2023/02	**Apologies for absence** Apologies for absence was received from Jennifer Lawson, Governance Lead.
FPI/2023/03	**Declarations of interest** There were no declarations of interest declared. The Chair reminded members that should a specific conflict of interest be evident during the course of the meeting for the two Provider representatives, they will be dealt with by the Chair as and when they occur.
FPI/2023/04	**Minutes of the previous meeting (1 December 2022)** It was AGREED that the minutes accurately reflected the meeting with the exception of the following amendment: Agenda item 'FPI/2022/12/13 Terms of Reference': page 6, paragraph 4, deputy cover for this committee is Nic Bailey.
FPI/2023/05	**Matters arising from the minutes**

	There were no matters arising from the minutes
FPI/2023/06	**Action log update** The action log was reviewed and agreed that the following actions can be marked as complete: **FPI/2022/11/07/01:** Outside of the meeting, David Purdue had advised that the action cards and discharge policy have been resent to Trusts and are being monitored through the daily discharge meetings with place directors. Committee agreed to close action. **FPI/2022/12/08/01:** Jacqueline Myers confirmed that the amendment to section 6.4 ICB Financial Oversight Arrangements had been amended to state the FPIC is supported by a monthly ICS finance meeting which includes directors of finance from both the ICS and the ICB, where the financial position is reviewed collectively. Committee agreed to close action. The following updates were provided: **FPI/2022/11/07/04:** – action is ongoing. Conversations with providers on model and narrative plan for ERF is progressing and final version is imminent. A further update to be given at February 2023 meeting. **FPI/2022/11/07/05:** – action ongoing. The inclusion of MHLD information in the performance pack is in development with specific metrics to be agreed. A further update to be given at February meeting. **FPI/2022/11/08/01: –** action ongoing. ICB Director of Finance, Lynne Walton to carry out a deep dive into contracts of largest independent sector providers to review whether overperformance is contributing to elective waiting times. **FPI/2022/11/09/01 –** action deferred to February 2023 meeting. **FPI/2022/12/11/01 –** ongoing. The Interim Executive Director of Finance confirmed notice had been given to NHSE that the ICB will incorporate the £17.5m guaranteed drawdown from CCG historical agreements into the 2022/23 plan. A further update will be provided at a future meeting. A question was asked if the £17.5m drawdown for historic surpluses was a confirmed allocation in month 8. The Interim Executive Director of Finance said this was a technical allocation and is recorded as a cumulative surplus but is not available to spend in year. **FPI/2022/12/12/01 –** ongoing – lead to be amended to Jacqueline Myers and update to be provided at February meeting.

FPI/2023/07	**Notification of urgent items of any other business** There were no urgent items of any other business raised.
FPI/2023/08	**Finance update 2022/23 and Financial Planning update 2023/24** The Interim Executive Director of Finance presented a brief update for the North East and North Cumbria Integrated Care Board (ICB) and the Integrated Care System (ICS) for the period to 30 November 2022 and focused on an overview of financial planning for the 2023/24 financial year. For the financial year 2022/23 the ICS, including the Q1 position of the NENC CCGs, is on track to deliver the planned breakeven position reporting a small surplus of £0.04m at month 8. The ICB is reporting a year-to-date overspend of £3.15m and a forecast outturn overspend of £5.55m, prior to expected retrospective funding adjustments of £11.22m. Once expected retrospective funding has been received, the ICB will be reporting a forecast surplus of £5.7m, in line with the previous month. In brief for month 8, there has been limited change from the previous month's position and financial risks, with £35m remaining in unmitigated risk for the ICS. Any variances for the ICB relate to risks and pressures around the independent sector, prescribing, and pay award pressures ~~risk~~ for the providers. The financial position of both the ICB and the wider ICS will continue to be reviewed, in detail, on a monthly basis. There were no questions raised for the month 8 financial position. A presentation was given on the progress of 2022/23 year end planning and achieving targets, as there is £35m of unmitigated risk across the ICS. A session has taken place in December 2022 with Directors of Finance across the ICS to discuss the pressures faced by each organisation and to agree the working principles between now and the end of the year. All of the organisations agreed they are aiming to increase income into the ICS, reduction variation to plan and reduce deficits. The discussion highlighted a number of potential risks to the wider ICS financial position within Foundation Trusts (FT's), including financial pressures associated with the pay award of £20m, alongside risks relating to general cost pressures and delivery of cost savings in a number of FTs totalling £10m. To help mitigate these risks it was agreed the ICB requested from NHS England (NHSE) additional non recurrent funding of £23m in financial support with flexibility on year end reporting m10 position and a light touch pragmatic approach to the change in forecast protocol. It has been confirmed that NHSE have agreed to allocate the ICB £19.9m of non-recurrent financial support, providing the ICS achieves a balanced position at year end and minimise variations across the system. NHSE also reserve the right to pull back any monies in 2023/24 should there be

	additional surplus or deficit delivered over the m10 forecast.
	
