Derby and Derbyshire Integrated Care Board

ICB BOARD MEETING IN PUBLIC

AGENDA

16th March 2023, 9am to 11.15am

Via Microsoft Teams

Questions from members of the public should be emailed to ddicb.enquiries@nhs.net and a response will be provided within 20 working days

This meeting will be recorded – please notify the Chair if you do not give consent

Time	Reference	Item	Presenter	Delivery
09:00	**Introductory Items**			
	ICB/2223/086	Welcome, introductions and apologies • Andy Smith	John MacDonald	Verbal
	ICB/2223/087	Confirmation of quoracy	John MacDonald	Verbal
	ICB/2223/088	Declarations of Interest • Register of Interests • Summary register for recording interests during the meeting • Glossary	John MacDonald	Papers
09:05	**Minutes and Matters Arising**			
	ICB/2223/089	Minutes from the meeting held on 19th January 2023	John MacDonald	Paper
	ICB/2223/090	Action Log from the meeting held on 19th January 2023	John MacDonald	Paper
09:10	**Strategy and Leadership**			
	ICB/2223/091	Chair's Report	John MacDonald	Paper
	ICB/2223/092	Chief Executive Officer's Report	Dr Chris Clayton	Paper
09:20	**Items for Decision**			
	ICB/2223/093	Delegation of Pharmacy, Optometry and Dental Services and Joint Commissioning Arrangements for Tier 1 and Tier 2	Dr Chris Clayton	Paper

Time	Reference	Item	Presenter	Delivery
	ICB/2223/094	Integrated Place Executive Chair and GP Lead Roles	Dr Chris Clayton	Paper
	ICB/2223/095	General Practice Provider Board	Dr Andy Mott	Paper
09:50	**Presentations**			
	ICB/2223/096	System Development • Integrated Care • Integrated Commissioning • Integrated Assurance	Penny Blackwell Stephen Posey Julian Corner Sue Sunderland	Presentations
10:20	**Items for Discussion**			
	ICB/2223/097	Integrated Care Strategy Update	Tracy Allen	Paper
	ICB/2223/098	Operational Plan Submission • Workforce and Commissioning • Finance	Zara Jones/ Amanda Rawlings Keith Griffiths	Paper
	ICB/2223/099	Report into Maternity Services at University Hospitals of Derby and Burton Foundation Trust (UHDBFT)	Dr Chris Weiner	Paper
10:45	**Corporate Assurance**			
	ICB/2223/100	Month 10 System Financial Position	Keith Griffiths	Verbal
	ICB/2223/101	Audit and Governance Committee Assurance Report – February 2023	Sue Sunderland	Paper
	ICB/2223/102	Derbyshire Public Partnership Committee Assurance Report – January and February 2023	Julian Corner	Paper
	ICB/2223/103	People and Culture Committee Assurance Report – March 2023	Margaret Gildea	Paper
	ICB/2223/104	Quality and Performance Committee Assurance Report – January and February 2023	Margaret Gildea	Paper
	ICB/2223/105	Population Health and Strategic Commissioning Committee Assurance Report – February and March 2023	Julian Corner	Paper

Time	Reference	Item	Presenter	Delivery
	ICB/2223/106	Board Assurance Framework Quarter 4 2022/23	Helen Dillistone	Paper
	ICB/2223/107	ICB Corporate Risk Register Report – February 2023	Helen Dillistone	Paper
	ICB/2223/108	Child Death Overview Panel Annual Report 2021/22	Brigid Stacey	Paper
11:05	**Items for Information**			
	The following items are for information and will not be individually presented			
	ICB/2223/109	Ratified minutes of ICB Corporate Committee Meetings: • Audit & Governance Committee – 22.12.22 • People & Culture Committee – 07.12.2022 • Public Partnerships Committee – 29.11.22 and 24.01.23 • Quality & Performance Committee – 22.12.22 and 26.01.23	John MacDonald	Papers
	ICB/2223/110	Ratified minutes of Health and Wellbeing Boards: • Derby City Council – 10.11.2022 • Derbyshire County Council – 6.10.2022	John MacDonald	Papers
11:10	**Closing Items**			
	ICB/2223/111	Forward Planner	John MacDonald	Paper
	ICB/2223/112	Any Other Business	John MacDonald	Verbal
	ICB/2223/113	Questions received from members of the public	John MacDonald	Verbal
Date and time of next meeting: Date: Thursday 20th April 2023 Time: 9.00am Venue: via MS Teams			John MacDonald	Verbal

Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Allen	Tracy	Partner Member - DCHS	Primary & Community Care Delivery Board Chair of Digital and Data Delivery Board Integrated Place Executive Meeting	CEO of Derbyshire Community Health Services NHS Foundation Trust Partner is a Director (not Board Member) for NHS Derby and Derbyshire ICB Trustee for NHS Providers Board	✓			✓ ✓	01/07/22 01/07/22 01/07/22	Ongoing Ongoing Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Austin	Jim	Chief Digital Information Officer	Finance & Estates Committee	Executive Director/Employee of Derbyshire Community Health Services NHS FT Spouse is a locum GP and the Local Place Alliance lead for High Peak (4 hours per week)	✓			✓	2015 01/07/22	Ongoing Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Bhatia	Avi	Partner Member - Clinical and Professional Leadership Group	Chair - Clinical and Professional Leadership Group, Derbyshire ICS	GP partner at Moir Medical Centre GP partner at Erewash Health Partnership Part landlord / owner of premises at College Street Medical Practice, Long Eaton, Nottingham Spouse works for Nottingham University Hospitals in Gynaecology	✓ ✓ ✓ ✓				2000 04/18 Ongoing Ongoing	Ongoing Ongoing Ongoing Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Clayton	Chris	Chief Executive	N/A	Spouse is a partner in PWC				✓	01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Corner	Julian	Non-Executive Member	Public Partnerships Committee Population Health & Strategic Commissioning Committee Remuneration Committee	As the CEO of Lankelly Chase Foundation, I may have an interest in organisations being commissioned by the JUCD if that would support a grant funding relationship that Lankelly Chase has with them.		✓			01/03/22	30/06/25	Not aware of any grant relationships between Lankelly Chase and Derbyshire based organisations, or organisations that might stand to benefit from JUCD commissioning decisions. If that were to happen I would alert the JUCD chair and excuse myself from decisions both at Lankelly Chase and JUCD.
Dhadda*	Bukhtawar	Non-Executive Member	Audit & Governance Committee People & Culture Committee Quality & Performance Committee Population Health & Strategic Commissioning Committee Remuneration Committee CPAG	GP Partner at Swadlincote Surgery Private GP work for Medical Solutions Online (Health Hero)	✓ ✓				01/07/22 01/07/22	Ongoing Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Dillistone	Helen	Executive Director of Corporate Affairs	Audit & Governance Committee Public Partnerships Committee	Nil							No action required
Gildea	Margaret	Non-Executive Member	People and Culture Committee Quality and Performance Committee Remuneration Committee	Director of Organisation Change Solutions Limited Coaching and organisation development with First Steps Eating Disorders Director, Melbourne Assembly Rooms	✓ ✓	 ✓			01/07/22 01/07/22 01/07/22	Ongoing Ongoing Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Green	Carolyn	Interim Chief Executive, DHcFT	People & Culture Committee Population Health & Strategic Commissioning Committee	Board Member - National Mental Health Nurse Directors Forum		✓			06/12/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Griffiths	Keith	Executive Director of Finance	Finance & Estates Committee Population Health & Strategic Commissioning Committee	Nil							No action required
Houlston	Ellie	Partner Member - Derbyshire Local Authority	Integrated Care Partnership Health and Wellbeing Board - Derbyshire County Council County Place Board	Director of Public Health, Derbyshire County Council Director and Trustee of SOAR Community	✓		 ✓		2005	Ongoing	Sheffield based - unlikely to bid in work in Derbyshire. Declare interest if becomes relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Jones	Zara	Executive Director of Strategy & Planning	Finance & Estates Committee Population Health & Strategic Commissioning Committee Quality & Performance Committee	Nil							No action required
MacDonald	John	ICB Chair	N/A	Chair at University Hospitals of Leicester NHS Trust	✓				01/07/22	Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair

Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Majid*	Ifti	Partner Member - DHcFT	People & Culture Committee Population Health & Strategic Commissioning Committee	CEO of Derbyshire Healthcare NHS Foundation Trust	✓				01/07/22	Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Co-Chair of NHS Confederation BME leaders Network		✓			01/07/22	Ongoing	
				Chair of the NHS Confederation Mental Health Network		✓			01/07/22	Ongoing	
				Trustee of the NHS Confederation		✓			01/07/22	Ongoing	
				Spouse is Managing Director (North) Priory Healthcare				✓	01/07/22	Ongoing	
Mott	Andrew	GP, ICB Partner Board Member	Joint Area Prescribing Committee Derbyshire Prescribing Group Clinical Policy Advisory Group System Quality Group ICB Board	GP Partner of Jessop Medical Practice	✓				01/07/22	Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Clinical Director, ARCH Primary Care Network	✓				01/07/22	Ongoing	
				Practice is shareholder in Amber Valley Health Ltd (provides services to our PCN)	✓				01/07/22	Ongoing	
				Interim Chair, Derbyshire GP Provider Board	✓				01/07/22	Ongoing	
				Wife is Consultant Paediatrician at UHDB FT				✓	01/07/22	Ongoing	
Rawlings	Amanda	Executive Director of People & Culture	People & Culture Committee Population Health & Strategic Commissioning Committee	Employed jointly between NHS Derby and Derbyshire Integrated Care Board and University Hospitals of Derby and Burton NHS Foundation Trust, as Chief People Officer	✓				01/07/22	Ongoing	This position was agreed by both the ICB and UHDB. Declare interest when relevant and withdraw from all discussion and voting if UHDB is potential provider, unless otherwise agreed by the meeting chair
Smith	Andy	Partner Member - Derby City Local Authority	N/A	Director of Adult Social Care and Director of Children's Services, Derby City Council	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Member of Regional ADASS and ADCS Groups		✓			01/07/22	Ongoing	
Stacey	Brigid	Chief Nurse Officer and Deputy Chief Executive Officer	Quality & Performance Committee System Quality Group Population Health & Strategic Commissioning Committee	Nil							No action required
Sunderland	Sue	Non-Executive Member - Audit & Governance	Audit and Governance Committee Finance and Estates Committee Public Partnerships Committee Population Health & Strategic Commissioning Committee IFR Panels CFI Panels	Audit Chair NED, Nottinghamshire Healthcare Trust		✓			01/07/22	Ongoing	The interest should be kept under review and specific actions determined as required
				Audit Chair of Joint Audit Risk & Assurance Committee for the Office of the Police & Crime Commissioner and Chief Constable of Derbyshire		✓			01/07/22	Ongoing	
				Husband is an independent person sitting on Derby City Audit Committee & Standards Committee.				✓	01/07/22	Ongoing	Unlikely for there to be any conflicts to manage
Weiner	Chris	Executive Medical Director	Quality & Performance Committee Population Health & Strategic Commissioning Committee EMAS 999 Clinical Quality Review Group	Nil							No action required
Wright	Richard	Non-Executive Member - Finance & Estates	Audit and Governance Committee Finance and Estates Committee Quality and Performance Committee Population Health & Strategic Commissioning Committee Remuneration Committee	Chair of Sheffield UTC Multi Academy Educational Trust		✓			01/07/22	07/11/22	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Member of National Centre for Sport and Exercise Medicine Sheffield Board		✓			01/07/22	24/11/22	

SUMMARY REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

A conflict of interest is defined as “a set of circumstances by which a reasonable person would consider that an Individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold” (NHS England, 2017).

Meeting	Date of Meeting	Chair (name)	Director of Corporate Delivery/ICB Meeting Lead	Name of person declaring interest	Agenda item	Details of interest declared	Action taken

Abbreviations & Glossary of Terms

A&E	Accident and Emergency
AfC	Agenda for Change
AGM	Annual General Meeting
AHP	Allied Health Professional
AQP	Any Qualified Provider
Arden & GEM CSU	Arden & Greater East Midlands Commissioning Support Unit
ARP	Ambulance Response Programme
ASD	Autistic Spectrum Disorder
BAF	Board Assurance Framework
BAME	Black Asian and Minority Ethnic
BCCTH	Better Care Closer to Home
BCF	Better Care Fund
BMI	Body Mass Index
bn	Billion
BPPC	Better Payment Practice Code
BSL	British Sign Language
CAMHS	Child and Adolescent Mental Health Services
CATS	Clinical Assessment and Treatment Service
CBT	Cognitive Behaviour Therapy
CCG	Clinical Commissioning Group
CDI	Clostridium Difficile
CEO (s)	Chief Executive Officer (s)

CfV	Commissioning for Value
CHC	Continuing Health Care
CHP	Community Health Partnership
CMHT	Community Mental Health Team
CMP	Capacity Management Plan
CNO	Chief Nursing Officer
COO	Chief Operating Officer (s)
COP	Court of Protection
COPD	Chronic Obstructive Pulmonary Disorder
CPD	Continuing Professional Development
CPN	Contract Performance Notice
CPRG	Clinical & Professional Reference Group
CQC	Care Quality Commission
CQN	Contract Query Notice
CQUIN	Commissioning for Quality and Innovation
CRG	Clinical Reference Group
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
CSE	Child Sexual Exploitation
CSF	Commissioner Sustainability Funding
CSU	Commissioning Support Unit
CTR	Care and Treatment Reviews

CVD	Chronic Vascular Disorder
CYP	Children and Young People
D2AM	Discharge to Assess and Manage
DAAT	Drug and Alcohol Action Teams
DCC	Derbyshire County Council or Derby City Council
DCHSFT	Derbyshire Community Health Services NHS Foundation Trust
DCO	Designated Clinical Officer
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHSC	Department of Health and Social Care
DHU	Derbyshire Health United
DNA	Did not attend
DoF(s)	Director(s) of Finance
DoH	Department of Health
DOI	Declaration of Interests
DoLS	Deprivation of Liberty Safeguards
DPH	Director of Public Health
DRRT	Dementia Rapid Response Team
DSN	Diabetic Specialist Nurse
DTOC	Delayed Transfers of Care
ED	Emergency Department
EDS2	Equality Delivery System 2
EDS3	Equality Delivery System 3

EIA	Equality Impact Assessment
EIHR	Equality, Inclusion and Human Rights
EIP	Early Intervention in Psychosis
EMASFT	East Midlands Ambulance Service NHS Foundation Trust
EMAS Red 1	The number of Red 1 Incidents (conditions that may be immediately life threatening and the most time critical) which resulted in an emergency response arriving at the scene of the incident within 8 minutes of the call being presented to the control room telephone switch.
EMAS Red 2	The number of Red 2 Incidents (conditions which may be life threatening but less time critical than Red 1) which resulted in an emergency response arriving at the scene of the incident within 8 minutes from the earliest of; the chief complaint information being obtained; a vehicle being assigned; or 60 seconds after the call is presented to the control room telephone switch.
EMAS A19	The number of Category A incidents (conditions which may be immediately life threatening) which resulted in a fully equipped ambulance vehicle able to transport the patient in a clinically safe manner, arriving at the scene within 19 minutes of the request being made.
EMLA	East Midlands Leadership Academy
EoL	End of Life
ENT	Ear Nose and Throat
EPRR	Emergency Preparedness Resilience and Response
FCP	First Contact Practitioner
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FIRST	Falls Immediate Response Support Team
FRP	Financial Recovery Plan
GDPR	General Data Protection Regulation
GP	General Practitioner
GPFV	General Practice Forward View
GPSI	GP with Specialist Interest
HCAI	Healthcare Associated Infection
HDU	High Dependency Unit
HEE	Health Education England
HI	Health Inequalities
HLE	Healthy Life Expectancy
HNA	Health Needs Assessment
HSJ	Health Service Journal
HWB	Health & Wellbeing Board
H1	First half of the financial year
H2	Second half of the financial year
IAF	Improvement and Assessment Framework
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICM	Institute of Credit Management
ICO	Information Commissioner's Office
ICP	Integrated Care Partnership
ICS	Integrated Care System
ICU	Intensive Care Unit
IG	Information Governance
IGAF	Information Governance Assurance Forum
IGT	Information Governance Toolkit
IP&C	Infection Prevention & Control
IT	Information Technology
IWL	Improving Working Lives
JAPC	Joint Area Prescribing Committee
JSAF	Joint Safeguarding Assurance Framework

JSNA	Joint Strategic Needs Assessment
JUCD	Joined Up Care Derbyshire
k	Thousand
KPI	Key Performance Indicator
LA	Local Authority
LAC	Looked after Children
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LGBT+	Lesbian, Gay, Bisexual and Transgender
LHRP	Local Health Resilience Partnership
LMC	Local Medical Council
LMS	Local Maternity Service
LPF	Lead Provider Framework
LTP	NHS Long Term Plan
LWAB	Local Workforce Action Board
m	Million
MAPPA	Multi Agency Public Protection arrangements
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
MDT	Multi-disciplinary Team
MH	Mental Health
MHIS	Mental Health Investment Standard
MIG	Medical Interoperability Gateway
MIUs	Minor Injury Units

MMT	Medicines Management Team
MOL	Medicines Order Line
MoM	Map of Medicine
MoMO	Mind of My Own
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MTD	Month to Date
NECS	North of England Commissioning Services
NEPTS	Non-emergency Patient Transport Services
NHSE/ I	NHS England and Improvement
NHS e-RS	NHS e-Referral Service
NICE	National Institute for Health and Care Excellence
NUHFT	Nottingham University Hospitals NHS Trust
OOH	Out of Hours
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PCCC	Primary Care Co-Commissioning Committee
PCD	Patient Confidential Data
PCDG	Primary Care Development Group
PCN	Primary Care Network
PHB's	Personal Health Budgets
PHE	Public Health England

PHM	Population Health Management
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PIR	Post Infection Review
PLCV	Procedures of Limited Clinical Value
POA	Power of Attorney
POD	Project Outline Document
POD	Point of Delivery
PPG	Patient Participation Groups
PSED	Public Sector Equality Duty
PwC	Price, Waterhouse, Cooper
Q1	Quarter One reporting period: April – June
Q2	Quarter Two reporting period: July – September
Q3	Quarter Three reporting period: October – December
Q4	Quarter Four reporting period: January – March
QA	Quality Assurance
QAG	Quality Assurance Group
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QUEST	Quality Uninterrupted Education and Study Time
QOF	Quality Outcome Framework
QP	Quality Premium

