

MINUTES OF NHS DERBY AND DERBYSHIRE ICB BOARD PUBLIC MEETING

Thursday, 19th January 2023

via Microsoft Teams

confirmed Minutes

Present:		
John MacDonald	JM	ICB Chair (Chair)
Tracy Allen	TA	Chief Executive DCHS & Place Partnerships (NHS Trust & FT Partner Member)
Jim Austin	JA	Chief Digital and Information Officer
Dr Avi Bhatia	AB	Clinical & Professional Leadership Group participant to the Board
Dr Chris Clayton	CC	ICB Chief Executive Officer
Julian Corner	JC	ICB Non-Executive Member
Dr Buk Dhadha	BD	ICB Non-Executive Member / Vice Chair of the ICB Board
Helen Dillistone	HD	Executive Director of Corporate Affairs
Margaret Gildea	MG	ICB Non-Executive Member
Carolyn Green	CG	Deputy Chief Executive DHcFT (NHS Trust & FT Partner Member)
Darran Green	DG	Acting Operational Director of Finance
Ellie Houlston	EH	Director of Public Health – Derbyshire County Council (Partner Member for Local Authorities)
Zara Jones	ZJ	Executive Director of Strategy & Planning
Dr Andrew Mott	AM	GP Amber Valley (Partner Member for Primary Medical Services)
Amanda Rawlings	AR	Chief People Officer
Andy Smith	AS	Strategic Director of People Services - Derby City Council (Local Authority Partner Member)
Brigid Stacey	BS	Chief Nursing Officer & Deputy Chief Executive Officer
Sue Sunderland	SS	ICB Non-Executive Member
Dr Chris Weiner	CW	ICB Chief Medical Officer
Richard Wright	RW	ICB Non-Executive Member
In Attendance:		
Helen Blunden	HB	Interpreter
Jacinda Bowen-Byrne	JB-B	Interpreter
Wynne Garnett	WG	Programme Lead for engaging VCSE
Chlinder Jandu	CJ	Corporate Administration Manager
Suzanne Pickering	SP	Head of Governance
Sean Thornton	ST	Deputy Director Communications and Engagement
Apologies:		
Keith Griffiths	KG	ICB Executive Director of Finance

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Introductory Items		
ICBP/2223/062	<p>Welcome and apologies</p> <p>John MacDonald (JM) welcomed everyone to the meeting.</p> <p>Apologies were noted as above.</p>	
ICBP/2223/063	<p>Confirmation of quoracy</p> <p>It was confirmed that the meeting was quorate.</p>	
ICBP/2223/064	<p>Declarations of Interest</p> <p>The Chair reminded committee members of their obligation to declare any interests they may have on issues arising at committee meetings which might conflict with the business of the ICB.</p> <p>Declarations made by members of the Board are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the ICB Board Secretary or the ICB website at the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/integrated-care-board-meetings/</p> <p>Dr Avi Bhatia (AB) declared a conflict of interest with part of Item 068 due to his role as Interim CPLG Chair. AB left the meeting when the Board were asked to discuss and approve the CPLG Chair Job Description and proposed appointment process.</p>	
ICBP/2223/065	<p>Questions received from members of the public</p> <p>Helen Dillistone (HD) shared a question from Daniel Feldman regarding the Commissioning Framework around Covid-19 therapeutics for non-hospitalised patients which was published by NHS England on the 22nd December 2022. The response was as follows:</p> <p><u>Which member of the Derbyshire ICB is responsible for overseeing the delivery of this new framework?</u></p> <p>Dr Chris Weiner, Chief Medical Officer and Mandy Simpson, Vaccination Programme Director. All enquiries should be made to Mandy Simpson in the first instance.</p> <p><u>Have the implications of this new framework been considered yet?</u></p> <p>Yes, both the draft Commissioning Framework and the final Commissioning Framework have been considered by the Joined Up Care Derbyshire system though the CMDU meetings which meet monthly with all stakeholders. A gap</p>	

