Join our Journey

North East and North Cumbria

Optimising Health Services

Programme Board

Terms of Reference v8 September 2019

1. Background

The North East and North Cumbria Integrated Care System (ICS) is a regional partnership between the NHS, local authorities, and others, taking collective responsibility for resources, setting strategic objectives and care standards, and improving the health of the people they serve. The Optimising Health Services (OHS) Board is one of six ICS Programme Boards and provides clinical oversight for the ICS.

The Board encompasses the North East and North Cumbria geography split into the 4 sub-regional areas or Integrated Care Partnerships (ICPs) - of neighbouring NHS providers and commissioners, working with their local authorities, to deliver sustainable health and care services for the people in their area (shown in figure 1):

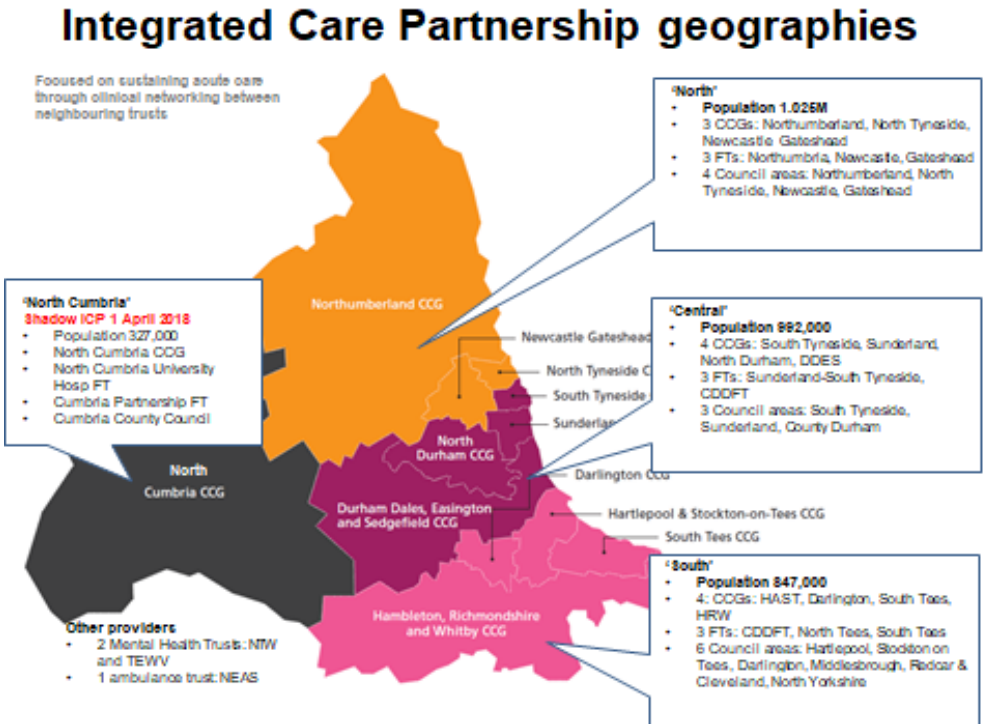


Figure 1 – ICS and ICP boundaries

2. Purpose

The purpose of The Board is to have **Clinical oversight and coordination of standards, strategy, service redesign and quality to support equitable local delivery**.

This is enabled by:

- Strategic clinical oversight of ICS development through its workstreams and network connections
- Strong ICP connections to understand wider impact of local delivery
- Clinical leadership and engagement including Senates, Networks and PCNs
- Comprehensive health system representation and oversight; community, mental health, primary care, acute, quality workforce (HENE)
- Identification of vulnerabilities and sustainability solutions–CNE wide view
- Co-ordinating transformation of specialist and local commissioned services e.g cardiology,
- Triangulation of provider/ICP transformation and strategies with the wider system and LTP delivery e.g. Respiratory and Child Health
- Management of key delivery programmes eg. Radiology, Pathology, Haematology,
- Co-production of ambitious standards for ICP delivery
- Workforce feedback loop
- Utilise the ICS governance and OHS Board membership to connect with other ICS initiatives (eg communication and workforce) and specialist areas (eg Education via HEE) to benefit the OHS programmes outcomes.

