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NHS
North East & North Cumbria

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

BOARD MEETING 27 September 2022	
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 presented report covers national updates including cabinet changes and a range of North East and North Cumbria business updates.	
Risks and issues	
There is a constant cyber risk to the NHS. The report describes a recent cyber security incident.	
Assurances	
The presented report provides assurance to the board of recent business activity and development carried out by the ICB Chief Executive and executive directors.	
Recommendation/Action Required	
The Board is asked to receive the report for information and assurance.	
Sponsor/approving director	N/A
Report author	Samantha Allen, NENC ICB Chief Executive
Link to ICB corporate aims (please tick all that apply)	
CA1: Improve outcomes in population health and healthcare	✓

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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?	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?	Not applicable – for information and assurance only.

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Chief Executive Report

1. Introduction

The purpose of this report is to provide an overview of recent activity carried out by the North East and North Cumbria Integrated Care Board (the ICB) Chief Executive and executive directors, as well as some key national policy updates.

2. National Issues

2.1 Cabinet Update

Thérèse Coffey was appointed Secretary of State for Health and Social Care and Deputy Prime Minister, on 6 September 2022. The immediate priorities the Secretary of State has set out have been described as:

A – Ambulances
B – Backlogs
C – Care
D – Doctors / Dentists

2.2 Delegation of specialised services to ICBs

In May NHS England (NHSE) published a roadmap setting out which specialised services may be suitable and ready for greater local leadership from April 2023. Prior to delegation, in April 2023 there will be a pre-delegation assessment of each ICB to determine readiness to assume responsibility. The delegated services will include:

- All pharmaceutical, general ophthalmic and dental services (POD)
- Specialised services that have been identified as suitable and ready for further integration subject to system readiness (65 services have been deemed to be both suitable and ready for integrated care system (ICS) leadership from April 2023, with 106 reserved to NHSE (typically services for no more than 500 patients per year). A final version of this list (Annex A) will be issued later this year.

A formal system readiness assessment will be conducted during quarter three which the NHS England Board will consider before making any final decision to delegate the commissioning responsibilities from April 2023. Specialised services will be funded based on historical financial allocations ahead of the planned delegation of

services to ICBs from 2023/24 – with a needs-based weighted population-based funding allocation from April 2024 (at the earliest).

For other direct commissioning functions, NHSE have begun to determine potential future commissioning models from April 2023:

- Health and justice, sexual assault and abuse service (SAAS) functions will remain with NHS England. However, the ambition is to work towards a model of joint working with ICBs
- Section 7A NHS public health functions (screening, immunisations, and child health information systems) will remain with NHS England but with progress towards joint working and possible delegation from April 2024
- Healthcare for serving members of the Armed Forces and their families registered with defence medical services, veterans' mental health and prosthetic services will remain with NHSE.

The ICB has started to work closely with the NHSE Regional Team to scope out the work required prior to delegation of responsibility. Given the scale of the ICB it is likely we will take responsibility for commissioning these services across the North East and North Cumbria subject to ICB and NHSE approval. At this stage I would prefer to take shadow responsibility from April 2023 prior to taking full responsibility from 2024.

3. North East and North Cumbria Issues

3.1 Clinical Commissioning Groups

The ICB was created from eight separate clinical commissioning groups (CCGs) and the ICB inherited their workforce, policies and ways of working. Whilst there was some integration and joint working (mainly on Teesside) there are a number of issues to consolidate, review and establish new ways of working across the ICB to ensure consistency across the place-based teams and ICB. Given the extent of this work and lack of integration across the CCGs in the lead up to the ICB, I anticipate this will take 12 – 24 months to complete. Whilst there is internal work underway with regard to culture, embedding and our new structures there is also significant work required to ensure our population is able to access care in accordance with national guidelines e.g., NICE. An initial look at compliance with NICE guidance suggests there are differing approaches based on the former CCG footprints. An audit of compliance is underway to identify priority areas to address.

3.2 Developing a multi-professional clinical leadership framework

Engagement is taking place on the development of a multi-professional clinical leadership framework. Internally, this process will inform the proposals for the ICB clinical leadership structure that will enable consultation with affected clinicians. Planning and scoping work is underway for this consultation process to commence on 3 October 2022. Consultation will run for 30 days until 1 November, and we will move into the recruitment process from 11 November.