Q&PC	Quality and Performance Committee
RAP	Recovery Action Plan
RCA	Root Cause Analysis
REMCOM	Remuneration Committee
RTT	Referral to Treatment
RTT	The percentage of patients waiting 18 weeks or less for treatment of the Admitted patients on admitted pathways
RTT Non admitted	The percentage if patients waiting 18 weeks or less for the treatment of patients on non-admitted pathways
RTT Incomplete	The percentage of patients waiting 18 weeks or less of the patients on incomplete pathways at the end of the period
ROI	Register of Interests
SAAF	Safeguarding Adults Assurance Framework
SAR	Service Auditor Reports
SAT	Safeguarding Assurance Tool
SBS	Shared Business Services
SDMP	Sustainable Development Management Plan
SEND	Special Educational Needs and Disabilities
SIRO	Senior Information Risk Owner
SOC	Strategic Outline Case
SPA	Single Point of Access
SQI	Supporting Quality Improvement
SRO	Senior Responsible Officer
SRT	Self-Assessment Review Toolkit
STEIS	Strategic Executive Information System
STHFT	Sheffield Teaching Hospital NHS Foundation Trust
STP	Sustainability and Transformation Partnership
T&O	Trauma and Orthopaedics
TCP	Transforming Care Partnership
UEC	Urgent and Emergency Care
UHDBFT	University Hospitals of Derby and Burton NHS Foundation Trust
UTC	Urgent Treatment Centre
YTD	Year to Date
111	The out of hours service is delivered by Derbyshire Health United: a call centre where patients, their relatives or carers can speak to trained staff, doctors and nurses who will assess their needs and either provide advice over the telephone, or make an appointment to attend one of our local clinics. For patients who are house-bound or so unwell that they are unable to travel, staff will arrange for a doctor or nurse to visit them at home.
52WW	52 week wait

MINUTES OF NHS DERBY AND DERBYSHIRE ICB BOARD PUBLIC MEETING

Thursday, 19th January 2023

via Microsoft Teams

Unconfirmed 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 Dhadda	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

Item No.	Item	Action
	Introductory Items	
ICBP/2223/062	**Welcome and apologies** John MacDonald (JM) welcomed everyone to the meeting. Apologies were noted as above.	
ICBP/2223/063	**Confirmation of quoracy** It was confirmed that the meeting was quorate.	
ICBP/2223/064	**Declarations of Interest** 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. 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/ 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.	
ICBP/2223/065	**Questions received from members of the public** 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: Which member of the Derbyshire ICB is responsible for overseeing the delivery of this new framework? Dr Chris Weiner, Chief Medical Officer and Mandy Simpson, Vaccination Programme Director. All enquiries should be made to Mandy Simpson in the first instance. Have the implications of this new framework been considered yet? 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	

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	analysis has been undertaken of the framework and is being worked through, to be implemented by 1 April 2023. 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. **The Board NOTED the question and response to the public question.**	
Strategy and Leadership		
ICBP/2223/066	**Chair's Report** JM highlighted the following from his report: • 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. **Comments/Questions** 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. **The Board NOTED the Chair's report.**	
ICBP/2223/067	**Chief Executive's Report** Dr Chris Clayton (CC) provided an update on the key messages and developments relating to work across the ICB and Integrated Care System (ICS): • 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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	is also necessary to have a continued and increased focus on the future.
	• 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:
	  ○ 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.
	
	CC thanked all colleagues who were linked to the above challenges and who provided support during this time.
	
	In regards to national developments, research and reports CC highlighted the following:
	• 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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	to the Board in March following the Chair's letter to Place leaders asking key questions; • 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. **The Board NOTED the Chief Executive's report.**	**CC** **CC**
	Items for Decision	
ICBP/2223/068	**Clinical and Care Professional Leadership developments: Progress and Forward Plan** 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: • 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;	

Item No.	Item	Action
	• 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. **Comments/Questions** • 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. 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. ***AB left the meeting at this point due to his conflict of interest.***	

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	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. 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. **Comments/Questions** • 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. **The Board:** • **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	

Item No.	Item	Action
	• **NOTED** the status of the discussions with Social Care colleagues. **ACTION: CC to commence the recruitment process for the Chair position.** ***AB re-joined the meeting at this point.***	**CC**
	Items for Discussion	
ICBP/2223/069	**Making the most of the Voluntary, Community and Social Enterprise (VCSE) sector contribution as a partner in the Integrated Care System** Wynne Garnett (WG) thanked JM and colleagues for helping to achieve significant progress in engagement with the VCSE sector and other partners. 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. The areas covered were as follows: <u>VCSE Contribution</u> 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: • 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 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.	

Item No.	Item	Action
	WG asked the following of the ICB: • 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. **Comments/Questions** • 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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	homes, as well as looking after people in the virtual ward setting (CW). • 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. **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'.**	
Corporate Assurance		
ICB/2223/070	**Integrated Assurance and Performance Report** 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. **Quality Report** 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. BS shared the following slides: • **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 Medical Examiner and good practice. The results will be	

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	presented to the Quality and Performance Committee for review and are being monitored through Clinical Quality Review Groups. • **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. **Performance Report** Zara Jones (ZJ) shared a presentation and pulled out key points from a number of dashboards: • **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. 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. **Workforce Report** AR assured the Board that significant effort is going into being able to track performance across the workforce, and highlighted the following: • 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 WTE. It also set an ambition to reduce staff sickness,	

Item No.	Item	Action
	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; • 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. **Finance Report** Darran Green (DG) shared the following updates: • 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. The 2023/24 financial outlook is a: • 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. **The ICB Board RECEIVED the Integrated Assurance and Performance Report for assurance purposes.**	

Item No.	Item	Action
ICB/2223/071	**Month 8 System Financial Position** DG had nothing further to report as this was covered in the preceding item. **The ICB Board NOTED the report on the Month 8 System Financial Position**	
ICB/2223/072	**Audit and Governance Committee Assurance Report – November to December** Sue Sunderland (SS) highlighted the following from the report: • 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. **The Board NOTED the Audit and Governance Committee Assurance Report – November to December.**	
ICB/2223/073	**Derbyshire Public Partnership Committee Assurance Report – November** 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. **The Board NOTED the Derbyshire Public Partnership Committee Assurance Report – November**	
ICB/2223/074	**People and Culture Committee Assurance Report – September to December** 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.	

Item No.	Item	Action
	The Board NOTED the People and Culture Committee Assurance Report – September to December.	
ICB/2223/075	**Quality and Performance Committee Assurance Report – November to December** 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. **The Board NOTED the Quality and Performance Committee Assurance Report – November to December.**	
ICB/2223/076	**Population Health and Strategic Commissioning Committee Assurance Report – December to January** JC took the paper as read and had nothing further to add. **The Board NOTED the Population Health and Strategic Commissioning Committee Assurance Report – December to January**	
ICB/2223/077	**Draft Board Assurance Framework 2022/23** 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. **The Board APPROVED the Draft Board Assurance Framework 2022/23.**	
ICB/2223/078	**ICB Corporate Risk Register Report – December 2022** HD took the paper as read and had no further comments to make. **The Board NOTED the ICB Corporate Risk Register Report – December 2022.**	

Item No.	Item	Action
The following items were for information only and were not individually presented		
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** • 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, 16th March 2023 **Time:** 9am to 10.45am **Venue:** via MS Teams		

ICB BOARD MEETING IN PUBLIC

ACTION LOG – JANUARY 2023

Item No.	Item Title	Lead	Action Required	Action Implemented	Due Date
ICBP/2223/067	Chief Executive's Report	Dr Chris Clayton	An item on Place will be brought to the Board in March following the Chair's letter to Place leaders asking key questions	Agenda Item	**Complete**
Item No. ICBP/2223/067	Chief Executive's Report	Dr Chris Clayton	System delivery and transformation, and the planning guidance for 2023/24 will be brought back to the Board in due course	Added to the forward planner for the 29th March 2023 Extraordinary meeting	March 2023
ICBP/2223/068	Clinical and Care Professional Leadership developments: Progress and Forward Plan	Dr Chris Clayton	CC to commence the recruitment process for the Chair position	The recruitment process is underway	**Complete**

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 091

Report Title	Chair's Report							
Author	Sean Thornton, Deputy Director Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	John MacDonald, ICB Chair							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	None.							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Not Applicable.							

Recommendations
The ICB Board are recommended to **NOTE** the Chair's Report.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
Integrated Care Strategy The first Derby and Derbyshire Integrated Care Strategy was received in draft form at the first meeting in public of the Integrated Care Partnership in February. Integrated Care is not a solution in itself; however it does allow us to develop new ways of working, utilise new technology, maximise the skills of our precious workforce to create new opportunities to collaborate and work together. It will not be easy but there is a shared local commitment to do all we can within the resources available to do our best for Derby and Derbyshire. Our Integrated Care Strategy summarises the first steps on the journey and describes how we will further grow and develop our shared approaches. There is huge ambition and commitment across the City and County to get this right for our communities. Delivering against the proposals in this strategy has the potential to help us provide a more preventative approach to health, tackle inequality and improve outcomes for local residents. The strategy recognises that there is a multitude of priorities across the health and care system, The process for developing the Strategy has resulted in system-wide agreement on three key

areas of focus that will help deliver key population health and service delivery outcomes, they are:

- **Start Well** - To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness
- **Stay Well** - To improve prevention and early intervention of the 3 main clinical causes of ill health and early death in the JUCD population - Circulatory disease, respiratory disease and cancer
- **Age/ Die Well** - To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations

Each area of focus is now mobilising to work through a collective approach to testing out integration as we seek to move to implementation phase. This will be coupled with bespoke engagement approaches to ensure that we are involving our citizens and staff in the conversation to ensure we benefit from their experience of care.