The programme board also acts as a focal point to address service vulnerabilities (either at ICS or ICP level). A vulnerable clinical service is one that has and continues to;

- *Consistently struggle to recruit consultants, is dependent upon locum / short term appointments and is reliant upon substantive staff to regularly undertake extra sessions or additional on call to cover service pressures and/or absences (planned or otherwise).*
- *Has recurrent gaps on any tier of shift or on call arrangement and for which there is reliance on ad hoc (including locum) arrangements for cover.*
- *Has already made adjustments to service provision in response to some of the sustainability challenges it faces (workforce, finance, quality)*

3. Governance, Accountability and Authority

The Optimising Health Services (OHS) Board is accountable to the Health Strategy Group, gaining assurance and financial and clinical assessment through the ICS Management Group and the Clinical and Financial Leadership Groups. Approval will be gained following the emerging process shown in Figure 2 and 3.

The OHS workstreams (as shown in Appendix 1) have existing reporting and governance which remain unchanged, but additional connections to the ICS through OHS Board is required. The OHS programme requires oversight on only two aspects of these workstreams:

1. Assurance that any service vulnerabilities are being addressed
2. Assurance that they both influence the development of and deliver on the emerging clinical strategy.

Each ICP has oversight of their specific programmes of work and a responsibility to exception report to the OHS Programme Board on all areas of work relevant to The Board's remit.

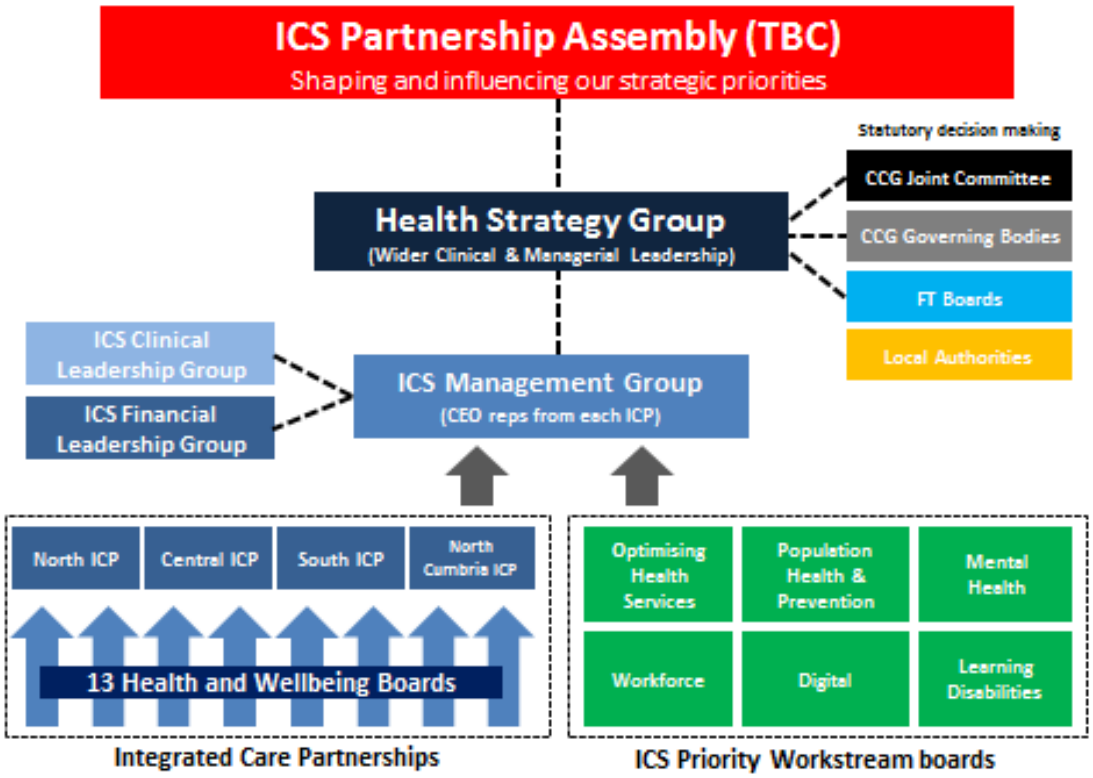


Figure 2 – Overarching ICS governance (draft)