	A question was asked if the £23m financial support request was specifically to address the pay award increase. The Interim Executive Director of Finance said the non-recurrent financial support provided by NHSE was not specifically to fund the pay award for 2022/23 but to recognise the ongoing pressures within the system and to support the ICS to a break-even position. If the system remains in balance, it will also then receive a fair share of additional capital monies in 2023/24 across the system, not to individual organisations.
	
	The Interim Executive Director of Finance was asked if the non-recurrent financial support allocation could impact on the £17.5m CCG historic surplus monies, it was confirmed that this was not linked and would have no impact.
	
	In terms of next steps, the Directors of Finance across the ICS will meet further to discuss and agree a collective approach for month 10 forecast outturns and the overspend protocol to ensure the ICS will reach a balanced position. There are three organisations that are at risk of going into deficit plans and there is a need to agree how to support each other collectively.
	
	A summary of the 2023/24 financial planning guidance update was presented, the key highlights included:
	
	Allocations:
	
	• NENC ICB receives lowest % growth in England
	  o deemed over-funded and low population growth
	• Headline Core Combined Allocation Headline Growth of 4.28%
	  o includes a convergence reduction of -0.71%
	• Like for Like Growth of 2.9%
	  o COVID-19 funding set at £24m - down from £127m – equivalent to reduction of 1.8%
	  o Elective Recovery Fund (ERF) set at £140m - up from 106m – equivalent to increase of 0.6%
	  o Bed Capacity £18m & ICB Discharge funding £14m
	• Primary Care Allocation Growth is 5.41%
	• Running Cost Allocations Flat – real terms cut of c7%.
	  o Expect reductions in 24/25
	
	Other:
	
	• System Development Funding (SDF) simplified (and reduced) - £68.7m in allocations (Mental Health largest at £37.7m) for 23/24
	• Elective Activity moves to Payment By Results (PbR)
	  o can agree variations for things like Waiting List Reductions Schemes
	• NHS Contract Inflation is 1.8% (includes 1.1% efficiency)

	○ More funding should flow if pay / non pay pressures prove higher than estimates • Mental Health Investment Standard (MHIS) – continues and Ringfenced Allocations for 23/24 • Specialised Commissioning – Joint Committees with ICB to manage delegated budgets A discussion took place on PbR and it was acknowledged that it will be challenging to identify the activity that is removed from block contracts for elective activity and into PbR. It will be a challenge to raise elective volume to the suggested 130% above ERF targets required before there is access to additional funding. It was acknowledged that the amount of growth allocation and spend in system will be difficult to achieve and may be a financial risk. There is work ongoing to understand this in contracting groups taking place across the ICS. The first draft plan is due to be submitted on 26 February 2023 with the final plan due to be submitted 31 March 2023.
FPI/2023/09	**Performance - Operational Planning Guidance update 2023/24** The Executive Chief of Strategy and Operations presented an update on the national planning guidance for 2023/24. The operational plan focus will be to recover core services and productivity, make progress in delivering the key ambitions in the NHS Long Term Plan and to continue transforming the NHS for the future. The key priorities for the operation plan were highlighted: • Urgent and Emergency Care • Community Health Services and Primary Care • Elective Care, Diagnostics and Cancer • Maternity • Use of resources and Workforce • Mental Health • People with a learning disability and autistic people • Prevention and health inequalities The operational plan objectives for each of the above key areas was briefly summarised and the overarching approach detailed within the presentation circulated. The need for finance and performance to work closely together to deliver the ask within the financial envelope was emphasised. There is specific guidance in the requirement for a joint forward plan 2023/24 – 2028/29 to be completed, the format and content of which will be the responsibility of the ICB and partner NHS trusts. The plan will be constructed from draft local authority place plans and draft