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	<p>analysis has been undertaken of the framework and is being worked through, to be implemented by 1 April 2023.</p> <p>To note, a meeting took place on 1 December 2022 to discuss the draft framework, to communicate the JUCD pathway in place and ongoing work regarding communication and identification of hesitant patients and how we address this going forward. Contact details for any ongoing work and follow up communications have been provided.</p> <p>The Board NOTED the question and response to the public question</p>	
Strategy and Leadership		
ICBP/2223/066	<p>Chair's Report</p> <p>JM highlighted the following from his report:</p> <ul style="list-style-type: none"> • Dr Buk Dhadda (BD) will be stepping down as a Non-Executive member and Chair of the Quality and Performance Committee. JM thanked BD on behalf of the Board and personally for all the work he has done over the years. Temporary arrangements will be put in place whilst recruiting to BD's post. • JM recognised the ongoing difficulties that the NHS is facing and thanked the Board members, frontline staff, leaders and other organisations for their resilience and determination to provide safe services which has mitigated a lot of the challenges faced. • A draft Integrated Care Strategy will be published soon and will consider how NHS bodies and local authorities will work together. • JM highlighted the importance of clinical leadership and the voluntary sector in terms of developing integrated working. This will be discussed further at the March meeting. <p>Comments/Questions</p> <p>Tracy Allen (TA) requested for the Board to note the Hewitt Report. TA has been asked to be a part of the Integration and Place Workstream and will feed back to the Board.</p> <p>The Board NOTED the Chair's report</p>	
ICBP/2223/067	<p>Chief Executive's Report</p> <p>Dr Chris Clayton (CC) provided an update on the key messages and developments relating to work across the ICB and Integrated Care System (ICS):</p> <ul style="list-style-type: none"> • The Board will be increasingly involved in developing the 5-year plan for the NHS. Although it is important to work on the immediate challenges facing the NHS system, it 	

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	<p>is also necessary to have a continued and increased focus on the future.</p> <ul style="list-style-type: none"> • The system collectively stepped down the critical incident status last week, however this remains a challenging time. Themes in the critical incidents were different and nuanced but the underlying challenge of flow through the hospitals was the key focus. • CC has overseen industrial action in different parts of the healthcare sector and will continue to support management with further industrial action. CC highlighted the following in regards to activity: <ul style="list-style-type: none"> ○ overall activity coming into hospitals has remained stable, however the flow out of hospital is collectively being worked through and managed across partnerships; and ○ the maintenance of flow throughout the system, especially in community settings, is crucial for the whole system. • The Operational Control Centre (OCC) is now up and running. It is anticipated to be in place for the foreseeable future as the urgent emergency care system is stabilised. • The 'Derby and Derbyshire Together' exercise reports are expected to assist in the direction of travel for the ICB. CC is keen to obtain input from the NHS family in Derby and Derbyshire. <p>CC thanked all colleagues who were linked to the above challenges and who provided support during this time.</p> <p>In regards to national developments, research and reports CC highlighted the following:</p> <ul style="list-style-type: none"> • the first analysis of the NHS planning guidance and what that means for 2023/24 is expected shortly. This will help the ICB to understand what the priorities should be for the NHS family in Derby and Derbyshire; • the King's Fund have published a long read on the first months of the ICS as statutory bodies; • significant work is ongoing locally, regionally and nationally with trade unions on the continued industrial action; • over 320,000 people have received treatment for cancer over the last year (November 2021–October 2022) – the highest year on record, and up by more than 8,000 on the same period pre-pandemic; • 91% of surveyed patients have provided positive feedback in regards to community pharmacists and NHS England have delegated commissioning responsibility from April to the ICB, which will continue to build on this work; • the Provider Collaborative Leadership Board have agreed to focus on two clinical areas as immediate improvement priorities. An item on Place will be brought 	

