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NHS
North East and North Cumbria

North East and North Cumbria Integrated Care Board

Minutes of the meeting held on 1 July 2022 at 12.30pm, City Hall, Sunderland.

Minutes

Present:

Professor Sir Liam Donaldson, Chair
Sam Allen, Chief Executive
Professor Eileen Kaner, Independent Non-Executive Member
John Rush, Independent Non-Executive Member
Claire Riley, Executive Director of Corporate Governance, Communications and Involvement
Jon Connelly, Executive Director of Finance
Professor Graham Evans, Executive Chief Digital and Information Officer
David Gallagher, Executive Director of Place Based Delivery (Central and South)
Mark Adams, Executive Director of Place Based Delivery (North and North Cumbria)
Annie Laverty, Executive Chief People Officer
Dr Neil O'Brien, Executive Medical Director
Jacqueline Myers, Executive Director of Strategy and System Oversight
Aejaz Zahid, Executive Director of Innovation
Ken Bremner, Foundation Trust Partner Member
Rajesh Nadkarni, Foundation Trust Partner Member
Tom Hall, Local Authority Partner Member (Designate)
Jacqui Old, attending for Cath McEvoy-Carr Local Authority Partner Member (Designate)
Ann Workman, Local Authority Partner Member (Designate)
Dr Mike Smith, Primary Medical Services Partner Member
Dr Saira Malik, Primary Medical Services Partner Member

In Attendance:

Jane Hartley, North East and North Cumbria Voluntary Organisations Network North East (VONNE)
David Thompson, North East and North Cumbria Healthwatch

Jan Thwaites (minutes)

B/2022/01 Welcome and Introductions

The Chair welcomed everyone to the North East and North Cumbria Integrated Care Board (the ICB) inaugural meeting. This was one of 42 such boards around the country which had been established by the Health and Care Act 2022 as part of Integrated Care Systems (ICSs), abolishing clinical commissioning groups (CCGs).

The Chair outlined that the ICB has responsibility for the planning and development of the organisation and funding of services with an NHS budget of circa £6bn to provide and plan care for a population of around 3 million people across the North East and North Cumbria (NENC). This responsibility had transferred from the former eight CCGs who had undertaken those functions for the past 10 years. Thanks were given to the chairs and governing bodies of the CCGs for all work they had undertaken and for all their achievements. The ICB was hoping to build on these achievements going forward and ensure the local population and neighbourhoods that made up the ICB were at the heart of its work.

Thanks were also given to the staff of the CCGs who were moving to the ICB and would continue to use their expertise in the new organisation.

The NHS had certain plans, goals and responsibilities to discharge and most would be delivered at a local level but some would be carried out on a larger scale.

The ICB had the opportunity to learn from developing innovations which included technology, medicine and the organisation of services. Whilst the focus would be on health locally, recognition would be given to the interconnectedness that would come from both local, national and a global perspective.

The challenge for this region was its health inequalities, high levels of preventative disease and premature deaths. The work on these issues would be assisted by a partner board that would be established as part of the new statutory arrangements – the Integrated Care Partnership. This would be set up with the local authority partners.

The Chair asked the members to introduce themselves.

B/2022/02 Apologies for Absence

Apologies were received from Hannah Bows, Independent Non-Executive Member Patient and Public Involvement, David Stout, Interim Independent Non-Executive Member (Audit), David Purdue, Executive Chief Nurse and Cath McEvoy-Carr, Local Authority Partner Member (Designate).

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B/2022/03 Declarations of Interest

Members had all submitted their declarations prior to the meeting and no additional declarations were raised.

The ICB had adopted the former CCG format for declarations of interest with the intention to extend these on the basis that they had been tied into the commissioning process with the ICB having a wider remit.

B/2022/04 Constitution and Standing Orders

The ICB's Constitution and Standing Orders had previously been formally approved by NHS England and provided for information only to members as the final version.

RESOLVED:

The Board **RECEIVED** the Constitution for information.

B/2022/05 Introduction to Governance Handbook and Functions and Decisions Map

An introduction to the governance handbook and its key documents was made, including the functions and decisions map.

Tribute was paid to the corporate governance leads for all the work they had put into this piece of work.

The functions and decisions map was part of a standard set of governance documents within the handbook that would require approval from the Board. The other documents detailed within the handbook would be covered by separate agenda items.

RESOLVED:

The Board **RECEIVED** the functions and decisions map for information and **NOTED** the other documents referenced in the handbook were to be covered as separate items on the agenda as they required formal approval.

B/2022/06 Standing Financial Instructions and Financial Limits

The standing financial instructions (SFIs) and proposed delegated financial limits were presented to the Board.