Meanwhile, the draft strategy is also being discussed in a range of partner forums during March, including council cabinets and NHS and Healthwatch Boards to secure buy-in, and will be returned to the Integrated Care Partnership meeting in April as a final draft.

Operational Plan for 2023/24
We have received initial feedback on the submission of our NHS Operational Plan for 2023/24, which we are seeking to address alongside our ongoing work to complete the planning process. The main risks for our system are the financial position, cancer waiting times and the elective care recovery plan: final submission of the 2023/24 plan is due in April. We will be extending this work into the development of our NHS Joint Forward Plan, which will respond directly to the Integrated Care Strategy and also set us off on our trajectory for longer-term goals for the NHS, in supporting health improvement and the reduction of health inequalities over the five year period of the plan and beyond. This plan is to be submitted to NHS England during June 2023.

Hewitt Review
The Hewitt Review is due to make its recommendations to the Secretary of State by 15th March 2023. This is independent review into oversight of Integrated Care Systems (ICSs) to reduce disparities and improve health outcomes across the country, will be completed, led by former Health Secretary the Rt Hon Patricia Hewitt.

The review is expected to consider how the oversight and governance of Integrated Care Systems (ICSs) can best enable them to succeed, balancing greater autonomy and robust accountability with a particular focus on real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement. It will cover ICSs in England and the NHS targets and priorities for which Integrated Care Boards (ICBs) are accountable, including those set out in the government's mandate to NHS England.

We are anticipating that the review will need to outline the changing role of NHS England as regulator, in relation to the role of ICBs in the performance management space, and in the context of the recent announcement of running costs reductions for ICBs.

Public Accounts Committee Report – Introducing Integrated Care Systems
The Public Accounts Committee published its report on the introduction of integrated care systems on 8 February 2023. The report notes that Department of Health and Social Care took an evolutionary approach to the design of ISCs, testing different models before bringing in legislation, and this is likely to have contributed to the introduction of ICSs being more widely

welcomed by those in the health and care sectors than previous reforms. The report notes that ICSs have the potential to improve the health of the populations they serve by better joining up services and focussing more on longer-term actions and preventative measures to address the causes of ill-health. The report concludes that ICSs will not succeed unless the Department addresses the multiple longstanding challenges facing the NHS and social care.

As an official House of Commons Committee report, the Department of Health and Social Care has six months to formulate a response to the recommendations made and further questions asked.

Provider Collaborative and Place Partnership Development
I wrote to the Chairs of the Provider Collaborative Leadership Board (PCLB) and the Integrated Place Executive (IPE) seeking to establish their roadmap for development over the next five years. Considerable work has been undertaken to respond, in part to this challenge, but also based on existing approaches underway in those forums. This works seeks to set out what PCLB and IPE consider their role should be in the developing integrated care system, including strategic objectives, priorities and milestones for the short, medium and longer term.

Sharing Experiences of Our Deaf Community
February's Mental Health Delivery Board welcomed guests from our Deaf communities, who shared their experiences of mental health care across the Midlands, highlighting key issues including communication difficulties, confidentiality and a shortage of qualified translators. We know that people who are Deaf or hard of hearing experience a higher rate of mental health issue, face multiple barriers in accessing services and experience poorer health outcomes than the hearing population.

With Derby and Derbyshire having the largest Deaf population in the UK outside of London, in part due the location of the Royal School for the Deaf, ensuring better access and communication with local mental health services is an identified priority for the Delivery Board. A Deaf Mental Health Day took place last July, which led to the development of a Deaf Mental Health Focus Group, including experts by experience. The group are developing a health needs assessment and a strategic action plan to improve understanding, access and communication for our Deaf communities. This will remain an ongoing priority for the Delivery Board.

Driving and Spreading Innovation in the ICS
The Accelerated Access Collaborative (AAC) has co-developed a series of case studies with AAC partners on the approaches taken in local ICSs to promote the adoption and spread of proven innovation. ICSs have a statutory duty to support innovation adoption and spread. Ways that ICSs can facilitate innovation include:

- driving local leadership in innovation through clinical and care professionals and/or dedicated innovation roles
- working to foster a culture of innovation across local health and care organisations and partnerships
- implementing local organisational structures which support and promote the adoption of innovation
- working to tackle health inequalities through increasing equity of access to innovation or through the promotion of innovative products which reduce health disparities
- facilitating collaborative partnerships working towards the adoption and spread of innovation, including working with the voluntary, community and social enterprise (VCSE) sector.

Case studies have been gathered from a range of ICSs and t will be important that our transformation programme in Derby and Derbyshire seeks to adopt best practice in innovation to support our productivity and integration agendas. It is also important that Derbyshire shares the

innovation already taking place within our ICS with our peers. In particular, the case study from the West of England on their voluntary sector partnership resonates with work we have done in Joined Up Care Derbyshire with the formation of our own VCSE Alliance.

Measuring the experience of integration
Team Up Derbyshire is an ambitious programme in Derby and Derbyshire that aims to create one integrated team across health and social care who see all patients currently receiving their care in their own home or a care home. These patients tend to have complex health and social care needs. Being housebound can be a permanent or temporary situation.

A research study conducted by Traverse, commissioned by Team Up Derbyshire and incorporating expert advice from The King's Fund, has assessed 'how do we measure how well integration is working from a service user, patient, carer and staff perspective?'. Team Up was an excellent service to use to explore this concept, as it aims to integrate services provided by Primary Care, Community Care, Mental Health Care, Adult Social Care, and the voluntary and community sector.

Following in depth qualitative interviews with users of services, families, carers, professionals, and other stakeholders in Derbyshire, the key themes that emerged in the findings were:
- Navigating health and care
- Joined-up communication
- Working together
- Trust
- Efficiencies
- Policies and procedures

These themes were then used to develop:
- a user questionnaire
- a carer questionnaire
- a staff questionnaire

These questionnaires capture data on key areas of integration that can be used to understand whether integration is working for users, carers, and staff. The study also examined barriers to giving feedback and barriers to listening to feedback and developed a methodology enabling service user, carer and family feedback to feed into the cycle of service improvements. There are suggested practical ways of using these questionnaires to ensure that user, carer and staff views about and experiences of integration are captured, analysed and used to shape and inform service improvements. The initial report is being shared and discussed at a number of forums with people being asked about the most practical ways of advancing the study.

Identification of Key Risks
Not applicable to this report.

Have any conflicts of interest been identified throughout the decision making process?
Not applicable to this report.

Project Dependencies

Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable to this report

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Not applicable to this report.					

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 092

Report Title	Chief Executive Officer's Report							
Author	Dr Chris Clayton, Chief Executive Officer							
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer							
Presenter	Dr Chris Clayton, Chief Executive Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	None.							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Not Applicable.							

Recommendations
The ICB Board are recommended to **NOTE** the Chief Executive Officer's Report.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
The first two months of 2023 have seen focus continue on the two ends of the spectrum of matters that are of great importance for any Integrated Care Board: managing today's pressure and focusing on tomorrow's solutions and improvements. As I have previously stated, dealing with the immediate challenges facing the system has been at the top of the agenda for many months, and has continued into 2023. Whilst services are still very stretched, we have seen some abatement in the extreme pressure and challenges with patient flow that led to the declaration of critical incidents around Christmas and the New Year. However, the commencement of a number of waves of industrial action have led to a continuation of escalation planning and preparation. Our system has established a clear rhythm for such events, and while public behaviour in using services wisely during the days of action has been a significant help, it is clear that our system planning has also enabled services to

cope while our workforce is reduced. NHS pay is a matter for the Government and unions, and we will continue to make such robust preparations while negotiations continue.

Looking to tomorrow, we have embarked on important pieces of work to fully understand how we can solve some historic challenges that have faced our system. Patient flow and discharge have been repeated themes through our periods of pressure during recent years; we're already working on some short and medium term solutions to our discharge position, and this has gained momentum through having protected leadership time for focus during recent months. We believe that patients being discharged home as the preferred option must be the central strategic aim of our discharge approach, with evidence that some of the interim measures we have taken in boosting community bedded care in order to help with flow have not been optimal for patients and have potentially added to the challenge. However, it is crucial that we align these tactical steps with the appropriate workforce, and it is well-documented across systems that this has proved to be the greatest challenge during the winter.

Aligned to the progress on discharge is work to fully review and diagnose the entirety of our urgent care flow into and out of hospitals. We are reviewing the whole pathway of care from initial paramedic contact, conveyances by ambulance into hospital, our 'front door' processes as patients arrive at hospital, our admissions processes, length of stay (including mental health beds) and discharge processes into the range of pathways into local authority, community and voluntary sector care and support. We will also be exploring what else can be done to get ahead of citizens reaching crisis and where we can provide earlier, preventative actions. This is a significant scope of work, takes account of all existing activities in these areas, and is seeking to straddle individual organisational interventions to seek further opportunities for integration. We expect the work to take place over the next two years, but we are very sighted on any earlier interventions that can help the system in the short and medium term, for example into next winter. The work is being overseen by the Integrated Place Executive, and is connected into other forums, including our delivery boards and our enabler groups.

Within the ICB we have completed phase two of our Derby and Derbyshire Together programme, through which we will coproduce our strategic framework with staff and key partners. This will include agreeing our purpose, behaviours and goals as we seek to confirm the role of the ICB within the new health and care landscape. Over 400 staff and partners have contributed to the discussions, and we are in the process of analysing the inputs before discussing the draft outcomes with the ICB Board in April.