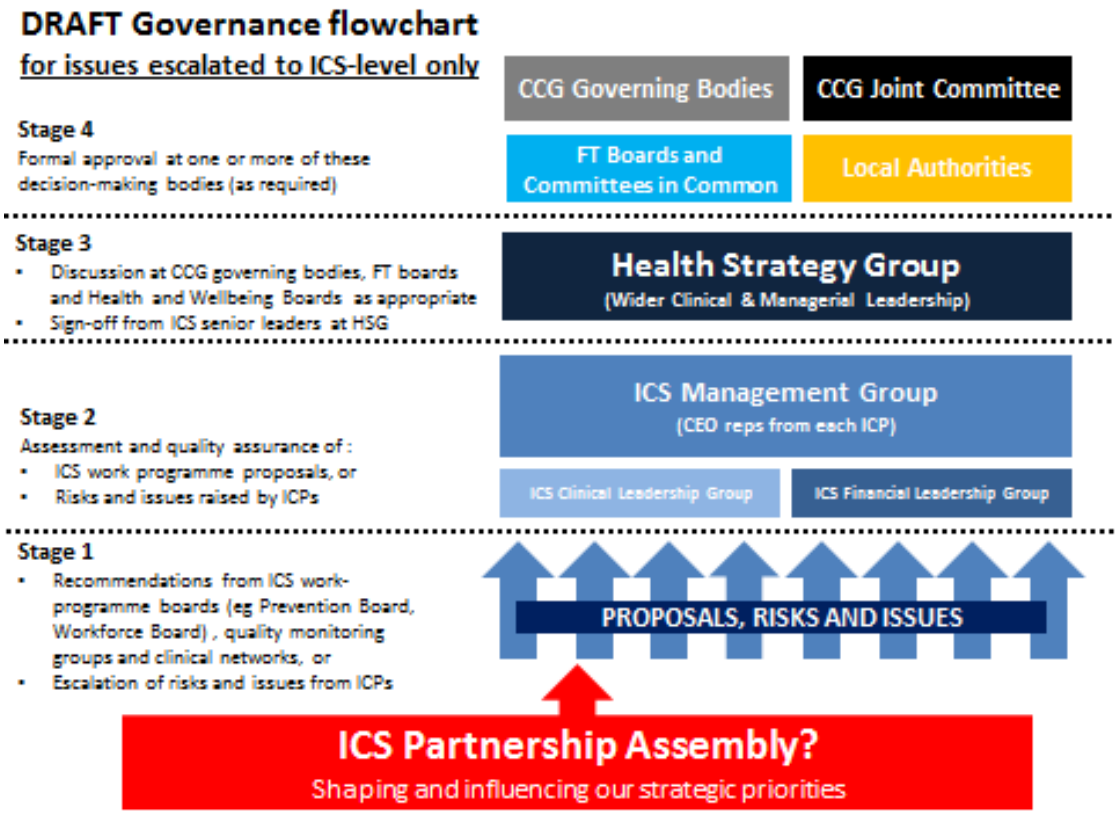


Figure 3 – ICS escalation and approvals process (draft)

4. Programme Board Connections

To ensure oversight across the wider system and conduit into the ICS, The Board has established reporting and membership connections through existing networks including:

- ICS workstreams
    - Population Health & Prevention
    - Digital Transformation
    - Workforce Transformation
    - Mental Health
    - Learning Disabilities
- Integrated Care Partnership networks
- Mandated Clinical Networks
- Primary Care and Primary Care Networks
- Northern Cancer Alliance
- Pathology Collaboration
- Care closer to home and the frailty network
- Pharmacy and medicine strategy group

These connections ensure the board has comprehensive oversight and awareness of any unintended consequences of their work.

4.1 Clinical networks

There are four nationally mandated clinical networks across the NENC ICS.

- Mental Health (including dementia, older people and CYP)
- Maternity (including. Perinatal MH)
- Cardiovascular disease (including vascular, stroke and cardiology)
- Diabetes

These networks will sit within the medical directorate of NHS England & Improvement: North East and Yorkshire but will support the delivery of transformation in these clinical areas within the NENC ICS. The number of mandated networks may increase as the implementation planning for the Long Term Plan becomes clearer (e.g. Child Health and Wellbeing and Respiratory) whilst other non-mandated networks also sit alongside their mandated counterparts (e.g. the North East and Cumbria Learning Disabilities Network).