3.3 Health Inequalities

At our ICB meeting in July we acknowledged that we met for the first time against the backdrop of some of the most persistent and growing health inequality challenges in the country. The ICB agreed that we needed to redouble our efforts in this area and resolved to convene a task and finish group to review our current coordination arrangements for reducing health inequalities across our system, and to make recommendations to the ICB and Integrated Care Partnership (ICP) for the formation of a multi-agency expert advisory group to drive this work going forward.

Such a group will draw on the skills of key partners to provide strategic leadership, support, challenge across the system to shape an inequalities strategy and ensure the delivery of key local and national priorities.

Dr Neil O'Brien is leading this work and will ensure that the following issues are addressed in the review:

- Review of all our current governance arrangements to ensure clarity and consistency, including the future roles of the current Prevention Board, Health Inequalities Advisory Group, and Population Health Management Group
- Coordinated oversight of our current priority areas and programmes – including the existing tobacco, alcohol and obesity programmes, and the 'deep end' GP practices network
- Making the links to other ICS workstreams, including workforce, child health, and sustainability, as well as input from procurement, finance, education and training and policy development
- Agreeing a consistent model of population health management (PHM), and how PHM tools are best utilised at both system-wide and place level
- How we resource and coordinate this work with partners including the joint work we will need to coordinate with our local and combined authorities on economic development
- What capacity we need to effectively analyse latest national thinking from government, universities and thinktanks – for example the recent Health Foundation Report on this subject
- How we measure, evaluate and audit the outcomes and improvement that our joint work delivers so that we understand what works and how we can share spread best practice.

More broadly, I am keen to see how we can think differently regarding funding streams to support grass-roots activity, including via a charitable foundation or other income-generating mechanisms.

We need to ensure we capture all elements and levers available to us to enable widespread mobilisation to tackle the challenges we face. As such, I am keen for this work to be reported to both the ICB and the ICP (and our four Area ICPs) to emphasise what a cross-cutting and system-wide challenge this is. I will bring some final proposals on this work to the November ICB meeting for the Board's consideration.

3.4 EFRA Committee Inquiry on Rural Mental Health

I was pleased to be invited to give evidence to this Committee on some of the mental health challenges faced by our rural communities alongside NHS England's National Mental Health Director, Claire Murdoch. The Committee's key areas of focus were on NHS England's commitment to work with Department for Environment, Food and Rural Affairs; the specific needs of agricultural and veterinary workers; data on suicides in rural areas; key metrics of success and the breakdown of ICB funding formulas and weightings to reflect rurality.

As the largest ICS area in the country, with a large rural population spread across Northumberland, Durham and North Cumbria I was able to update the Committee on the challenges of service delivery in rural areas with their hidden pockets of deprivation, relatively high rates of suicide (especially among men in the agriculture sector), patchy digital infrastructure and the challenges of attracting and retaining a workforce to work in rural settings. I also highlighted the barriers to accessing specialist services at some distance from rural communities.

We explored some of the innovative solutions that we have pioneered so far including the ICB-led initiatives on recruitment and retention – e.g., the successful "find your place" campaign, and engaging communities and the voluntary, community and social enterprise sector (VSCE) to develop co-produced plans for good mental health and suicide prevention. We also looked at the opportunities as well as challenges in whatever replaces the Common Agricultural Policy which provided financial support to farmers pre-Brexit (in 2019-20 farmers in England received over £1.8 billion in direct payment subsidies), and how the UK government might balance effective land management, and a sustainable and productive farming sector, alongside mental wellbeing for rural communities and benefits for the environment.

As an ICS that covers an area of 5,500 square miles – which is over half the size of Wales – with some of the most remote and rural communities in England, I was clear that adequately weighted funding for ICBs is a matter for government and it needs to take into account the unavoidable cost of providing services across the large rural areas that make up the North East and North Cumbria.