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	<p>to the Board in March following the Chair's letter to Place leaders asking key questions;</p> <ul style="list-style-type: none"> • System delivery and transformation, and the planning guidance for 2023/24 will be brought back to the Board in due course; • work has been continuing within the People Services Collaborative, bringing together the HR and people services teams across our providers who are working on seven workstream areas including recruitment and retention, staff wellbeing, aligning policies and collaborative workforce planning. <p>The Board NOTED the Chief Executive's report</p>	<p>CC</p> <p>CC</p>
Items for Decision		
ICBP/2223/068	<p>Clinical and Care Professional Leadership developments: Progress and Forward Plan</p> <p>CC introduced this item and reminded colleagues that conversations were had about clinical leadership back in the Spring of 2022, and as a consequence the Shadow Integrated Care Board and the Integrated Care Partnership set out a number of asks to the Clinical and Professional Leadership Group. Following these conversations it was also agreed for the NHS to fund an interim leadership arrangement and CC thanked AB for undertaking this role. AB presented the report and highlighted the following:</p> <ul style="list-style-type: none"> • CPLG started as Clinical and Professional Reference Group (CPRG), but has since developed into the Clinical and Professional Leadership Group. The movement to leadership group is important in the system as it represents not just leadership from clinicians but also expertise from professional individuals within social care, local authority and allied health professionals. It also provides a focus on developing leaders for tomorrow, and ensuring individuals have the capacity to be able undertake these roles; • CPLG has been a part of decision-making in a variety of areas in the ICS including the Population Health and Strategic Commissioning Committee, the Provider Collaborative Leadership Board and the Integrated Care Partnership. AB highlighted the importance of clinicians, professionals, executives, managers and directors working well together going forward; • a couple of live engagement events for the wider group of clinical professionals have been held and received well; • a clinical pathway governance model has been developed and co-produced by all of CPLG. This is to ensure that any clinical change is mandated system-wide if it impacts on multiple organisations; 	

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	<ul style="list-style-type: none"> a national support event is to be held on the 16th February for the wider clinical and professional community and those sitting on corporate committees and decision-making. The event aims to aid with the understanding of how the CPLG concept synergises with other areas, in an informal setting. A request for colleagues to attend if possible was made; the Terms of Reference have been refined and the Board are asked to approve these; work is ongoing with Foundation Trusts, General Practice and others to enable a 'system clinical voice' to reduce duplication and increase efficiency; engagement with social care colleagues has continued and a plan has been developed to continue with this. AB provided an example of what has been done to increase this engagement, which has included a change to the structure of the meeting to ensure all individuals can attend and access relevant information. <p>Comments/Questions</p> <ul style="list-style-type: none"> JM queried whether discussions will be held about what happens within individual organisations and how we can make sure they are aligned to enable a more consistent approach across all the different organisations and partners towards clinical and professional leadership. AB confirmed the group had a discussion recently on this. Specific areas covered were expert advisory forums and how the larger organisations would be made available for this work and developing these relationships. Good progress on this has been evidenced through the Provider Collaborative Leadership Board and an appetite has been seen in other areas. JM also queried as part of this development, whether there will be change in the clinical ask and how we are able to support this. AB confirmed that there will be an evolution as the architecture evolves, however we currently have a number of members who represent Place and PCNs, which will allow this support to happen. <p>CC reminded colleagues that clinical and professional leadership was one of the core areas that the ICB wanted to establish in the ICS, long before the ICB was established. CC provided an update on the significant progress which has been made on this in the past 12 months, however there is further work to be done across the NHS family to embed this. An area of work that the CPLG has embarked upon is professional leadership and felt there was further work to be done in terms of that boundary with public health colleagues.</p> <p><i>AB left the meeting at this point due to his conflict of interest</i></p>	