Also for the future, we have taken further strides in setting out the areas of focus for the health and care system, and the response required from the NHS to help deliver those improvements. The Chair's report talks about the detail of our integrated care strategy progression, and we have now also submitted the first draft of our operational plan for 2023/23 to NHS England. The plan is robust but contains a number of risks around ongoing issues that challenge our health system, namely finance, cancer waiting times and the elective care recovery plan, which we will continue to work through ahead of final submission in April. Aligned to this is the emerging work in setting out our NHS Joint Forward Plan, which will respond directly to the Integrated Care Strategy and also set us off on our trajectory for longer-term goals for the NHS, in supporting health improvement and the reduction of health inequalities over the five year period of the plan and beyond.

Underpinning our ability to deliver our vision of improving health and reducing health inequalities is our financial position. ICB Board reports have already highlighted that we have agreed a deficit position of £19m for the 2022/23 financial year and we are on track to achieve that position. Our challenge is that much of our measures to achieve this position are non-recurrent and will reset for 2023/24, creating a much larger financial challenge. Work continues to assess that position and to seek recurrent solutions to reduce our underlying financial deficit, and additionally we continue to seek to understand the opportunities for investment in population

health and a reduction in health inequalities which will see long term benefits for local citizens as well as for the financial health of the local NHS.

For the ICB, we have recently received a letter from NHS England setting out a running costs reduction target of 20% for the financial year 2024/25 and a further 10% for the financial year 2025/26. We will be discussing this in more detail with the ICB Board and of course with ICB staff and will proceed with balance and care to minimise disruption to the work of our teams.

A further item on the immediate horizon is the delegation from NHS England to Integrated Care Boards of commissioning responsibilities for Pharmacy, Ophthalmology and Dentistry services. ICBs already have delegated authority for the commissioning of general practice. ICBs will take over responsibilities in these areas from 1 April 2023, with existing NHS England staff transferring into ICBs from 1 July 2023. To ensure there is continuity of expertise and a critical mass of this commissioning team able to continue to deliver the work, host ICBs have been identified into which teams will transfer on a 'lift and shift' basis; for the East Midlands, Nottingham and Nottinghamshire ICB will take on the host responsibility, and we are working closely across the region to understand inter-dependencies and accounting arrangements, among other things. We are also expecting further collective arrangements at regional or Eats Midlands level for some areas of specialised commissioning in due course, likely from April 2024.

Chris Clayton
Chief Executive Officer

Chief Executive Officer calendar – examples from the regular meetings programme

Meeting and purpose	Attended by	Frequency
JUCD ICB Board meetings	ICB	Monthly
JUCD ICP Board meeting	ICB	Bi-Monthly
System Review Meeting Derbyshire	NHSE/ICB	Monthly
ICB Executive Team Meetings	ICB Executives	Weekly
Derbyshire Chief Executives	CEOs	Bi Monthly
EMAS Strategic Delivery Board	EMAS/ICB	Bi-Monthly
Joint Health and Wellbeing Board	DCC/ICB/LA	Bi-Monthly
NHS Midlands Leadership Team Meeting	NHSE/ICB	Monthly
Partnership Board	CEOs or nominees	Monthly
East Midlands ICS Commissioning Board	Regional CEOs/NHSE	Monthly
Team Talk	All staff	Weekly
JUCD Finance & Estates Sub Committee	ICB	Monthly
Midlands ICS Executive & NHSEI Timeout	ICB/NHSE	Ad Hoc

2022/23 Financial Planning	NHSE/ICB	Ad Hoc
ICB Development Session with Deloitte	ICB	Ad Hoc
Meeting with Derby and Derbyshire MPs	ICB CEO/Chair	Ad Hoc
ICB Remuneration Committee	ICB	Ad Hoc
Place & Provider Collaborative	ICB	Ad Hoc
Derbyshire Dialogue	ALL	Ad Hoc
System Escalation Calls (SEC)	ICS/LA	Ad Hoc
NHS National Leadership Event - London	NHSE	Ad Hoc
NHS Clinical Leaders Network	NHSE	Ad Hoc
Joint Emergency Services Interoperability Protocol (JESIP) Training	ICB	Ad Hoc
ICS Connected Leadership Programme – Leeds	ICB	Ad Hoc
Derbyshire LHRP Meeting	NHSE/LA/ICS	Monthly

National developments, research and reports

NHS Digital merges with NHS England

NHS Digital has merged with NHS England. This means that NHS England has assumed responsibility for all activities previously undertaken by NHS Digital. This includes running the vital national IT systems which support health and social care, and the collection, analysis, publication and dissemination of data generated by health and social care services to improve outcomes.

Health Education England set to join NHS England

In April 2023, Health Education England will also join NHS England. That means NHS England will hold responsibility for ensuring that the healthcare workforce has the right numbers, skills, values and behaviours in place to support the delivery of excellent healthcare and health improvement to patients and the public.

Major plan to recover urgent and emergency care services

The NHS and the government have published a two-year delivery plan to help recover urgent and emergency care services, reduce waiting times, and improve patient experience. The plan for recovery comes amid record demand for NHS services, with the latest data showing more A&E attendances than ever before, growing numbers of the most serious ambulance call outs, and millions of NHS 111 calls a month over winter.

Hundreds of thousands more patients to benefit from major NHS surgical capacity boost

Hundreds of thousands more patients will benefit from NHS treatment by next year thanks to dozens of new surgical spaces. As part of the biggest and most ambitious catch-up plan in NHS history, an estimated 780,000 additional surgeries and outpatient appointments will be provided

at 37 new surgical hubs, 10 expanded existing hubs and 81 new theatres dedicated to elective care.

NHS pilots artificial intelligence software to cut missed hospital appointments
Artificial intelligence (AI) that predicts likely missed appointments and offers back-up bookings will be piloted by the NHS in a bid to maximise resources and potentially save billions.

Through algorithms and anonymised data, the technology breaks down the reasons why someone may not attend an appointment – using a range of external insights including the weather, traffic and jobs.

Expansion of NHS 111 to transform patient access
Patients are set to receive an enhanced NHS 111 offer including increased access to specialist paediatric advice for children and direct access to urgent mental health support to help recover urgent and emergency care services. Parents and carers seeking health advice for children and young people using NHS 111 online or by calling NHS 111 will have increased access to specialist advice, including support from paediatric clinicians who can help them manage illness at home or decide the best route for their care.

NHS launches ad campaign as new polling shows just one in five would visit high-street pharmacy for minor illnesses
With new polling finding that just one in five people aged 18-40 would visit their local pharmacy first for expert advice with a minor illness, the NHS has launched a new campaign to highlight how high-street pharmacies can support patients with non-urgent health advice for minor conditions including coughs, aches and colds.

New figures show NHS workforce most diverse it has ever been
The NHS workforce is more diverse than at any other point in its history, according to an annual report into race equality across the health service. Published on Wednesday 22 February, the NHS Workforce Race Equality Standard shows Black and minority ethnic (BME) staff make up almost a quarter of the workforce overall (24.2% or 383,706 staff) – an increase of 27,500 people since 2021 (22.4% of staff). The analysis shows more than two fifths (42%) of doctors, dentists, and consultants, and almost a third (29.2%) of our nurses, midwives, and health visitors are from Black and minority ethnic backgrounds.

NHS Volunteer Responders programme reintroduces its Check in and Chat service
Over a thousand volunteers have signed up to provide friendly phone calls for patients in England who are vulnerable, isolated or lonely, as the NHS Volunteer Responders programme reintroduces its Check in and Chat service. GPs, pharmacists, and other healthcare workers are being encouraged to request Check in and Chat support for patients who are socially isolated or would benefit from a phone call and a bit of encouragement – with an option to request just a one-off call or a series of calls.

Opioid prescriptions cut by almost half a million in four years as NHS continues crackdown
GPs and pharmacists have helped cut opioid prescriptions in England by 450,000 in under four years, latest data shows.

NHS scheme reduces chances of Type 2 diabetes for at risk adults
The NHS has stopped thousands of people from getting type 2 diabetes, thanks to the world leading NHS Diabetes Prevention Programme. Analysis by University of Manchester

researchers shows the risk of developing type 2 diabetes was one fifth lower in people with raised blood sugars referred to the programme, compared to people not receiving NHS support.

New NHS campaign urges people to use their bowel cancer home testing kit
Millions of people in England who have been sent a lifesaving home testing kit that can detect early signs of bowel cancer are being encouraged to use it and return it, as part of a new, first-of-a-kind NHS campaign.

Women urged to take up NHS breast screening invites
Thousands of women are being urged to take up NHS breast screening appointments as new figures today reveal that while the highest number ever were screened last year, nearly four in 10 did not take up the potentially lifesaving offer.

More than 86 million Covid vaccination appointments booked through NHS online system in first two years
The national booking service launched in January 2021 to allow people to book their Covid vaccine online and via the 119 phoneline.

Local developments

East Midlands Combined County Authority
The public consultation on devolution deal for the proposed East Midlands Combined County Authority closed on the 9th of January. Feedback from all respondents will be used as the basis of a report by independent adviser Ipsos, who have been analysing the data and comments. This report, due to be completed soon, will be considered by Derbyshire County Council, Nottinghamshire County Council, Derby City Council, and Nottingham City Council at council meetings in March, where all four councils will formally decide whether to move forward with plans for an East Midlands Combined County Authority. If all four councils decide to go ahead, they will need to agree on a final proposal for submission to the Government; the four councils would need to make a decision this autumn to approve a draft statutory instrument, which would form the legal basis for the creation of the East Midlands Combined County Authority. This statutory instrument would then go before Parliament towards the end of this year, before going for Royal Assent in early 2024.