3.5 New Local Authorities of Cumberland and Westmorland and Furness

Board members will be aware that Cumbria County Council and its six constituent district councils are being abolished and replaced by two new unitary authorities from 1 April 2023:

- Cumberland Council – comprising the former districts of Carlisle, Allerdale and Copeland
- Westmorland and Furness Council – comprising the former districts of Eden, South Lakeland and Barrow-in-Furness.

Our current ICB footprint is based on the old North Cumbria CCG boundary, which covers Carlisle, Allerdale and almost all of Copeland (except the town of Millom,

which was previously in Morecambe Bay CCG due to hospital flows to Furness General Hospital in Barrow).

Therefore, our ICB area covers (a) almost all of the new Cumberland Council footprint (except Millom which will be in Lancashire and South Cumbria ICB), as well as (b) approximately 50% of the new Westmorland and Furness Council area due to our retention of the Eden district.

ICB footprints have been largely determined based on historic patient flows, and from as early as the foundation of the NHS in the 1940s, patient flows from North Cumbria/Cumberland across the Pennines for specialist treatment were recognised in the drawing of the NHS's regional boundaries – indeed, our current ICB footprint matches almost exactly the 'Newcastle Regional Hospital Authority' (RHA) boundary established by the first NHS Act in 1946.

However, both myself and NHS and local authority colleagues in Cumbria recognise that system boundaries should always be managed carefully and kept under review, so I have had early discussions with my counterpart in Lancashire and South Cumbria ICB, Kevin Lavery. I was also very pleased to be invited to participate in the recruitment of both Andrew Seekings as Chief Executive of Cumberland Council, and Sam Plum as Chief Executive of Westmorland and Furness Council and have met with both since their appointments. These will be key relationships for us going forward and I look forward to supporting our North Cumbria Place Team to work closely with Andrew and Sam.

3.6 Surge Management Workshop

It was great to see over 140 delegates at our session on the 17 August where we came together as a system to test our winter plans. The event was chaired by Helen Ray, Chief Executive, North East Ambulance Service, and the opening address was given by Jacqueline Myers, the ICB's Executive Director of Strategy and System Oversight.

The event gave us all the time out to consider how we best pool our vast skills, experience and knowledge from across the spectrum of our system to develop a shared action plan that balances our urgent operational challenges whilst planning for the future in a strategic way. The stakes have never felt higher and this was expressed by many who participated: the surge we are seeing all year round, the backlog created by the Covid pandemic, the cost of living crisis and the tightening economic outlook in the health and social care sectors (and the pressure on the workforce) all create a multi-faceted challenge that we must respond to as a system.

We were pleased to welcome Matthew Taylor, Chief Executive of the NHS Confederation, to give a keynote address, and his emphasis on 'split screen thinking' (considering our immediate and longer term priorities) alongside empowering our staff, overcoming boundaries and freeing up capacity - and how we communicate clearly to the public - was extremely helpful. He also spoke eloquently about our how we have tended to invest in bricks but not the mortar, in pistons but not the oil, and was referring to us all in our system as the mortar that binds us together and the oil

that enables the parts to work in congruence, to deliver high quality urgent and emergency care in the most challenging of circumstances.

I was inspired by all the speakers, and it is clear that we need to take the best learning from the Covid period, where whole communities and voluntary services were activated, where organisations shared and re-deployed staff in agile and flexible ways, where we all rallied around a compelling need. Such an approach should be a guiding principle for ICSs, but the event also helped us to identify some key emerging areas of focus:

System focus on managing inflow - right care, right time, right place

- How we manage the 'front end' including call handling, clinical advice, alternative dispositions
- The role of anticipatory care in unblocking pressure points at handover and discharge
- How this approach is integrated into primary, community, and mental health services.

Making the best use of all of our resources especially our staff –

- Exploring options for flexible staffing and the freedoms that worked during Covid
- Redeployment opportunities, careers and working across health and care
- Integrated neighbourhood team developments, and how we implement the Fuller Report.

Call to Action

- As the country faces a humanitarian crisis, a call to action across our system and communities
- Creating integrated lists of vulnerable people, mobilise VCSE and community support, proactively support those in fuel, energy and food poverty, and those socially isolated
- Lobbying nationally and to businesses and regulators about support packages, and sensitive policy changes that anticipate the looming cost of energy crisis.