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	<p>CC continued to share that AB was appointed on an interim basis to lead and chair the CPLG. From an executive point of view CC has asked Amanda Rawlings (AR) to bring the CPLG into the broader workforce and people work. Chris Weiner (CW) has also been asked to continue to provide senior medical leadership guidance to the Chair and other colleagues and strategically the CPLG remains dominantly an NHS development vehicle. It is proposed that this is continued with an NHS funded model at this stage, recognising that it may need to change. CC's recommendation was for the Board to commit formally to the ongoing leadership of this work and maintain this pseudo-independence to harness the full opportunity of professional leadership. Expressions of interest will be sought from the current clinical and professional leadership body which will set up a process to then appoint the Chair and other key members. The ICB would be part of that process for assurance. CC felt that there is certainty now for the need to embed the clinical and professional movement and therefore two years should be the minimum term of the position. Ideally it should be a three year term, as it would be for any office holder appointment.</p> <p>CC recommended to the Board that the NHS commits through the ICB to recruit a permanent Chair. Over time there will be conversations across the ICP in regards to joint arrangements. The appointment process was agreed and the Board advised to look for expressions of interest from the clinical and professional and leadership community because it is important to build on what has been created.</p> <p>Comments/Questions</p> <ul style="list-style-type: none"> • The Board were in agreement to the Chair role being a 3-year term position. • Suggestion was made that the advert for the Chair position is shared widely with other parts of the system and not just within the CPRG group, to seek a good range of input. <p>The Board:</p> <ul style="list-style-type: none"> • NOTED the Clinical and Care Professional Leadership Developments – Progress and Forward Plan; • APPROVED the new Joined Up Care Derbyshire Clinical and Professional Leadership Group (CPLG) Terms of Reference and NOTED the approved clinical pathways development process embedded within the Terms of Reference; • APPROVED the CPLG Chair Job Description and proposed appointment process, and AGREED the 3-year term position; • SUPPORTED the NHSE offer and ENCOURAGED target group/strategic leader participation; • SUPPORTED the direction of travel for GP Clinical Leads resourcing; and 	

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	<ul style="list-style-type: none"> NOTED the status of the discussions with Social Care colleagues. <p>ACTION: CC to commence the recruitment process for the Chair position</p> <p><i>AB re-joined the meeting at this point</i></p>	CC
Items for Discussion		
ICBP/2223/069	<p>Making the most of the Voluntary, Community and Social Enterprise (VCSE) sector contribution as a partner in the Integrated Care System</p> <p>Wynne Garnett (WG) thanked JM and colleagues for helping to achieve significant progress in engagement with the VCSE sector and other partners.</p> <p>WG shared a presentation of an overview of what the VCSE sector is bringing to the ICS and the particular work around the ICB, including some of the challenges and what is being done to address these.</p> <p>The areas covered were as follows:</p> <p><u>VCSE Contribution</u></p> <p>WG shared statistics in Derbyshire and highlighted the fact that there are 10,000 FTE paid staff working in the sector, which is equivalent to staff employed at the Derby Royal. This shows a significant contribution from the VCSE sector, who provide:</p> <ul style="list-style-type: none"> • soft intelligence and data; • engagement with communities; • innovative service design; • delivery (complementarity, innovation, flexibility and responsiveness); • value (cost effective and access to other resources); • release of community potential; and • prevention <p>The sector underpins what is happening around health and social care and is a sector relevant to all aspects of health and social care. WG reported on a number of challenges which will be brought together in a Memorandum of Understanding (MoU) between the VCSE Alliance and the ICB on behalf of the wider system by April 2023. The aspiration in Derbyshire is to launch it at a cross sector event to promote VCSE sometime in June 2023, as well as through discussions between the system and ICB to understand what everyone would like to see in VCSE engagement.</p>	