	thematic plans in consultation with partners and public, including ICP, Health and Wellbeing Board, NHSE, Healthwatch and providers. The plan will be updated by the end of March each year and will be fully aligned with the wider system ambitions. A draft of the joint forward plan is to be submitted late March 2023, with the final version submitted end of June 2023. It was noted that commissioning intentions for each sector need to be very clear on the planning priorities as an ICS, in addition to the national ask. Thematic leads will work collectively to agree on the planning process and priorities so that providers are clear from the start. The provider level plans to capture performance trajectories, workforce and finance plans will be coordinated through the 4 local ICP footprints. There is some further guidance still to be released, including publishing of long term workforce plan, strategic recovery plan for general practice and urgent and emergency care, single maternity plan and cancer. A discussion took place regarding funding for winter planning and it would be welcomed if NHSE would release funds for winter planning at an earlier stage in the financial year to build into the operational plan from the beginning.
FPI/2023/10	**FPIC Cycle of Business** The focus of February 2023 meeting will be on the 2023/24 planning guidance.
FPI/2023/11	**Any Other Business** The Interim Executive Director of Finance informed committee members of the ICB Financial Sustainability Group that has been newly established. This group will be Chaired by the Chief Executive on a monthly basis and will work with places to ensure plans are clear and there is a strong PMO in place to deliver. A discussion is needed to agree which committee the group will report any findings to, this will be either FPIC or the Executive Committee. **Action: The Interim Executive Director of Finance to discuss and agree with the Chief Executive the reporting committee for the ICB Financial Sustainability Group and agree by 2 March 2023.**
FPI/2023/12	**Review of the Meeting** All committee members agreed the meeting worked well online and the focus on operational planning had been most informative. Date of the next meeting confirmed as 10:00hrs on Thursday 2 February 2023 at Pemberton House, Sunderland. Close

Signed: 

Position: Chair
Date: 2 February 2023

NHS
North East and North Cumbria

North East and North Cumbria Integrated Care Board

Finance, Performance and Investment Committee

Minutes of the meeting held on Thursday 2 February 2023, 10:00hrs
Pemberton House, Sunderland

Present:	Jon Rush, Chair David Chandler, Interim Executive Director of Finance Dave Gallagher, Executive Director of Place Based Delivery Eileen Kaner, Vice Chair Jen Lawson, Governance Lead Jacqueline Myers, Executive Chief of Strategy and Operations Rajesh Nadkarni, Executive Medical Director, CNTW (via MS Teams) Neil O'Brien, Executive Medical Director
In attendance:	Richard Henderson, Director of Finance David Stout, ICB Audit Committee Chair Emma Ottignon-Harris, Executive Assistant (minutes)

FPI/2023/13	**Welcome and introductions** The Chair welcomed everyone to the Finance, Performance and Investment Committee (FPIC) meeting and introduced Emma Harris who had taken over the admin duties for the committee.
FPI/2023/14	**Apologies for absence** Apologies for absence was received from Ken Bremner, Chief Executive, South Tyneside and Sunderland NHS FT
FPI/2023/15	**Declarations of interest** During the Finance update, the Interim Executive Director of Finance declared a declaration of interest for agenda item 8.2 ICB Financial Planning 2023/24 update, as his spouse is employed as Deputy Director of Finance at Gateshead NHS FT, although it was deemed appropriate to continue with discussions.
FPI/2023/16	**Minutes of the previous meeting (5 January 2023)** It was **AGREED** that the minutes accurately reflected the meeting with the

	exception of the following amendment: **Agenda item 'FPI/2023/06 Action log update'**: page 4, paragraph 1, Outside of the meeting, David Purdue had advised that the action cards and discharge policy have been resent to Trusts and are being monitored through the daily discharge meetings with place directors.
FPI/2023/17	**Matters arising from the minutes** There were no matters arising from the minutes
FPI/2023/18	**Action log update** The action log was reviewed and the following updates were provided: **FPI/2022/11/07/04:** – action is closed. Work is ongoing on modelling for waiting lists and received a draft narrative for elective recovery plan. To be incorporated in 2023/23 Planning. **FPI/2022/11/07/05:** – action is closed. Executive Chief of Strategy and Operations confirmed additional metrics have been added and the appointment of Director of Performance and Improvement will support the work. Replace with new action: **FPI/2023/18/01: -** Revision of the overall approach to presenting a broader set of data for the ICB Performance position. Delivery plan to be presented at April meeting with a view to be complete within 6 months. **FPI/2022/11/08/01: –** action is closed. Executive Chief of Strategy and Operations confirmed approximately 80% overspend in Opthalmology across 3 large providers. Work has been undertaken by the NENC ICB Executive team and this will be incorporated in to the 2023-24 planning. **FPI/2022/11/09/01 –** on February meeting agenda for discussion. **FPI/2022/12/11/01 –** action is closed. The Interim Executive Director of Finance confirmed a draft plan to be submitted in February and will incorporate the request for £17.5m guaranteed drawdown – a business case will be required. Interim Executive Director of Finance to raise with Deputy Finance Director NHSE. **FPI/2022/12/12/01** – action is ongoing. The Executive Chief of Strategy and Operations to provide update at March meeting.
FPI/2023/19	**Notification of urgent items of any other business** There were no urgent items of any other business raised.