The Northern England Mental Health Network reports into the NENC ICS Mental Health Workstream and the North East and Cumbria Learning Disabilities Network reports into the NENC ICS Learning Disabilities Workstream. However, the remaining mandated clinical networks report into the Optimising Health Services workstream and ensure:

- Joint accountability between NHSE/I and ICS through sign-off of workplans
- Clear decision-making routes for issues requiring ICS level approval
- Central route for clinical networks to feed into standing processes (e.g. clinical input into annual planning processes etc)
- Providing the ICS with clinical leadership to meet any requirements set out by national / regional programmes
- Create a forum for discussion around temporary flex of capacity to carrying out ICS requested work covered in a service area covered by a clinical network

4.2 Northern Cancer Alliance

Cancer Alliances have been tasked with improving quality and outcomes across cancer pathways, based on shared data and metrics. The 19/20 planning guidance re-affirms the role of cancer alliances as system leaders bringing together partners to agree and deliver a system wide plan delivering both improved operational performance and transformation in outcomes, working with and on behalf of the ICPs and ICS.

Cancer Transformation funding for the North East and North Cumbria is allocated via the Northern Cancer Alliance which has responsibility for the financial governance and delivery of this work. This oversight is enabled via OHS Board membership. The Alliance Board reports into both the ICS (via the OHS Board) and NHSE through region. (shown in figure 4 below).

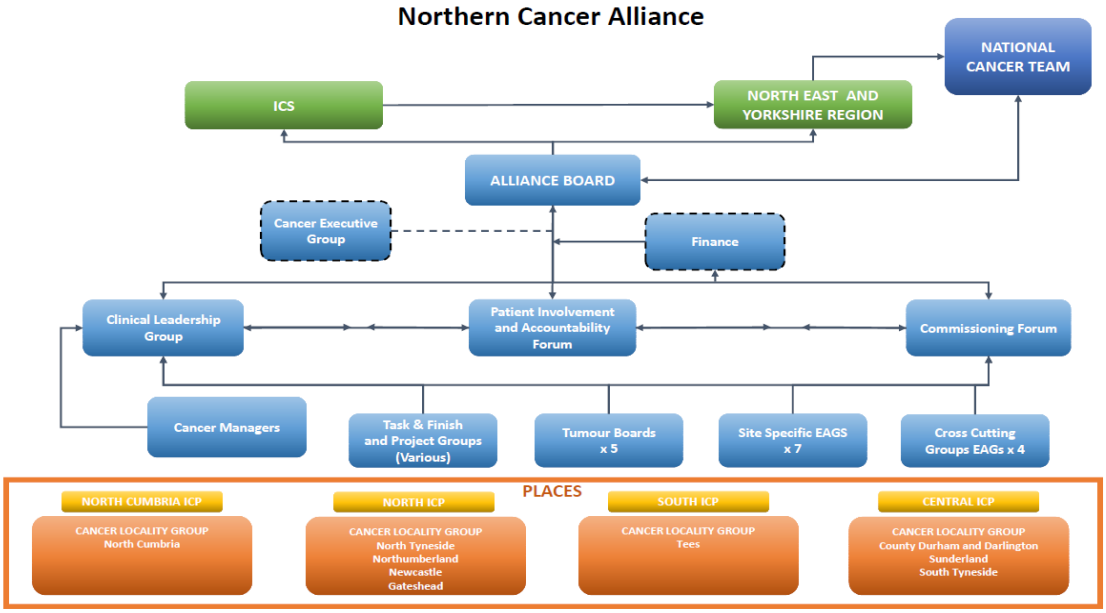
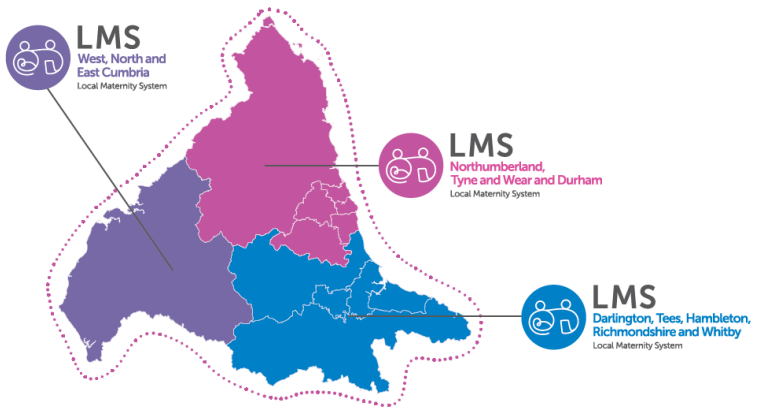