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	<p>WG asked the following of the ICB:</p> <ul style="list-style-type: none"> • work together because it makes things better, not because guidance tells us to! Make partnership systemic, “Have we involved the VCSE sector?”; • be prepared to work differently and sometimes take more risks; • work together to build mutual understanding, relationships and trust; • be willing to look at change to procurement and commissioning processes to build on local assets, reward collaboration and generate long term relationships; • consider using grants to invest in local VCSE activity through LPAs supporting areas such as social prescribing; • engage communities through the VCSE sector and use local intelligence; • explore links between keeping people in their own homes, social prescribing and hospital discharge; often the same people and the same VCSE organisations; • help us with pump priming work such as sector skills analysis, provider collaborative set up etc.; • support enabling capacity; and • use the MoU as a tool to build and strengthen how we work together. <p>Comments/Questions</p> <ul style="list-style-type: none"> • This was a hugely important and insightful presentation. The ICB and the Board should work closely with this sector to manage some of the issues within the NHS in regards to in-flow (BD). • In relation to front-line support, the VCSE sector has been pivotal in managing the critical incident over the past few weeks. It is also worth noting that strategic and operational relationships was strengthened through the pandemic, therefore it is important to see the VCSE sector as an equal partner around the table. Furthermore, as SRO and Chair of the Children's Delivery Group, the VCSE importantly provide challenge and enable the group to think differently (AS). • In terms of commissioning and procurement, we need to be clear about what kind of value the VCSE sector represents for our system, for example what are the enabling conditions for that value. These organisations are often isolated, with very little access to understand the context of delivering their work legally, financially and also when engaging with large systems like ourselves to gain support (JC). • It is important for collaborative working with VCSE in the future and how the system work with the VCSE sector shapes care pathways and keeps people in their own 	

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	<p>homes, as well as looking after people in the virtual ward setting (CW).</p> <ul style="list-style-type: none"> • HD highlighted an interest in talking with WG around the role that the sector has in regards to patient, public and community insight, and the work that is happening within the Public Partnership Committee. <p>The ICB Board NOTED and DISCUSSED the presentation for 'making the most of the Voluntary, Community and Social Enterprise sector contribution as a partner in the Integrated Care System'</p>	
Corporate Assurance		
ICB/2223/070	<p>Integrated Assurance and Performance Report</p> <p>CC introduced the paper, which looks not to duplicate the work of sub-committees but bring out key issues for the unitary Board's attention and rigor and managing the statutory duties of the ICB.</p> <p>Quality Report</p> <p>Brigid Stacey (BS) shared detail on some of the quality issues on a day to day basis and highlighted where recovery action plans have been requested. The delivery action plans are monitored through the System Quality Group and any concerns are escalated to the Quality and Performance Committee.</p> <p>BS shared the following slides:</p> <ul style="list-style-type: none"> • Eating Disorders – the expansion of services to 7 days a week across extended hours and working with East Midlands CAMHS Provider Collaborative to ensure pathway integration with specialist tier 4 inpatient services. • Perinatal Mental Health Services – additional staff groups have been added to those who will do assessments under supervision to increase access. This includes occupational therapists, social workers and additional assistant psychologists. • Infection Prevention and Control – there has been a rise nationally in Clostridium Difficile (C.diff). The pandemic saw a significant decrease because of universal IPC intervention. However, now that the interventions have decreased the rates of C.diff are now increasing. Both Acute Trust IPC teams have joined the Regional NHSEI C.diff collaborative and are part of the task and finish groups – one of which is looking at developing a regional post infection review tool. • Hospital Standardised Mortality Ratio (HSMR) – figures show that UHDB's HSMR has risen now to 108.7. One of the significant actions taken is a mortality summit which was held on the 20th October 2022 to share learning from Structured Judgement Review (SJR's), the 	