The SFIs are the financial framework that the ICB operates within and form a key part of the control environment. The SFIs were a standard national template.

The main change to the standard template was to post titles, for example Chief Finance Officer to Executive Director of Finance.

The financial limits had been prepared and led by the former CCG chief finance officers and were an aggregate of previous CCG arrangements. Caution had been undertaken with the limits as this was a new organisation. It was noted that these limits would be tested and develop over time.

RESOLVED:

The Board **APPROVED** the standing financial instructions and proposed financial delegated limits.

B/2022/07 Scheme of Reservation and Delegation

The Scheme of Reservation and Delegation were presented to the Board.

This was a standard document which set out the responsibilities and functions reserved to the Board and those that were to be delegated through either committees or individuals.

RESOLVED:

The Board **APPROVED** the Scheme of Reservation and Delegation.

B/2022/08 Establishment of Board Committee Structure

The proposed Board committee structure was presented to the Board.

A significant amount of work had been undertaken in proposing the committee structure along with considering the relevant national requirements and supporting guidance.

The proposal was to establish five committees of the Board as follows:

- Audit Committee
- Remuneration Committee
- Executive Committee
- Quality and Safety Committee
- Finance, Performance and Investment Committee

The paper set out the proposed chairing arrangements for the committees. Each committee would be chaired by an independent Non-Executive Member with the exception of the Executive Committee which would be chaired by the Chief Executive.

The naming convention for the Audit Committee would be checked to ensure it had been applied consistently throughout the document.

Clarification was sort in relation to the recruitment process to the committees and it was noted that this would be worked through with the corporate governance team and circulated to all members.

Action: The proposed committee membership to be circulated to all Board members for information.

RESOLVED:

The Board **APPROVED** the establishment of each of the committees, along with the proposed chairing arrangements and membership.

B/2022/09 Terms of Reference for agreed board committees

The terms of reference for each agreed Board committee were presented to the Board for approval.

These followed a standard template in line with NHS England guidelines and had been developed in partnership across the North East and North Cumbria by governance colleagues.

RESOLVED:

The Board **APPROVED** the terms of reference for the committees.

B/2022/10 Adoption of Key Policies

As part of ICB establishment, the Board was being asked to approve and ratify those corporate policies that were considered high-risk and substantive, as outlined in Schedule A of the paper, and agree a proposal to ensure the early approval of all other policies and strategies.

The policies had been adopted from the former clinical commissioning groups' procedures for continuity of business. They had not been reviewed fully in an ICB context and would require more detailed discussion and adjustment and need would need to be modernised. It was proposed to agree the policies for the moment but they would be brought back in a modified form in the near future.

Action: all policies to be reviewed within the first six months following the establishment of the ICB to ensure they reflected an ICB perspective.

RESOLVED:

The Board:

- **RATIFIED** the strategies, policies and plans outlined in Schedule A
- **DELEGATED** authority for Executive Directors to approve any minor/immaterial future updates, taking into account that the policies had been drafted by subject matter experts and governance colleagues

- **DELEGATED** the 'first approval' of HR related and other corporate related strategies, policies and plans to the Executive Committee. Subsequent approvals would be in line with the Scheme of Reservation and Delegation.

B/2022/11 The People and Communities Involvement and Engagement Framework (Strategy) 2022

The People and Communities Involvement and Engagement Framework (Strategy) outlined the ambition to develop a strategic approach and consistent standard across the region for the ICB, reflecting the following principles:

- Involving and engaging partners, stakeholders and the public in planning, design and delivery of our services is essential if we are to get this right.
- Wherever, and whenever, possible we will include meaningful involvement as part of our work. We want people to help us design, develop and improve services by sharing their views and experiences. The people we listen to and involve need to reflect the communities we serve.

Tribute was paid to the engagement leads across the North East and North Cumbria for the development of the comprehensive document.

Positive feedback had been received from NHS England in that the strategy was one of the most robust they had seen and set out the ambition, drive and motivation to achieve for the ICB and wider Integrated Care System (ICS). A lot of work was still to be done in conjunction with partners and Healthwatch.

The strategy set out a very comprehensive voice of the people with clear intentions, however this now needed to be translated into practice and to engage with the wider public. It was recognised that there was excellent work being undertaken at a place base level with voluntary sector organisations and communities that would continue to be built upon.

A process for development of an integrated care strategy would be taken to the first Integrated Care Partnership meeting along with a communication, engagement and co-production plan that would sit alongside the strategy. An offer was made from Healthwatch to assist with this in any possible.

The pressures on primary care were highlighted and how patient and public involvement could be improved in relation to these services. It was important to bring patients into the conversation to explain the issue and come up with solutions.