Once all these steps are taken, a new East Midlands Combined County Authority could officially come into existence in spring 2024, with new powers and funding available to our region. The ICB provided a detailed submission to the original consultation process, including highlighting areas where it was felt we would benefit from a seat round the authority table; the partners will be providing additional opportunities for stakeholder engagement looking to develop spaces for stakeholder engagement and work with us to develop and refine what devolution could look like locally.

Developing a provider collaborative work programme
The provider collaborative continues to develop its five year roadmap as part of wider ICS development. A productive meeting with provider Chairs and Chief Executive Officers to shape the focus for the collaborative took place, setting an expectation that that the collaborative needs to be ambitious in what it sets out to achieve, responding to our shared population's heath needs in the context of challenges to clinical and financial sustainability across the NHS.

Areas of focus for the collaborative work programme include; aligned provider clinical strategy addressing fragile services and prevention, referral management, corporate efficiencies, system estates strategy and reducing premium workforce costs. Executive leads for each of these areas have been identified and will lead work with colleagues to scope opportunities and propose priorities for the collaborative's future workplan in the coming weeks.

A clinically-led workshop on sustainable clinical services took place, led by the collaborative in partnership with the system Clinical and Professional Leadership Group. We have identified a list of services which are clinically vulnerable using a shared definition of fragility. Next steps include agreeing high impact areas where there are opportunities to strengthen clinical services through partnership working and pathway redesign.

As part of our work on organisational development there are plans to develop a collaborative leadership compact and a workshop of chairs and chief executives will be held later in the month.

Derby and Derbyshire Integrated Care Partnership holds meeting in public for the first time

The Derby and Derbyshire Integrated Care Partnership (ICP) met in public for the first time on Wednesday 8 February and agreed the three strategic areas of focus for our system, as part of our first Integrated Care Strategy. The strategy – in draft form as it visits a range of partner boards for review and agreement before submission to NHSE in April – reflects areas in which the system believes that integrated working can make the biggest difference; there are other priorities that we will continue to work through as individual organisations and in partnership, but we will test integration through these topic areas:

- Start Well - To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness
- Stay Well - To improve prevention and early intervention of the three main clinical causes of ill health and early death in the JUCD population - circulatory disease, respiratory disease and cancer
- Age/Die Well - To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations

We have published a framework document so far, which was agreed in December. The draft strategy is available to view as part of the meeting papers.

Additional investment to support discharge and NHS England Urgent and Emergency Care Plan

We have been informed of some significant additional investment into the Joined Up Care Derbyshire system in recent weeks to support our efforts around discharge and the broader impact this can have on the urgent and emergency care system. The investment will come to either the ICB or our local authorities and we are working through how we can use this funding to support our community support and rehabilitation offers to improve flow through our hospitals.

We've also now received the NHS England Urgent and Emergency Care Plan, which outlines £1bn of support for acute hospital bedded care and ambulance services across England, and we

await the details of the local allocations that result and the implementation detail behind the plan. One challenge will be identifying the appropriate workforce to support improvements, and this work continues.

Winter hubs help meet patient need and reduce pressure on GPs
An initiative run by community interest company DHU Healthcare aimed at providing additional primary care appointments in Derbyshire to support with greater demand in winter is expanding to more areas, relieving pressure on the health system. The aim of the service is to provide more 'on the day', face-to-face GP or Practitioner appointments to reduce the pressure on primary care and support reducing the number of people visiting Emergency Departments (ED) or UTCs who could more appropriately be seen by a GP. This is part of the Derbyshire system's winter plan to help relieve pressure on the system.

Staffa Health earns Outstanding rating from CQC
The Staffa Health general practice, which runs sites in Tibshelf, Holmewood and Stonebroom, has been rated as Outstanding again after its latest CQC inspection.

University Hospitals of Derby and Burton NHS Foundation Trust publishes Maternity Learning Review report
University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) has published the report from an independent maternity learning review it requested from NHS Derby and Derbyshire last year. NHS Derby and Derbyshire commissioned HSIB to carry out the review to seek an independent view in relation to seven patient cases. We will be working closely with colleagues at UHDB to provide support but also in an oversight role to ensure the recommendations of the report are progressed and delivered appropriately.

Identification of Key Risks
Not applicable to this report.
Have any conflicts of interest been identified throughout the decision making process?
Not applicable to this report.
Project Dependencies

Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable to this report

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Not applicable to this report.					

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 093

Report Title	Delegation of Pharmacy, Optometry and Dental Services and Joint Commissioning Arrangements for Tier 1 and Tier 2							
Author	Chrissy Tucker, Director of Corporate Delivery Suzanne Pickering, Head of Governance							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs Zara Jones, Executive Director of Strategy & Planning							
Presenter	Dr Chris Clayton, Chief Executive Officer							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	• Appendix 1 - Delegation Agreement (draft form, final form expected 13th March and will be circulated separately • Appendix 2 - Tier 1 Part A Joint Working Agreement ICB/NHSE • Appendix 3 - Tier 1 Part B Joint Working Agreement ICB/ICB • Appendix 4 - Tier 2 East Midlands Joint Commissioning Group Terms of Reference • Appendix 5 - Risk Share Framework • Appendix 6 - Draft Derby and Derbyshire ICB Joint POD Governance Structure.							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	ICB Board Confidential – 19 January 2023 Audit & Governance Committee – 9 February 2023							

Recommendations
The ICB Board are recommended to **NOTE** the contents of this report and in particular to: • **APPROVE** the two joint working agreement documents listed in the paper to enable the delivery of the operating model from April 2023; and • **TAKE ASSURANCE** on the draft national Delegation Agreement and delegate approval and signature to the ICB Chief Executive by 31st March 2023.
Purpose
The purpose of this paper is to provide assurance to the ICB Board that the necessary plans are in place for the satisfactory delegation of Pharmacy, Optometry and Dental services to the ICB.
Background
The delegation from NHS England (NHSE) to Integrated Care Boards (ICBs) of Primary Pharmacy Services, Optometry Services and Primary and Secondary Dental Services is in accordance with NHSE's long-term policy ambition of giving systems responsibility for managing local population health needs, tackling inequalities and addressing fragmented pathways of care. The expectation

is that by giving ICBs responsibility for a broader range of functions, they will be able to design services and pathways of care that better meet local priorities. ICBs will also have greater flexibility to integrated services across care pathways, ensuring continuity for patients and improved health outcomes for the local population.

By delegating some of NHS England commissioning functions to ICBs, the aim is to break down barriers and join up fragmented pathways to deliver better health and care so that our patients can receive high quality services that are planned and resourced where people need it.

The services that will be delegated to ICBs are:

- Primary Pharmacy, Optometry & Primary and Secondary Dental Services on 1st April 2023.
- Complaints functions associated with Primary Pharmacy, Optometry & Primary and Secondary Dental Services on the 1st July 2023.
- Specified Specialised Services (Acute & Pharmacy) April 2024.

In all cases the responsibility and liability for the planning, performance, finance, quality, and improvement will move from NHS England to ICBs upon delegation. The ICB will be responsible for any claims (negligence, fraud, recklessness, or breach of the Delegation). However, in all cases NHS England remains accountable to the Secretary of State for the services, which means that NHSE will have oversight, set standards and service specifications for the services. ICS and NHSE have working together to Co-produce an approach to delegation in order to achieve the safest and most effective approach, given the challenges facing the NHS at this time and the Midlands region as a whole.

Report Summary

The ICBs in the Midlands have worked together to develop arrangements to jointly commission POD on an East and West footprint. The approach is for the workforce to be hosted by one single ICB for each footprint. This multi-ICB approach has been developed with consideration to the future delegation of other NHSE commissioning functions that will also be delivered on an East/West Midlands footprint and will support Derby and Derbyshire ICB in its aim to enhance productivity and value for money while meeting the needs of the population.

As a basis for joint planning for delegated and devolved functions, ICB Chief Executives and officers of the eleven ICBs in the Midlands have been working closely with NHSE Midlands colleagues to put in place the governance and financial arrangements and processes to deliver this model.

Whilst all decisions will be through formal joint committees, ensuring equal and equitable decision making for each individual ICB with no one ICB having primacy over another, the hosting of the workforce requires one ICB to provide this function on behalf of the other ICBs (and, for specialised services, NHSE).

The host ICB will provide, oversight, leadership, and support for the workforce. The workforce will work for and on behalf of each ICB within the planning footprint (East/West Midlands). This will be supported by a formal hosting agreement between the ICBs and, for specialised services, between the ICBs and NHSE. The host will not make commissioning decisions on behalf of other ICBs or NHSE; all decisions will be made through the joint committees and their sub-groups.

The Primary Care Pharmacy, Optometry and Dentistry workforce will be hosted on an East and a West footprint. The host ICBs have been approved by the ICB CEOs and are as follows:

- East Midlands - Nottingham and Nottinghamshire ICB
- West Midlands – Birmingham and Solihull ICB

The full scope of functions being delegated from 1 April 2023 is set out in Schedules 2B, 2C and 2D of the draft Delegation Agreement (Appendix 1).

Whilst delegation for the POD Services will take effect on 1 April 2023, it is planned that, subject to consultation, the workforce will transfer from NHSE to the ICB host on 1 July 2023. The workforce includes POD, primary medical service support and complaints staff. Specialised healthcare public health team members aligned or embedded to teams will not transfer but will continue to perform their roles.