FPI/2023/20	**ICB Financial performance update** The Interim Executive Director of Finance presented the finance report for the financial year 2022/23 for the period to 31 December 2022 which included the Month 9 financial position. The report demonstrates at Month 9 that the ICS is on track to deliver the planned breakeven position, reporting a small surplus of £20k. The ICB is forecasting a surplus of £5.7m which offsets a forecast deficit across NHS Providers. Month 9 key highlights included: • There have been significant financial pressures in the independent sector (IS) with an overspend of over £20m linked predominantly to elective recovery, in particular across ophthalmology, trauma and orthopaedics activity. Total spend of approximately £75m is projected in 2022/23 compared to approximately £50m in 2019/20. • Significant pressures are also evident in prescribing predominantly linked to the impact of price concessions when there is limited availability of certain drugs. To date there is an impact of £12.1m and forecast impact of £20.7m, with further pressure experienced due to Category M price uplifts. A further increase in the cost of drugs is expected until year end which has been offset and identified as a key risk. • Additional funding has been agreed with NHSE to support system financial pressures and as a result the unmitigated financial risk had been reduced from £35m to £13m at Month 9. A question was asked if there was a risk of an underspend against the capital allocation. The Interim Executive Director of Finance noted that a more detailed update on capital was in the presentation to follow but explained that discussions were ongoing regarding additional capital departmental expenditure limit (CDEL) funding for specific schemes which would impact the final position. Work had been undertaken with the Provider Collaborative to assist with their financial forecasting. The Provider Collaborative Capital Leads have confirmed that there will be a formal assurance process into the ICB to identify any risk and potential mitigations. A concern regarding the potential perception from local authorities around the information in "Table 1.1: ICS in year financial position which detailed the financial allocations to place" was raised. The Interim Executive Director of Finance reminded the Committee that those allocations had been set at CCG level based upon an NHSE formula. Moving forward the Resource Allocations Group will consider and propose options for allocating resources. A point was raised that any approach to level up or level down plans should be explicit and transparent and questioned if a similar level of efficiencies should be applied to areas which incur overspend and underspend.

	A concern was raised regarding how to ensure underspend in "Community Health Services and Primary Care, highlighted in Table 1: ICB financial position" was not used in future financial planning to subsidise other areas of health spend, and that a well-structured plan should be in place to ensure growth and investment in Primary Care services.
	
	It was emphasised that the vast majority of underspends shown in the report had been driven by one off non-recurrent benefits. Whilst individual place positions and budgets would always need to be managed to ensure delivery of the overall ICB position, assurance was provided that places would be responsible for making best use of their allocations.
	
	The Committee discussed the requirement for a well structured and visible plan on spend using historical budgets with credible and realistic budget setting and to avoid variations, although it was noted that this could take several years to achieve.
	
	The discussion highlighted that the Integrated Care Strategy should drive the policy statements required to develop effective budget setting and an ability to measure in year variance and emphasised the importance of ensuring last minute non-recurrent funding is used strategically and effectively.
	
	Further points raised for the Committee to consider were the use of required outcomes to focus on financial allocations, the link to the ICB Quality Committee and the transformational use of strategy in utilising underspends.
	
	The Committee was asked to consider how to alleviate the growing inequality and inequity in the region.
	
	The Chair summarised key points of the discussion:
	
	• Await the outcome of ICB delegations to Place.
	• How to get activity closer to community and Primary Care which will involve planning and additional funding.
	• The risk of elective care payment by results versus block contracts.
	• What is the strategy and how to do it?
	