A follow up event is planned for the 28 September where we will build on these discussions and agree a programme of action, and I will update the Board at our meeting in November.

3.7 Cyber Security Incident

Strengthening our cyber resilience is a crucially important responsibility, and that was a key driver for the appointment of Graham Evans to be the ICB's Executive Chief Digital Officer. Our cyber security arrangements ensure that we comply with relevant standards, protect patient data and can respond effectively in the event of a cyber incident.

We recently experienced a cyber security incident, which Graham will outline in more detail at our Board meeting. 'Advanced', a key NHS clinical and line-of business technology service provider, was impacted by a Ransomware attack on 4 August 2022. A national Level 3 incident, coordinated by ICB emergency preparedness,

resilience and response (EPRR) teams – including ours – was initiated and business continuity arrangements mobilised, and the current position is now moving into a phase of recovery and restoration.

Cyber security threats of this nature are an on-going and present risk for us as an ICB, and something that can have far reaching adverse impacts to the health and care system – not least as our health and care system is increasingly digitally dependent on some common/shared digital systems and services as well as common vendors within the health and care supply chain.

I would like to commend the prompt action and thorough follow up to this led by Graham's team, and this will remain an area of focus for us and a key risk that we will formally register once formal after-action reviews have concluded, and appropriate lessons learned.

3.8 Reducing the use of Agency Staff Across our System

NHS England (NHSE) is introducing a new ceiling on the amount spent within each integrated care system on agency staff as part of a drive to find further savings across the health service. Agency spending caps were first applied to trusts from 2015 but agency spending has grown due to the operational challenges faced during the pandemic.

The move is part of a wider efficiency programme from NHSE, with further national control measures to be introduced over the next 18 months, and system spending will be assessed under NHSE's oversight framework. NHS England has set a 2022/23 agency spend cap for each Integrated Care Board. This is based on an aggregate of plans submitted by provider organisations. The cap for the North East and North Cumbria is £74.6m, which is a relatively low target, but one that is based on an ambitious plan to reduce the level of 2021/22 spend by almost 30%. This will be challenging to deliver so to support our system in managing spend on agency staff we are working closely with our Foundation Trust Provider Collaborative, providing analysis of the position and helping to identify good practice in the management of agency spend.

3.9 North East and North Cumbria Learning and Improvement Community

Central to our improvement approach, on 21 September the ICB will be hosting a special event to bring together diverse teams from across the region so we can start to create a learning and improvement community for the North East and North Cumbria.

A learning community is a group of peers who come together in a safe space to share their judgements and uncertainties about their current practice and to share ideas or experiences to collectively improve. A shared understanding of what excellence looks like is co-created. This peer – or horizontal – accountability is core to the learning community purpose: the approach has its roots in complexity theory and the benefits arising from adopting a 'positive error culture'.

The event will be held at St James' Park in Newcastle. It will be an interactive day, designed so that everyone can contribute. The aims of the day are to:

- Mobilise people from across North East and North Cumbria (NENC) who can contribute to achieving our system goals for health improvement
- Create the founding membership of our NENC learning and improvement network.
- Enable 'boundaryless' learning across the NENC, making connections and sharing data and learning - across geographical, system, organisational and sector boundaries
- Acknowledge and celebrate the existing strengths and assets of our system for learning and improvement.
- Agree actions to co-create the network and the outcomes we want it to help improve.

3.10 Workshop with the Association of Directors of Adult Social Services (ADASS)

The ICB Executive Team members held a constructive workshop with our ADASS colleagues from across our local authorities on 2 August where we explored principles of future working, shared priority areas and focussed action, and how ADASS can be supported to work across the system.

As the North East branch of ADASS is almost coterminous with the ICS (with colleagues from Cumbria unofficially attending their branch meetings), this offers us a real opportunity to work smarter and make the best use of capacity and skills. We explored how the ICB has taken over the eight CCGs' budgets and responsibilities (but delegating much of these powers back to ‘place level’). Several budget lines including continuing health care, and funded nursing care are interdependent with social care budgets, and new social care funding is being allocated to ICBs. We have the potential for greater alignment and pooling of budgets to promote the key determinants of good health, and we will work with ADASS on shaping our approach to integrated commissioning at place and system level. We also considered a range of important areas of mutual interest, including how we have approached the commissioning of learning disability and autism services, the emerging work on 'fare cost of care' (FCOC) and our joint approach to strategic housing.