A model of Distributed Leadership will be adopted to implement shared vision and values and continue the ICBs and regional commitment to collaboration and building a strong learning culture. Nottingham and Nottinghamshire ICB will host the workforce for the delivery of the POD functions for the East Midlands, however decisions will be taken by the formal Tier 1 Joint Committee and their Tiers 2 and 3 sub-groups, thus ensuring equal and equitable decision making for each individual ICB with no one ICB having primacy over another. The three tiers of joint committees and sub-groups will be responsible for oversight and decision making of all aspects of the delegated services, such as finance, quality and performance. In light of this, the Terms of Reference for the ICB's Committees currently responsible for all aspects of these areas will be updated for ICB Board approval in April 2023.

The finance risk share agreement sets out the rules and behaviours which will govern the way in which the financial risk is managed across the Midlands systems. This will be to mitigate the potential risks to systems from allocation methodology change over the coming financial year, as well as in year budget variation across ICB's as factors emerge that are currently unknown. The financial risk to each system will therefore be minimised for the Pharmacy, Optometry and Dental services across the region. There does still remain a potential financial risk to the ICB for 2023/24, however the detail continues to be worked through across the East and West regions, and will further develop during transition and into next financial year.

The proposed governance structure attached sets out how the ICB's internal governance is intended to link to the East Midlands governance structure, with the Population Health and Strategic Commissioning Committee having oversight of discussions and decisions within the Tier 2 level, and the Primary Care Sub-Group also taking a role in the more detailed discussions to feed up to PHSCC. This will be refined over time.

The paper sets out the final Tier 1 and Tier 2 governance documents for the delegation of NHSE Functions to ICBs for Primary Care Pharmacy, Optometry and Primary and Secondary Dentistry (POD). The final Tier 2 Joint Working Agreement version is expected by 20th March.

The following documents are provided in the appendices:

- Appendix 1 – draft Delegation Agreement for Primary Medical Services confirming that Schedules 2B, 2C and 2D are to be delegated to the ICB from NHS England. The final version is expected by 13th March and must be signed by the ICB CEO.
- Appendix 2 - Tier 1 Joint Working Agreement between NHSE and ICBs.
- Appendix 3 - Tier 1 Joint Working Agreement between ICBs.
- Appendix 4 – Tier 2 East Midlands Joint Commissioning Group Terms of Reference.
- Appendix 5 - Finance Risk Share Agreement.
- Appendix 6 - Draft Derby and Derbyshire ICB Joint POD Governance Structure.

The Board are requested to approve these documents to delegate authority to the East Midlands Multi ICB/NHSE Joint Commissioning Committee for the commissioning and oversight of POD

services and to make the necessary changes to the internal ICB arrangements, and to approve CEO signature of the final version of the Delegation Agreement.

The following will be required to be drafted and approved by the ICB Board in April 2023:

- ICB Scheme of Reservation and Delegation.
- ICB Standing Financial Instructions.
- ICB Functions and Decisions Map.
- ICB Terms of Reference for the ICB Board Sub Committees; Population Health Strategic Commissioning Committee, Finance and Estates Committee, Audit and Governance Committee and Quality and Performance Committee.

The ICB has established a Programme Board to manage the transition of delegated functions for Derbyshire, chaired by the Executive Director of Corporate Affairs, attended by staff from across the ICB's functions who are members of NHSE regional working groups. Further groups are established with Nottingham and Nottinghamshire ICB to establish the host arrangements and ways of working.

Identification of Key Risks

Staff will transfer from NHSE to their host ICB and therefore liability for the workforce does not sit with the ICB, however the full operational detail of how ICBs will work with their hosts has not yet been fully worked through, including membership of a number of different groups and which may pose a resource risk to the ICB. This will be clarified in the coming months.

The delegation means financial liability will sit with the ICB. Arrangements for managing and sharing financial risk and for oversight of finances are currently being worked through as detailed above.

Has this report considered the financial impact on the ICB or wider Integrated Care System?

Yes ☐	No☐	N/A☒
Details/Findings		**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision making process?

None identified.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Summary:**	

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
There are no implications that would affect the ICB's obligations.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
The ICB Board is committed to the delivery of Net Zero Carbon targets.

DATED: 2022

Delegation Agreement in respect of:

[Delete as applicable]

(i) Primary Medical Services

(ii) Primary Dental Services and Prescribed Dental Services

(iii) Primary Ophthalmic Services

(iv) Pharmaceutical Services and Local Pharmaceutical Services

between:

NHS England

-and-

NHS [Insert Name] Integrated Care Board

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Delegation Agreement for Primary Care & Dental Functions

1. PARTICULARS

1.1 This Agreement records the particulars of the agreement made between NHS England and the Integrated Care Board (ICB) named below.

Integrated Care Board	**[Insert Name]**
Area	**[Insert Area of the ICB as defined in its Constitution]**
Date of Agreement	**[Date]**
Effective Date of Delegation	**[Date]**
ICB Representative	**[Insert details of name of manager of this Agreement for the ICB]**
ICB Email Address for Notices	**[Insert Address]**
NHS England Representative	**[Insert details of name of manager of this Agreement for NHS England]**
NHS England Email Address for Notices	**[Insert Address]**

The following parts of Schedule 2 are included in this Agreement[1]:

Schedule 2A – Primary Medical Services	**Yes**
Schedule 2B – Primary Dental Services and Prescribed Dental Services	**Primary Dental Services: [Yes/No]** **Prescribed Dental Services: [Yes/No]**
Schedule 2C – Primary Ophthalmic Services	**[Yes/No]**
Schedule 2D – Pharmaceutical Services and Local Pharmaceutical Services	**[Yes/No]**

1.2 This Agreement comprises:

1.2.1 the Particulars (clause 1);

1.2.2 the Terms and Conditions (clauses 2 to **Error! Reference source not found.**); and

1.2.3 the Schedules.

[1] This table must be completed to indicate which services are included in the Delegation.

Signed by **NHS England**

[Name]

[Title]

(for and on behalf of NHS England)

Signed by **NHS [Insert name] Integrated Care Board**

[Insert name of Authorised Signatory]

[Insert title of Authorised Signatory]

(for and on behalf of NHS [Insert name] Integrated Care Board)

Terms and Conditions

2. **INTERPRETATION**

2.1 This Agreement is to be interpreted in accordance with SCHEDULE 1 (Definitions and Interpretation).

2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

2.2.1 the Particulars and Terms and Conditions (clauses 1 to **Error! Reference source not found.**);

2.2.2 SCHEDULE 1 to SCHEDULE 6, SCHEDULE 8 and SCHEDULE 9 to this Agreement; and

2.2.3 SCHEDULE 7 (Local Terms).

2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

2.4 Where it is indicated that a provision in this Agreement is not used, that provision is not relevant and has no application in this Agreement.

2.5 Where a particular clause is included in this Agreement but is not relevant to the ICB because that clause relates to matters which do not apply the ICB (for example, if the clause only relates to functions that are not Delegated Functions in respect of the ICB), that clause is not relevant and has no application to this Agreement.

3. **BACKGROUND**

3.1 By this Agreement NHS England delegates the Delegated Functions to the ICB under section 65Z5 of the NHS Act while retaining the Reserved Functions.

3.2 Arrangements made under section 65Z5 may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the ICB.

3.3 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB and the Parties' associated responsibilities and measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. **TERM**

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with clause 27 *(Termination)* below.

5. **PRINCIPLES**

5.1 In complying with the terms of this Agreement, NHS England and the ICB must:

5.1.1 at all times have regard to the Triple Aim;

5.1.2 at all times act in good faith and with integrity towards each other;

5.1.3 have regard to the intention that commissioning functions in respect of Primary Medical Services, Primary Dental Services and Primary Ophthalmic Services will in future be directly conferred on the ICB;

5.1.4 consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local

communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

5.1.5 consider how in performing their obligations they can address health inequalities;

5.1.6 at all times exercise functions effectively, efficiently and economically;

5.1.7 act in a timely manner;

5.1.8 share information and best practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost; and

5.1.9 have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

6. DELEGATION

6.1 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for the people of the Area, as further described in this Agreement ("**the Delegation**").

6.2 The Delegated Functions are the functions described as being delegated to the ICB in such of the following Schedules as have been marked as included within this Agreement:

6.2.1 Schedule 2A: Primary medical services;

6.2.2 Schedule 2B: Primary dental services and prescribed dental services;

6.2.3 Schedule 2C: Primary ophthalmic services;

6.2.4 Schedule 2D: Pharmaceutical services and local pharmaceutical services.

6.3 The Delegation has effect from the Effective Date of Delegation.

6.4 NHS England may by Contractual Notice allocate Primary Care Contracts or Arrangements and Prescribed Dental Services Contracts in place at the Effective Date of Delegation to the ICB for the purposes of determining the scope of the Delegated Functions. The Delegated Functions must be exercised both in respect of the relevant Primary Care Contract or Arrangement or Prescribed Dental Services Contract and any related matters concerning the Primary Care Provider that is a party to that Primary Care Contract or Arrangement, or provider of Prescribed Dental Services that is party to that Prescribed Dental Services Contract.

6.5 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, any new Primary Care Contract or Arrangement entered into in respect of premises in the Area shall be managed by the ICB in accordance with the provisions of this Agreement as if it had been allocated to the ICB in accordance with clause 6.4.