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	<p>Medical Examiner and good practice. The results will be presented to the Quality and Performance Committee for review and are being monitored through Clinical Quality Review Groups.</p> <ul style="list-style-type: none"> • Perinatal Mortality Review Tool (PMRT) – UHDB stillbirth rates are rising slowly with a current rate of 3.89/1000 live births. Neonatal death rates have shown a slight decrease to 2.06/1000. CRHFT is below both national averages. <p>Performance Report Zara Jones (ZJ) shared a presentation and pulled out key points from a number of dashboards:</p> <ul style="list-style-type: none"> • Urgent and emergency care – there have been fluctuations over the winter period and the overall message is ongoing work needed to improve activity and a very comprehensive urgent emergency care recovery plan is in place to ensure the in-flow and out-flow elements are delivered. With regard to GP access, the data is showing positivity around recovery of access to appointments, by increasing face to face and on the day appointments. • Planned Cancer & Care – this is a key area of focus for both the system and nationally to ensure patients on waiting lists are treated in a timely manner and their clinical needs are met quickly. There have been some positive improvements around treating a large number of people waiting for a long time. Work is being carried out to understand referral activity, theatre productivity, and how people access diagnostic tests. The overall waiting lists are reducing but some of the backlog is not, so a lot of targeted work with individual organisations and across the system is to be done. • Mental Health – this sector is under significant strain from both an adult and children's perspective. A lot of work throughout the system is being carried out to improve some of the areas including urgent care and planned care, inpatients and outside in the community. <p>ZJ recommended that it is key for the to think about the learning from the critical incidents and industrial action, how it has been managed and what impact there has been on performance. ZJ also highlighted the investment available from national and local monies to open more capacity and be more resilient through the winter period.</p> <p>Workforce Report AR assured the Board that significant effort is going into being able to track performance across the workforce, and highlighted the following:</p> <ul style="list-style-type: none"> • the annual plan for the year 2022/23 was to grow the NHS staff by of 735.33 whole time equivalents (WTE); to date the NHS has increased the workforce by 579.58 	

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	<p>WTE. It also set an ambition to reduce staff sickness, vacancies and improve retention; and reduce agency staff usage during the year. This is above plan due to operational demands and increased staff sickness and staff turnover for the period April to October. However, an improvement was seen during November and December, and the pool of bank staff has increased, to reduce the reliance on agency staff;</p> <ul style="list-style-type: none"> • further plans are in place to increase workforce to support the additional winter plan and virtual ward initiatives. Progress to date shows that this is on track due to increased staffing levels; • other key metrics that are being put into place are to monitor vacancies, sickness and absence across each organisation in order to share best practice and align policies and procedures. <p><u>Finance Report</u> Darran Green (DG) shared the following updates:</p> <ul style="list-style-type: none"> • year to date (YTD) shows significant pressure across the system, especially in regards to pressure for efficiencies increases; • there is a YTD system deficit position of £28.2m as at M8; • the forecast outturn at M8 will be £29.9m, a £5.5m improvement from M7; • the system has agreed a £19m deficit position for 2022/23 as of M9, of which a road-map has been developed between system partners to achieve this; • the M8 System Capital position is £3.4m surplus with a breakeven full year FOT expected. <p>The 2023/24 financial outlook is a:</p> <ul style="list-style-type: none"> • current system shortfall against M8 efficiency target of £18.9m; • position bolstered by non-recurrent efficiencies, which shall adversely affect our position into 2023/24; • need to understand the position of the ICB and the wider system, in light of the 2023/24 planning guidance, linked to activity and workforce projections; • requirement for extensive improvement across the system, in light of the challenging economic climate; • intention in 2023/24 to ringfence resources for population health issues and help reduce health inequalities. <p>The ICB Board RECEIVED the Integrated Assurance and Performance Report for assurance purposes</p>	