The framework presented an opportunity to share best practice, to ensure to listen and engage with all parts of the communities. It was acknowledged that

some parts of the community would not be accessing health services for active treatment.

In terms of mental health there were a number of policies looking at integrated community transformation bringing communities together and to look at mental wellbeing. The challenge was to draw upon these opportunities to make a significant impact.

There was an expectation that all business cases should have evidence of involvement and engagement, this it was noted was a positive step towards embedding the principles of the strategy.

The Board noted it was positive to hear of the existing engagement and involvement mechanisms and pockets of good practice across both the health and care system, however there may be some areas where messages had not yet reached and these needed to be focussed upon.

Staff had been involved in shaping the values and listening to communities in a respectful and compassionate way. An in depth engagement exercise had been undertaken with over 3,000 individuals asking what was important to them in terms of their health and wellbeing.

The Board was encouraged to hear the commitment from all partners and to have the opportunity to focus on this area of work.

RESOLVED:

The Board **APPROVED** the framework (strategy), understood the resource and governance implications and committed to a learning approach developing the strategy as the ICB matures and learn and develop with partners and communities.

B/2022/12 Confirmation of Special Lead Roles

The report set out the specialist lead roles and appointed board members roles that were required to be appointed by the Board. It was noted that Dr Nadkarni was from a mental health and learning disability organisation and as a member of the Board would fulfil the role of board mental health lead.

There were five further roles that had not been captured in the paper but were a specific request from NHS England as follows:

- Executive lead for children and young people - this would be the Executive Chief Nurse David Purdue who would also hold the role for the North East and North Yorkshire region
- Lead for children and young people with special education needs and disabilities and also the executive lead for safeguarding – this responsibility would also sit with David Purdue as Executive Chief Nurse

- Executive Lead for learning disability and autism - this would be Mark Adams Executive Director of Place Based Delivery (North and North Cumbria)
- Executive lead for Downs syndrome – this would be Dr Neil O'Brien, Executive Medical Director.

RESOLVED:

The Board **AGREED** the named leads as identified in the report to undertake the special Board roles as highlighted and **CONFIRMED** the mental health board level lead would be fulfilled by the foundation trust partner member Dr Nadkarni.

B/2022/13 Appointment of founder board member of the Integrated Care Partnership

The report provided the Board with an update on the development of the Integrated Care Partnership (ICP).

The ICP was made up of the constituent places across the North East and North Cumbria and the paper proposed that the founding member was to be Professor Sir Liam Donaldson.

The ICP would have a core role setting the strategy for the next five years and seek to address inequalities and wider social determinates of health.

The preference was for one large ICP and four small area ICPs to work on a more day to day basis to be more sensitive to local needs. These would be distributed nearer to local populations elements of the ICP which was still open to discussion.

RESOLVED:

The Board **APPOINTED** the ICB Chair as the founder member of the Integrated Care Partnership for the North East and North Cumbria Integrated Care System.

B/2022/14 Integrated Delivery Report

The peport provided an NENC ICS overview of quality, performance and outcomes. It was noted finance would be included in future reports. The report was a high-level and parallel view of performance and quality to ensure oversight and delivery of the 2022/23 planning priorities.

Thanks were given to all the staff involved in pulling the report together.

It was noted that going forward the report would be structured into categories of oversight, assurance, escalation and improvement support.

There was still work to do to ensure true intelligence with regards to the position of services and also to include health and inequalities throughout the report.

The NHS system oversight framework had been published recently and this would be brought to a future meeting following further work around its implementation with NHS England.

The outcome measures and health inequalities were discussed highlighting smoking prevalence, noting the lower and slight reduction in gaps from the highest to lowest. In regard to depression prevalence a higher level had been seen and a widening of inequalities. There was a national strategy around health and inequalities (Core20Plus5) which looked at the 20% of the population suffering the worst inequalities and focussing on delivering improvements in this area.

A summary was shown on the quality oversight work highlighting the significant workforce pressures and absence rates driven by the Covid-19 pandemic.

It was noted that a detailed report on the Ockenden maternity review would be brought to the next Board meeting.

In relation to primary care activity levels the following were highlighted:

- a trend rate for Did Not Attends (DNA) was identified
- the provision for face-to-face appointments
- a single data point to give a sense of scale 1.2m appointments had been delivered

The national A&E performance standard stood at 78% against the required 95% target. The national performance stood at 73% which was a cause for concern. There had been an increase in trolley waits and admittance to beds across the region.

Ambulance handovers and response times in May were highlighted as to what was being measured and where the issues were. An action plan had been put in place to address these.