	The Interim Executive Director of Finance provided a presentation which covered the following areas:
	
	• Challenge to achieve break-even 2022/23 revenue.
	  o Unmitigated pressures of c. £40m.
	• Objectives for ICS Finance and Year End.
	  o The principles had previously been brought to FPIC for review.
	• Options for ICS financial balance.
	  o Option 2 – allocate pressures funding and support the organisations at risk of deficit or increase in deficit had received the

	most support at the FPIC meeting in January 2023.
	• NENC ICS month 10 forecast out-turns as at 27 January 2023.
	  o £20m of additional funding had been agreed with NHSE, subject to the ICS achieving a balanced position. Of this, approximately £5m had been allocated to the ICB with approximately £15m allocated to those providers who required it to support pay award costs.
	  o Additional funding received from NHSE Specialised Commissioning had enabled the redistribution of some COVID funding.
	  o Following all proposed adjustments, a revised forecast surplus across the ICS of £663k was expected. Discussions were ongoing with one provider trust and it was expected this could be reduced further to below £500k.
	  o This included a revised forecast for the ICB of £2.7m.
	  o The proposed figures reflected the agreement to support those organisations at risk of going into deficit to achieve break-even plan.
	• ICS capital position for Month 9.
	
	In response to a question of how many organisations were at risk of a deficit position, the Interim Executive Director of Finance replied that South Tees and North Cumbria NHS FTs were in a deficit position and support had been provided to either reduce or avoid a larger deficit.
	
	The Committee recognised the willingness from all providers to offer mutual financial aid across the system, but the risk of a shift from a needs-based allocation was highlighted.
	
	It was asked how do providers envisage a plan for improvement and avoid continuing deficit positions. The Interim Executive Director of Finance replied that there is work to do on maturity of the system. The additional funding received is not recurring and organisations will require a recovery plan to assure financial sustainability in the long term.
	
	There was a brief discussion regarding financial control within the Provider Trusts which had been impacted by some external factors such as PFI debt.
	
	RESOLVED:
	The Finance, Performance and Investment Committee **NOTED** the content of the report.
	
	A short discussion took place around the role of the Committee in relation to Capital and based on a brief development session prior to the meeting. It was decided that some work needed to be undertaken with regard to this to ensure that the TOR accurately reflected the Committees role.
	
	ACTION:
	Interim Executive Director of Finance to work with DoFs regarding the role of the FPIC in relation to Capital and revise the ToR accordingly.

FPI/2023/21	**ICB Financial Planning 2023/23** The Interim Executive Director of Finance provided a brief overview of the System Financial Planning update paper which outlined a summary of the draft NHS financial planning guidance for 2023/24 and 2024/25, including funding allocations, and to set out next steps for development and agreement of ICS finance plans. There were no questions raised for discussion. **RESOLVED:** The Finance, Performance and Investment Committee **NOTED** the content of the report.
FPI/2023/22	**ICB Performance position update** The Executive Chief of Strategy and Operations introduced the Integrated Delivery report which provided an ICS overview of quality, performance and finance using published performance and quality data for November and December 2022 unless otherwise stated. Key changes from the previous report highlighted were: **Handover delays:** • Some of the ambulance service data in the report ran to week ending 15 January 2023 and therefore did not reflect the full month position. In future a request has been made that incomplete months of data should not be included within the charts as it may provide an inaccurate performance position, the latest, unvalidated position may be referenced in the commentary, where this is helpful. • In the case of handover delays, the position had improved considerably through to the end of January; from a peak of 220 hours lost on average per day to around 20 for the last 2 weeks of January 2023. • It was confirmed that the ICB Chief Executive had met with Trusts to ensure the planned changes and commitment to endeavour to achieve the 59 minute handover go live from 1 February 2023, although it was acknowledged that not all providers would be at that position by then. In excess of one hour delays in North Cumbria will be measured but NWAS were not included in the 59 minute maximum protocol agreement. **Elective Care:** • County Durham and Darlington Foundation Trust (CDDFT) has moved into Tier 2 due to an increase of patients waiting in excess of 78 weeks. The ongoing industrial action was highlighted as a risk to delivery of plans for Newcastle University Teaching Hospitals NHD FT's plans too as it has already resulted in resulted in a step down for some elective activity and more strikes are planned. **Cancer:**