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ICB/2223/071	<p>Month 8 System Financial Position</p> <p>DG had nothing further to report as this was covered in the preceding item.</p> <p>The ICB Board NOTED the report on the Month 8 System Financial Position</p>	
ICB/2223/072	<p>Audit and Governance Committee Assurance Report – November to December</p> <p>Sue Sunderland (SS) highlighted the following from the report:</p> <ul style="list-style-type: none"> the ICB is now in a position to commence with the delivery of the additional needs of becoming a category 1 responder. This will also include developing a system for gaining assurance from other organisations on their emergency planning approach and to avoid duplication. SS has been discussing with other Audit Chairs on how this can be taken forward. <p>The Board NOTED the Audit and Governance Committee Assurance Report – November to December</p>	
ICB/2223/073	<p>Derbyshire Public Partnership Committee Assurance Report – November</p> <p>JC updated the Board on the continued work in taking direct assurance on public engagement around public service change. Developmentally we are trying to widen the approach by looking beyond direct assurance at the wider systems of public engagement throughout the ICS, looking at different organisational approaches to public engagement, how insight gained from the public is used and trying to balance scrutiny work with wider developmental work to see how the whole system is approaching public engagement.</p> <p>The Board NOTED the Derbyshire Public Partnership Committee Assurance Report – November</p>	
ICB/2223/074	<p>People and Culture Committee Assurance Report – September to December</p> <p>Margaret Gildea (MG) spoke about the three big issues – recruiting and retaining staff, and the overspend on agency staff for which mitigating actions have been put in place. These include the ICB growing its own bank of staff and the impact of industrial relations. MG highlighted the development of the One Workforce Plan which will link into the Clinical & Professional Leadership Workforce Group and the nationally funded project to improve the retention of midwifery and nursing staff. System partners from all organisations are pulling this together having identified five key priorities and seven workstreams to deliver this.</p>	

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	The Board NOTED the People and Culture Committee Assurance Report – September to December	
ICB/2223/075	<p>Quality and Performance Committee Assurance Report – November to December</p> <p>BD stated that the performance metrics are a reflection of the pressures the NHS is under nationally and this will be a focus for the Quality and Performance Committee this month. This will involve looking into the low metrics for 13-day cancer performance, 62-day cancer performance, children and young people's eating disorders, Category 2 EMAS performance and looking at the RAPS to seek assurance on behalf of the Board.</p> <p>The Board NOTED the Quality and Performance Committee Assurance Report – November to December</p>	
ICB/2223/076	<p>Population Health and Strategic Commissioning Committee Assurance Report – December to January</p> <p>JC took the paper as read and had nothing further to add.</p> <p>The Board NOTED the Population Health and Strategic Commissioning Committee Assurance Report – December to January</p>	
ICB/2223/077	<p>Draft Board Assurance Framework 2022/23</p> <p>HD presented the first draft of the Board Assurance framework and thanked the committees for their work to develop the strategic risks. The framework now identifies the measures, controls and mitigations which need to be against each of those strategic risks assigned to the relevant committee. The responsible Executive lead has also been identified, together with system leads and system groups that will also have an important contribution to the overall assurance and management of the risks. Each committee has agreed an initial score and target score which will be refreshed each quarter. At this stage the committees have been unable to work on the risk appetite score and these will be agreed during February and March.</p> <p>The Board APPROVED the Draft Board Assurance Framework 2022/23.</p>	
ICB/2223/078	<p>ICB Corporate Risk Register Report – December 2022</p> <p>HD took the paper as read and had no further comments to make.</p> <p>The Board NOTED the ICB Corporate Risk Register Report – December 2022</p>	

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<i>The following items were for information only and were not individually presented</i>		
ICB/2223/079	ICB Constitution Update The above paper was NOTED	
ICB/2223/080	Joint Forward Plan and 2023/24 Planning Guidance The above paper was NOTED	
ICB/2223/081	Ratified minutes of ICB Committee Meetings <ul style="list-style-type: none"> Audit & Governance Committee – 27.10.22 and 24.11.22 People & Culture Committee – 7.9.22 Public Partnership Committee – 20.9.22 and 18.10.22 Quality & Performance Committee – 27.10.22 and 24.11.22 The above papers were NOTED	
Minutes and Matters Arising		
ICB/2223/082	Minutes from the meeting held on 17.11.2022 The Board AGREED the minutes from the previous meeting as a true and accurate record.	
ICB/2223/083	Action Log from the meeting held on November 2022 No actions noted.	
Closing Items		
ICB/2223/084	Forward Planner Nothing further actions noted on the forward planner.	
ICB/2223/085	Any Other Business No further items were discussed.	
Date and Time of Next Meeting		
Date and time of next meeting: Date: Thursday, 16 th March 2023 Time: 9am to 10.45am Venue: via MS Teams		