Figure 3 – Northern Cancer Alliance structure

4.3 Local Maternity Systems (LMS)

There are 3 Local Maternity Systems (LMS) across the North East and North Cumbria ICS area. They are coterminous with ICP areas with the exception of the Northumberland, Tyne, Wear and Durham LMS which covers both the North and Central ICPs.



LMSs are charged with the delivery of a number of the Long Term Plan clinical priorities for maternal health and receive dedicated transformational funding to support delivery of the aims of Better Births. Each LMS has its own LMS Board with named Senior Responsible Officers and senior clinical/midwifery leads and LMS plans are expected to be integrated into wider ICS plans.

There is a national expectation that Local Maternity Systems have a clear reporting route into ICS governance structures and as such, the Northumberland, Tyne, Wear and North Durham LMS and the Durham, Darlington and Tees (including Hambleton, Richmondshire and Whitby) LMS will be represented on the Board by the LMS Programme Lead for the North East. The North Cumbria LMS will report in via the North Cumbria ICP representative.

OHS Board - Clinical oversight - conduit into the ICS and connection to ICP delivery

4.4 Pathology Collaboration

The Pathology Collaboration has historically been an independent ICS workstream which was brought into OHS in 2018. The governance model is shown in figure 4 below which illustrates that:

- Optimising Health Services Board is responsible for oversight of the regional NENC Pathology Programme - sign off of workplan, mid year review and exception reporting.
- Sub-regional groups and Speciality Reference Groups to feed into NENC Laboratory Services Group.
- Regional LIMS procurement led by NUTH but with a NENC regional technical evaluation group and links into the regional digital and IT work through the CIOs.

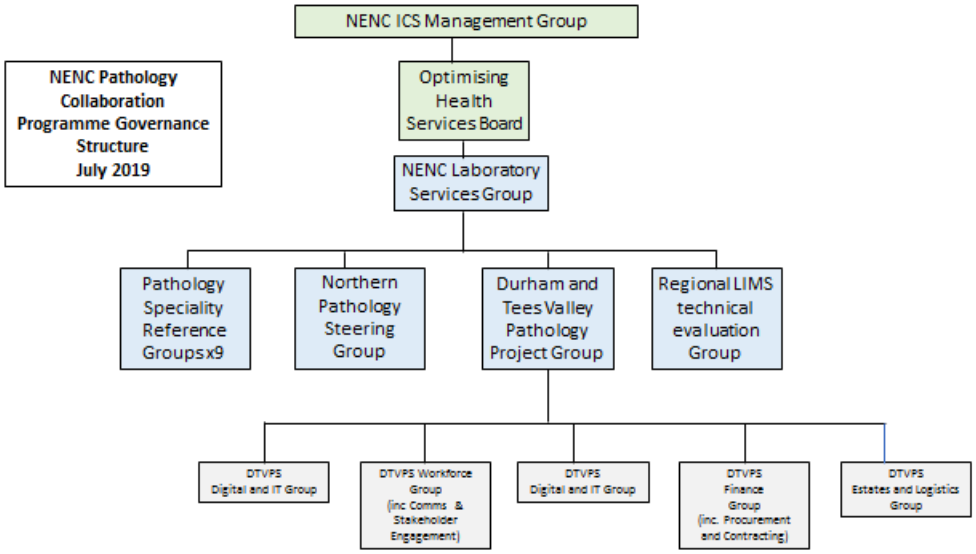


Figure 4 – Pathology Collaboration Governance

5. Membership

It is important that stakeholder organisations, networks and groups across the region are represented. The Board membership is:

Name	Position	Organisation	Board Role/Focus
Ken Bremner	Chief Executive	South Tyneside & Sunderland NHS Foundation Trust	OHS and Workforce ICS Programme SRO and Central ICP
Professor Chris Gray	Medical Director - System Improvement and Professional Standards	NHS England: NHS North East and Yorkshire	Programme Clinical Lead & Regional Quality Surveillance Group member
Ben Clark	Associate Director – Clinical Networks	NHS England: North (Cumbria and North East)	Clinical Networks