	• Positive news included that the Cancer diagnosis standard within 28 days of referral had been met in November 2022. The report included information regarding work with the Cancer Alliance and Trusts on the 62 day specific pathway work. **Mental Health:** • Due to a cyber-attack incident some NHSE mental health data may not be available until May 2023. Dialogue is ongoing with organisations to obtain alternative data sources and the recent appointment of a joint Trust Chief Information Officer for the 2 Mental Health Trusts should result in an improvement in the data platform availability. Rajesh Nadkarni left the meeting **12 hour delays in A&E from decision to admit:** • The position in January 2023 was concerning although bed occupancy had started to reduce. It was noted that the 12 hour delay pathway an important metric which is linked to increased mortality rates. **Ambulance response times:** • Data for December 2022 had deteriorated to a 1:36 hour mean time wait for Category 2 calls which was below the national meantime. The response time peaked in January 2023 at 1:53 hours but has since reduced. More time is needed to measure the impacts and work underway to understand if it is sustainable. The Executive Chief of Strategy and Operations summarised that overall waiting lists were increasing, and in response was asked what was the mechanism in place with providers to improve the position. It was confirmed that the Trusts need to deliver higher volumes of activity together with plans to increase the use of mutual aid from Trusts with lower waiting times to Trusts with higher ones; use of independent sector; redesign of pathways to optimse the use of staff and resources , for example digital-dermatology and improved productivity and using the data and support provided via the getting it right first time (GIRFT) Team. The ICB have delegated delivery of the elective recovery plan with the Provider Collaborative although the plan was in the early stages. The Interim Exec Director of Finance confirmed that work had commenced on oversight and assurance and there was a description of the recently introduced ICB Oversight Framework process. Data packs had been provided to Trusts in advance of meetings and a more standardised system approach is expected in the coming months. There was a discussion regarding plans required for organisations with historical overspend to return to a financial breakeven balance position over a strategic timescale.

FPI/2023/23	**Operational planning submission 2023/24 update** The Executive Chief of Strategy and Operations gave a presentation which detailed operational plan submission requirements and process. A number of system planning meetings have been set up in order to progress the work required. The Elective activity target for the ICB is 109% of 2019/20 activity. Key dates were highlighted between 20 February through to 28 March 2023 for briefings with Board Committees in advance of the final submission on 30 March 2023. Guidance states that plans must be ICB Board and Foundation Trust approved. **ACTION: Executive Chief of Strategy and Operations and Interim Executive Director of Finance to provide a further operational planning submission 2023/24 update to be added to agenda for 2 March meeting.** The Interim Executive Director of Finance continued with the presentation which detailed the financial elements of the planning process. It was noted that there had been a significant reduction in Covid funding from £125m to £24.8m. 2023/24 growth funding amounted to £282m and expectations for use of the funding were explained, although at least a third will be allocated to inflation. The presentation outlined the proposed approach to various funding streams and proposed contract mandate assumptions for the purposes of the draft plan submission. There was a discussion regarding how reference to the new Strategy will be required with regard to growth funding allocations. Additional funding has been allocated which included additional beds capacity funding and should be treated as recurrent, although this was not guaranteed. A risk was highlighted in CHC and Prescribing which could be in excess of national growth assumptions. The Board acknowledged the challenges as stated on page 55 of the system financial planning update report which outlined the NENC ICS 2023/24 underlying ICB and provider deficit positions.
FPI/2023/24	**Resource allocation group – terms of reference** The Director of Finance Corporate outlined the purpose for the Committee to consider and approve the amended terms of reference for the Resource Allocations Group. The Executive Chief of Strategy and Operations requested that a sentence be

	added to section 2: Purpose to include the delivery of the strategy. There was a brief discussion regarding the work and governance for the Efficiencies group. **ACTION:** **Richard Henderson to amend the resource Allocation Group terms of reference to include the delivery of the strategy in section 2: Purpose.** **RESOVLED:** The Finance, Performance and Investment Committee **APROVED** the Resource Allocation Group Terms of Reference, subject to the above amendment to section 2: Purpose.
FPI/2023/25	**FPIC Cycle of Business** There was a discussion regarding the frequency and level of reporting required on a monthly basis, although the Chair confirmed the current requirement in the terms of reference states a commitment of 10 meetings per calendar year.
FPI/2023/26	**Any Other Business** No further business was discussed.
FPI/2023/27	**Review of the Meeting** There was overall agreement that future meetings should focus on 2023/24 planning rather than historic business, apart from a mid-year review stage.

Signed: 

Position: Chair
Date: 2 March 2023