The North East ADASS representative on the ICB Board - Ann Workman, Director of Adult Social Services (DASS) for Stockton – will be the overall ADASS lead for the ICB, and we also committed to looking at DASS representation in each of our ICP a We also committed to aligning DASS leads to the ICS priority areas – making better use of the North East ADASS governance structure, avoiding duplication of effort and allowing the best person/organisation to lead.

The creation of a statutory Integrated Care Partnership of the ICB and our 13 local authorities setting joint system priorities in an integrated care strategy, and it has been extremely helpful to have DASS involvement in the working group looking at the formulation of this strategy, and we will also need to engage with the Adult Social Care Lead Member Network.

Much of our collaborative work is already in train and focused on the day-to-day operational challenges of delayed discharge, market frailty, sustainable funding flows and more importantly driving quality and improvement for service users and carers. However, we also considered a range of other strategic areas where we share priorities, including workforce planning, market shaping and longer-term commissioning and understanding our shared financial position and future pressures for the ICB and local authorities.

There are a number of key enablers which will support these shared priorities, including housing (where each local authority is responsible for a refresh of their housing needs assessment, and ADASS have established a housing board which we will participate in), technology, and joint work on the Great North Care Record and electronic care records and sensory equipment is already in train, and quality and safeguarding – as ICBs and local authorities are statutory partners for children's and adult's boards – and preparation for inspections given that both the ICB and local authorities will be inspected next year.

In terms of next steps, we committed to building relationships via informal workshops between the North East ADASS and the ICB senior leadership team, meeting at least three times per year, where we will focus on a small number of joint priority areas to add value and pace for the system. We also agreed to take forward a range of practical next steps which will further strengthen our joint-working arrangements:

- Joint project roles, integrated posts and secondments
- Developing joint communication messages and campaigns
- Scoping an service level agreement regarding analysis of data/information as happens in other ICS areas
- Agreeing a protocol of how the system/ICB engages with the independent social care sector, building on existing local authority-led local provider forums).
- Supporting user and carer involvement arrangements to better understand lived experience
- Supporting each other with the new assurance frameworks for social care and ICSs
- Coordinating interactions with Department of Health and Social Care and NHS England regional teams
- Involving ADASS colleagues in key ICB workshops, e.g., those on winter planning and assurance

3.11 <u>First Meeting of the Integrated Care Partnership</u>

The inaugural meeting of our Integrated Care Partnership (ICP) was held on the 20 September. The ICP is a statutory joint committee of the ICB and the 13 local authorities in the North East and North Cumbria and responsible for setting the priorities for our system through the development and approval of an integrated care strategy for our ICS. Sir Liam Donaldson helpfully agreed to chair the meeting in the interim, although we agreed that we will appoint a substantive chair at our second meeting in December.

The meeting was very well attended, and we were able to consider national guidance on the establishment of ICPs, as well as it's chairing and membership arrangements. We also considered recommendations on ways of working between the strategic ICS-wide ICP and our four locally-focused 'area ICPs' and how they in turn will develop a picture of need from each of their constituent health and wellbeing boards. These arrangements were agreed by the strategic ICP and our executive directors of place-based delivery will now begin to convene the first meetings of their area ICPs in November.

We were also able to consider presentations on the economic outlook for the North East and North Cumbria, delivered by Rob Hamilton, the Chief Economist at the North of Tyne Combined Authority, alongside a presentation that I gave on our current health and care challenges and opportunities. We then considered the recommendations of a working group jointly convened by Jacqueline Myers and Jane Robinson (Corporate Director of Adult's and Health Services at Durham County Council and ADASS Chair for the North East) on the formulation of our integrated care strategy, and the drafts of this strategy are now being consulted on, ahead of formal approval the next meeting of the strategic ICP in December.

4. Recommendations

The Board is asked to receive the report for assurance and information.

Name of Author: Samantha Allen, NENC ICB Chief Executive

Name of Sponsoring Director: N/A

Date: 20/09/2022