Lyn Simpson	Integration and Transformation Director	NHS England	South Review
Susan Watson	Director of Strategy & Transformation	QE Gateshead	North ICP
Ramona Duguid	System Executive Director of Strategy	North Cumbria Integrated Health & Care System (STP)	North Cumbria ICP (including LMS)
Sue Jacques	Chief Executive	County Durham and Darlington NHS Trust	Sub Region – South ICP
Dan Jackson	Head of Strategic CCG Development	Sunderland CCG	Governance
Mary Bewley	STP Engagement and Communications Lead	North of England Commissioning Support	Engagement and Communications
Julie Turner	Senior Service Specialist for Specialised Commissioning	NHS England, Specialist Commissioning	Specialist Commissioning (as appropriate)
Peter Blakeman	Deputy Post Graduate Dean and Director for Clinical Quality	Health Education England	Multi Professional Education & Post Graduate Training
Lucy Topping	Interim Deputy Director of Delivery	NHS England: North (Cumbria and North East)	Elective Care & Demand Management ICS Workstream
Tracy Johnstone	Interim Deputy Director of Commissioning	NHS England	All areas of Primary Care and Public Health Commissioning
Graham Evans	Chief Digital Officer	North Tees and Hartlepool NHS FT	NENC – Integrated Care System
Rajesh Nadkarni	Executive Medical Director	Northumberland, Tyne & Wear, NHS FT	Mental Health
Caroline Thurlbeck	Director of Strategy, Transformation and Workforce	North East Ambulance Services NHS Foundation Trust	Ambulance
Neil O'Brien	Chief Clinical Officer	Five South CCGs	Local Commissioning
Kathryn Hardy	North East LMS Programme Lead	NTWND LMS and DTHRW LMS	Local Maternity Systems
Alison Featherstone	Cancer Alliance Programme Director	Northern Cancer Alliance	Cancer Alliance financial Governance
Heather Corlett	Assistant Director	South Tees CCG	Programme Manager

The ICS has an overarching communications and engagement strategy ensuring Local Authorities are effectively updated and engaged on the ICS.

OHS Board - Clinical oversight - conduit into the ICS and connection to ICP delivery

Partnership working with Local Authorities and Mental Health representation on The Board is necessary at sub-regional and programme level and will be exception reported by the sub-regional chairs to the OHS Board. Strategic Mental Health oversight is delivered through the Board through the ICS Mental Health Clinical Lead. Strategic ICS Workforce connections are through the SRO and operational connections are reported to the Workforce Programme Leadership Group via the programme manager.

The OHS SRO will represent each workstreams at The Board.

6. Quoracy

The meeting will be quorate where all of the following apply

- The chair or deputy chair are present, and
- There is at least one member from each sub-regional/ICP area (agenda will clearly record items for decision)

7. Meeting Arrangements

Where the chair person is unavailable the meeting will be run by a deputy chair. The Optimising health Services Programme Board will meet every 4 weeks.

In the event of the loss of an existing member the associated organisation or work programme will be asked to nominate a replacement.

Where any members are unable to attend meetings they must ensure a deputy is nominated to attend, and that this deputy will attend fully briefed and empowered to act as a member of the group.

Meetings will be supported by WebEx and conference calls to minimise travel and maximise productivity whenever possible. Meeting papers will be circulated to members no later than 3 days before each meeting takes place and electronic files circulated will be no larger than 8mb.

Administrative support will be provided by the CNE Regional Delivery Unit.

8. Reporting

The OHS workstreams with existing reporting and governance remain unchanged, but additional connections to the ICS and OHS Board is required.

The OHS programme requires oversight on two aspects of these workstreams and to that end their annual workplan needs approval followed by short exception reporting for the board to gain:

1. Assurance that any service vulnerabilities are being addressed
2. Assurance that they both influence the development of and deliver on the emerging clinical strategy.

The onward reporting of issues and cascade of information to the ICS can be progressed as appropriate.