Targets had been set for the referral to treatment (RTT) 18-week standard to progress the waiting times on these.

Waiting times were noted to be falling. The national ask was that no patients would wait for 104 weeks, however there were still a small cohort of patients awaiting complex spinal operations. Work was ongoing at a national level with NHS England to find a solution to this issue.

The national cancer standards in terms of faster diagnosis stood at 76% against a target of 75% across the region. Challenges were highlighted in regard to the 62-day pathway, there had been a backlog over this referral to treatment standard. A recovery plan had been put in place.

The increasing numbers of patient contacts, treatments and assessments taking place in relation to mental health, learning disabilities and autism was noted.

The Chair suggested a short break in the proceedings at this point.

The meeting was paused from 2.05 to 2.25pm.

On returning to the meeting the Chair asked for any comments on the integrated delivery report.

The report was welcomed acknowledging that it was work in progress. adding that this may be an opportunity to look at other data sets to add to the report including the voice of the citizens helping to identify any issues of concern going forward.

A point was made in relation to the primary care data set recognising the amount of activity throughout the pandemic and the face-to-face consultations that had continued. Also to recognise that 70% of the vaccinations given nationally were administered by primary care.

Going forward it will be important to look at the social care data and to analyse the data and the impact of this and highlighting inequalities.

Thanks were given to foundation trust colleagues for the collaboration shown in focussing on driving down waiting times. Thanks were also given to GP colleagues for their work in continuing to increase face to face appointments and address those patients who 'did not attend' their appointments.

Workforce was noted as a significant challenge and a discussion took place as to how this could be addressed as a system. The profile of the workforce was highlighted as a number of staff were reaching retirement age and some were leaving early due to the pressures of the role. It was noted that were a number of doctors in training in the area at the new Sunderland Medical School and would be encouraged to remain local. Workforce planning was also underway with Health Education England.

Recruitment work had been ongoing with Health Education North East (HENE) regarding the NHS campaign which focussed on attracting junior doctors into the region into specialty positions and GP training positions. There was more to be done to revitalise this and look at how to attract junior doctors into the area.

A plea was made in light of the increased use of technology to attract and retain people in data and technical careers.

Staffing issues were highlighted from a local authority perspective in relation to carers, home care and nursing homes. Work was underway to understand the position and the implications across the system.

RESOLVED:

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

B/2022/15 ICS 2022/23 Operational Plan

A high-level overview of the ICS's operational plan for 2022/23 was presented.

In terms of context, the NHS had issued operational planning guidance to providers and the former CCGs (more latterly to ICS's) to lead the planning process on behalf of the NENC ICS involving all providers and commissioners. This process was concluded by 20 June and submitted.

A summary of the key points was given, these included:

- Finance – a balanced plan for the ICS had been submitted. In terms of capital expenditure, conversations were still being held with NHS England. The main drivers were increased pay costs, a reduction in income and exceptional inflationary costs. The planned efficiencies of 3.5% were challenging as the plans relied on some non-recurrent measures. The ICS was in a challenging environment and to deliver these plans would require careful management with a robust planning process to enable delivery
- Workforce plan – the aim was to increase the substantive workforce by 3.8% to recruit to existing vacancies and create additional posts. The corresponding reduction in agency and bank staff spend was highlighted. There was an ambition to grow the primary care workforce by 1.26%
- Activity plan – the plan met the 104% value weighted activity in numbers and value to reflect the complexity of activity and rise in demand. The plan included an ambition to increase diagnostic tests to 120% of the 2019/20 volume of activity
- Triangulation – to ensure a workforce plan that met the needs of the activity plan and a financial plan

The plan included an ambition to have a 25% reduction in outpatient follow ups by March 2023. This was a challenge due in part to the backlog caused by the pandemic but also increased activity however there were opportunities to undertake transformation work around this.

Key risks to the organisation were shared, these included the following:

- A challenging revenue position
- 104% activity by value
- A range of workforce issues including recruitment and retention issues
- The awaited development of the ICS clinical strategy
- Urgent and emergency care pressures remained high and a number of medically fit patients awaiting discharge

- Managing pressures on mental health services
- Sustaining elective recovery and deliver of planned activity.

It was noted that the planning process had been long and plans were usually produced earlier in year. Nationally, ICSs were in a similar balanced position although there were still issues to address.

It was recognised that a lot of work had been undertaken and had been very NHS focussed. In terms of ambition, the focus would be on the bigger picture to address health inequalities. There was, from a social care perspective, the need to understand the shift in activity from health to social care and to work jointly as a system avoiding duplication.