Quality assurance concerns from the Optimising Health Board will be reported by exception through a template submitted to the Regional Quality Surveillance Group (QSG) and supported by OHS representation at the QSG by the OHS Clinical Lead. *This arrangement will be reviewed and may be superseded as the ICP Quality Committees become established.*

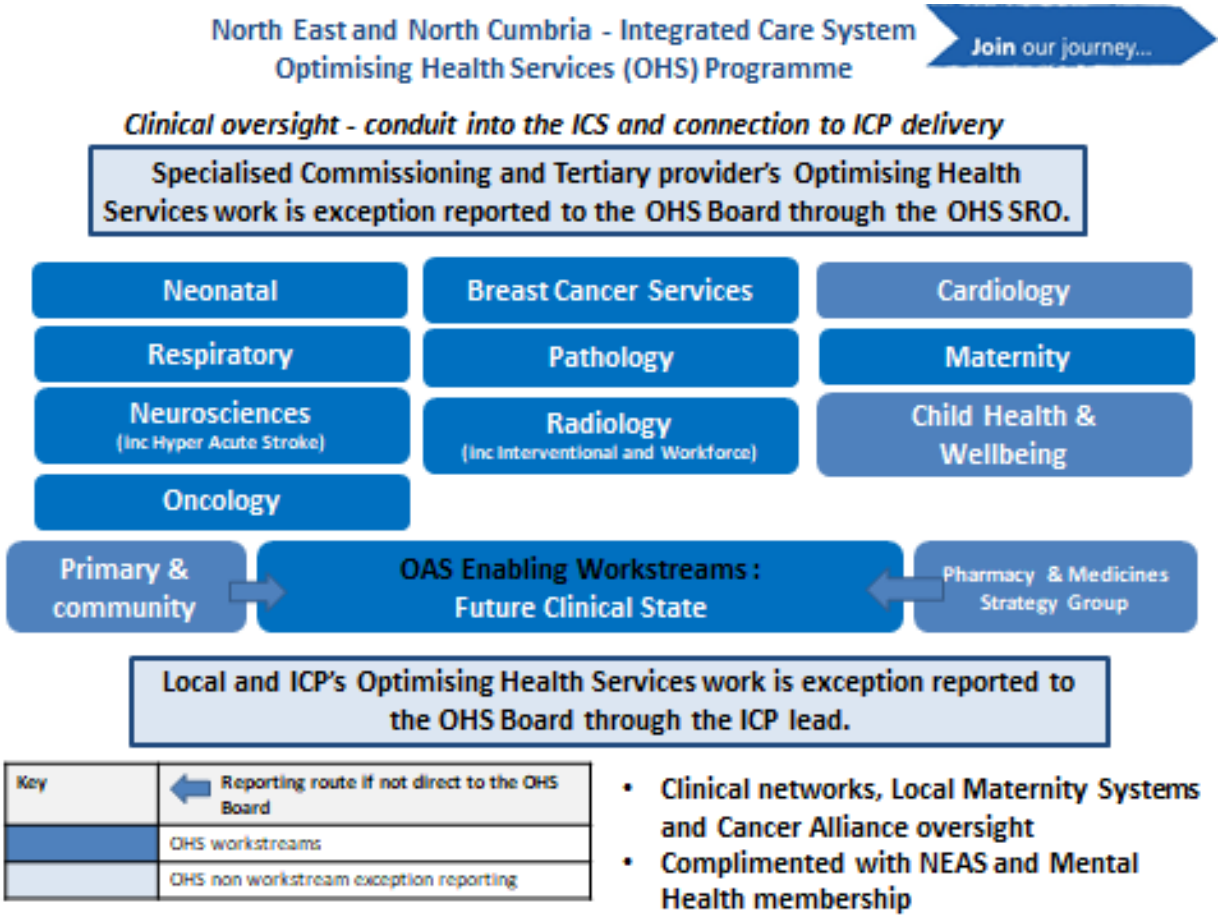
Appendix one and two list the workstreams and reporting routes. Each sub-region will have oversight of their specific programmes of work and will exception report to the OHS Programme Board.

Any risks and issues requiring onward escalation will be agreed by the board and will be reported to the ICS Lead Management Group and Health Strategy Group.

9. Document Review

The terms of reference will be reviewed every 6 months.

Appendix 1 – Programme Overview



OHS Board - Clinical oversight - conduit into the ICS and connection to ICP delivery