A discussion took place in relation to social care and care in homes. It was noted that additional funding was going into local authorities for adult social care and would be directed via the ICS. This would present an opportunity to understand the system issues and priorities to ensure resources were appropriately allocated.

It was noted that the Learning Disability Network were looking into the process for health checks and utilising learning from the voluntary sector on these.

The risks and priority challenges in the care sector were recognised. The data showed that the system required transformation due to a combined number of issues such as unprecedented levels of hospital occupancy; significant pressures on the elective recovery plan; and the implications of increasing activity for social care. A strategy to address this was important alongside identifying new ways of working within the constrained financial position.

RESOLVED:

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

B/2022/16 ICB Budget 2022/23

The report provided the Board with an overview of the high-level commissioning budgets for the ICB for the financial year 2022/23 and reporting period July 2022-March 2023.

As set out in the standing financial instructions, the Board was required to approve budgets to allow the ICB to incur expenditure. The report acknowledged the wider NENC ICS but focussed on the ICB.

Highlights from the report included:

- The £4.9bn allocation for the remaining nine-month period for 2022/23, plus the £2.6m surplus in the plan for the whole year

- The report had been prepared under national guidance but informed by the local knowledge and expertise of the preceding CCGs.
- The continued focus on elective recovery and delivery of long term plan objectives
- The reduced Covid-19 funding compared with 2021
- The cessation of the hospital discharge recovery

In terms of risk for the ICB, the delivery of efficiencies and performance overall across the ICS were sufficient to earn the relevant elective recovery funding to cover the amount identified within the plan. The risks would be managed throughout the year and reported to the Board on a regular basis.

RESOLVED:

The Board **APPROVED** the high-level commissioning budgets for the period July 2022 to March 2023.

B/2022/17 Health inequalities and Sustainability for north East and North Cumbria ICS

The report presented an overview of the current health inequalities faced by communities across the North East and North Cumbria (NENC).

The report gave an overview of recovery from the Covid-19 pandemic and highlighted a 40 year high in terms of cost of living which had an increase in the number of families in poverty. From a NENC perspective, the significant work on prevention by Dr Guy Pilkington, Applied Research Collaboration and Amanda Healy, Director of Public Health in Durham, had been recognised. They had co-chaired the NENC Prevention Board and undertaken a number of prevention initiatives.

The report set out the circumstances that were particular to the NENC. Life expectancy was below average in the most deprived communities. There was a significant amount of work to be undertaken to address health inequalities and a recommendation made to establish a group to examine the work on health and inequalities and bring proposals back to a later Board meeting. The group would draw on the skills of key partners across our ICS to provide strategic leadership, support, challenge across the system to shape an inequalities strategy for the ICS and ensure the delivery of key local and national priorities.

A discussion took place as to how the Board would gain assurance on the strategy work and ensure health and inequalities were considered in every agenda item. It was noted there were existing ICS workstreams focussing on this agenda, although further connections could be made for this area of work. For example, the experience of the local universities and how to connect across the number of places across the NENC.

The Applied Research Collaboration (ARC) linked together universities across the NENC with all partners across NHS, social care and public health and had 58 organisations as part of the collaborative. The ARC had a budget of approximately £4m to take forward this work under health and care and prevention.

In Cumbria and Lancashire, a health equity commission had been initiated by the local authority and partners and this work should be considered by the relevant workstreams.

A note of caution was made in that there may be a number of organisations tackling the same agenda and this could lead to duplication. The Board noted that work should be coordinated to avoid this and the task and finish group needed to consider this.

There were clear priorities and outcomes in place and how these could be measured as to the impact on our communities was crucial. The task and finish group would be asked to bring their outcomes back to the Board at a later meeting and ensure work was not duplicated.

RESOLVED:

The Board **AGREED** to convene a task and finish group to review the current coordination arrangements for reducing health inequalities across our system, and to make recommendations to the ICB and ICP for the formation of a multi-agency expert advisory group to drive this work going forward.

B/2022/18 CCG Closedown due diligence handover report

The North East and North Cumbria CCGs' closedown report was presented to the Board, setting out the due diligence process and activities that had taken place over the previous six months.

RESOLVED:

The Board **NOTED** the content of the report and the outlined high level and shared CCG closedown activity risks and issues.

B/2022/19 Schedule of future meetings

To provide members with the Board meetings date for the remainder of the financial year for 2022/23.

It was noted that additional meetings would only be arranged if it was felt they were needed and would add value. For instance, a deeper dive into broader issues such as rural or coastal health, population health and access to services.

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RESOLVED:

The Board **RECEIVED** the Board dates for information.

B/2022/20 Any other business

There were no other items of business and the meeting closed at 15:35.