6.6 NHS England may by Contractual Notice add or remove Primary Care Contracts or Arrangements or Prescribed Dental Services Contracts to or from the list of those allocated to the ICB for the purposes of this Agreement. In particular, NHS England may add or remove Primary Care Contracts or Arrangements or Prescribed Dental Services Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

6.7 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.8 The ICB is not authorised by this Agreement to take any step or make any decision in respect of Primary Care Services or Prescribed Dental Services beyond the scope of the Delegated Functions.

6.9 NHS England may, at its discretion, substitute its own decision for any decision which the ICB purports to make that is outside the scope of the Delegated Functions. This will take the form of NHS England considering the issue and decision purportedly made by the ICB and then making its own decision. The ICB must provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision. In any event such a decision by NHS England shall not extend to those actions or decisions that are of themselves not capable of being delegated by NHS England to the ICB.

6.10 The terms of clause 6.9 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.1.1 the terms of this Agreement;

7.1.2 any Contractual Notices, including without limitation any Standing Financial Instructions;

7.1.3 all applicable Law and Guidance;

7.1.4 the ICB's constitution;

7.1.5 the requirements of any assurance arrangements made by NHS England, and;

7.1.6 Good Practice.

7.2 In exercising the Delegated Functions, the ICB must comply with the Mandated Guidance set out at SCHEDULE 9 or otherwise referred to in this Agreement and such further Mandated Guidance as may be issued by NHS England from time to time, including on the Direct Commissioning Guidance Webpage.

7.3 NHS England may, at its discretion, issue Contractual Notices from time to time relating to the manner in which the Delegated Functions must be exercised by the ICB. Contractual Notices will have effect as variations to this Agreement.

7.4 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.5 The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under sections 65Z5 and 75 of the NHS Act.

7.6 The ICB must develop an operational scheme of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme of delegation within its general organisational scheme of delegation.

7.7 Subject to clauses 7.1 to 7.6, the ICB may determine the arrangements for the exercise of the Delegated Functions.

7.8 The ICB must perform the Delegated Functions:

7.8.1 in such a manner as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Delegated Functions and to enable NHS England to fulfil its Reserved Functions; and

7.8.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions.

8. PERFORMANCE OF THE RESERVED FUNCTIONS

8.1 NHS England will exercise the Primary Care Functions and functions in respect of Prescribed Dental Services, other than the Delegated Functions, including but not limited to those set out in SCHEDULE 3 to this Agreement ("the Reserved Functions").

8.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to clause 25 *(Variations)* of this Agreement.

8.3 NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

8.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions.

8.5 The Parties acknowledge that, as from the date of this Agreement, the ICB shall provide administrative and management services to NHS England in relation to certain Reserved Functions and that such administrative and management services are as follows:

8.5.1 the administrative and management services in relation to the Capital Expenditure Functions and the Capital Expenditure Funds as more particularly set out in clauses 9.14 to 9.17; and

8.5.2 the administrative and management services in relation to the Section 7A Functions and Section 7A Funds as more particularly set out in clauses 9.18 to 9.21.

8.6 The Parties further acknowledge that NHS England may ask the ICB to provide certain administrative and management services to NHS England in relation to other Reserved Functions.

8.7 Notwithstanding any arrangement for or provision of administrative or management services in respect of certain Reserved Functions, NHS England shall retain and be accountable for the exercise of such Reserved Functions.

9. FINANCE

9.1 Without prejudice to any other provision in this Agreement, the ICB must comply with the NHS England central finance team's operational process (as such process is updated from time to time) for the reporting and accounting of funds used for the purposes of the Delegated Functions.

9.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the "Delegated Funds") and that these are in addition to the funds allocated to it within its Annual Allocation.

9.3 Subject to clause 9.4, the ICB may use:

9.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions; and

9.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB's functions other than the Delegated Functions.

9.4 The ICB's expenditure on the Delegated Functions must be no less than that necessary to:

9.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently;

9.4.2 meet all liabilities arising under or in connection with all Primary Care Contracts and Arrangements allocated to the ICB in accordance with clauses 6.4 to 6.6;

9.4.3 meet all liabilities arising under or in connection with all Prescribed Dental Services Contracts allocated to the ICB in accordance with clauses 6.4 to 6.6 in so far as they relate to the Delegated Functions; and

9.4.4 meet national commitments from time to time on expenditure on specific Delegated Functions including, without limitation, the Community Pharmacy Contractual Framework.

9.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

9.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation adjustments following any changes to the Delegated Functions, changes in allocations, changes in Primary Care Contracts or Arrangements or otherwise;

9.5.2 in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act;

9.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under clause 15;

9.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions and/or funds transferred (or that should have been transferred) to the ICB and in respect of which the ICB has management or administrative responsibility under clauses 9.14 to 9.23 of this Agreement; or

9.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

9.6 NHS England acknowledges that the intention of paragraph 9.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change

the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

9.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

9.8 NHS England may in respect of the Delegated Funds:

9.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;

9.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including without limitation, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

9.9 SCHEDULE 5 (Financial Provisions and Decision Making Limits) sets out further financial provisions in respect of the exercise of the Delegated Functions and, in particular, Table 1 in SCHEDULE 5 (*Financial Provisions and Decision Making Limits)* sets out certain financial limits and approvals required in relation to the exercise of the Delegated Functions.

9.10 NHS England may issue Mandated Guidance in respect of the use of funds for the purposes of the Delegated Functions.

Payment and Transfer

9.11 NHS England will pay the Delegated Funds to the ICB monthly using the same revenue transfer process as used for the Annual Allocation or using such other process as notified to the ICB from time to time.

9.12 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must use its resources for the purposes of the Delegated Functions in accordance with:

9.12.1 the terms and conditions of this Agreement;

9.12.2 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time;

9.12.3 any Capital Investment Guidance;

9.12.4 any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts); and

9.12.5 the HM Treasury guidance *Managing Public Money* (dated July 2013 and found at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212123/Managing_Public_Money_AA_v2_-_chapters_annex_web.pdf).

9.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions.

Administrative and/or Management Services and Funds in relation to the Capital Expenditure Functions

9.14 The Parties acknowledge that the Capital Expenditure Functions are a Reserved Function.

9.15 The Parties further acknowledge that:

9.15.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Capital Expenditure Functions (**"Capital Expenditure Funds"**); and

9.15.2 NHS England remains responsible and accountable for the discharge of the Capital Expenditure Functions and nothing in clauses 9.14 to 9.17 shall be construed as a divestment or delegation of NHS England's Capital Expenditure Functions.

9.16 Without prejudice to clause 9.15 above, the ICB will comply with any Mandated Guidance issued in relation to the Capital Expenditure Functions and shall (on request from NHS England) provide the following administrative services to NHS England in respect of the Capital Expenditure Funds:

9.16.1 the administration and payment of sums that NHS England has approved as payable in relation to the Capital Expenditure Functions;

9.16.2 if requested by NHS England and taking into account (i) any other support or services provided to NHS England by NHS Property Services Limited or otherwise and (ii) any Mandated Guidance issued in respect of the Capital Expenditure Functions, the provision of advice and/or recommendations to NHS England in respect of expenditure to be made under the Capital Expenditure Functions; and

9.16.3 such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Capital Expenditure Functions.

9.17 NHS England may, at the same time as it allocates the Delegated Funds to the ICB under paragraph 9.11, transfer to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this clause 9 *(Finance)* in respect of the Capital Expenditure Functions.

Administrative and/or Management Services and Funds in relation to Section 7A Functions

9.18 The Parties acknowledge that the Section 7A Functions are part of the Reserved Functions.

9.19 The Parties further acknowledge that:

9.19.1 accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Section 7A Functions (whether such arrangements are included in or under Primary Care Contracts or Arrangements or not) (**"Section 7A Funds"**); and

9.19.2 NHS England remains responsible and accountable for the discharge of the Section 7A Functions and nothing in this clause 9 *(Finance)* shall be construed as a divestment or delegation of the Section 7A Functions.

9.20 The ICB will provide the following services to NHS England in respect of the Section 7A Funds:

9.20.1 the administration and payment of sums that NHS England has approved as payable under or in respect of arrangements for the Section 7A Functions; and

9.20.2 such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Section 7A Funds.

9.21 NHS England shall, at the same time as it allocates the Delegated Funds to the ICB under paragraph 9.11, allocate to the ICB such amounts as are necessary to enable the discharge of the ICB's obligations under this clause 9 *(Finance)* in respect of the Section 7A Funds.

Administrative and/or Management Services and Funds in relation to other Reserved Functions

9.22 NHS England may ask the ICB to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the ICB) in relation to the carrying out of any of the Reserved Functions.

9.23 If NHS England makes such a request to the ICB, then the ICB will, but only if the ICB agrees to provide such services, from the date requested by NHS England, comply with:

9.23.1 provisions equivalent to those set out above in relation to the Capital Expenditure Functions (clauses 9.14 to 9.17) and the Section 7A Functions (clauses 9.18 to 9.21) including in relation to the administration of any funds for such functions but only to the extent that such provisions are relevant to the management or administrative services to be provided; and

9.23.2 such other provisions in respect of the carrying out of such management and administrative services as agreed between NHS England and the ICB.

Pooled Funds

9.24 The ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund in respect of any part of the Delegated Funds with:

9.24.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act;

9.24.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement; or

9.24.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act; and

9.24.4 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act.

9.25 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

10. INFORMATION, PLANNING AND REPORTING

10.1 The ICB must provide to NHS England:

10.1.1 all information or explanations in relation to the exercise of the Delegated Functions (including in relation to this Agreement), (and in such form) as requested by NHS England from time to time; and

10.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

10.2 The provisions of this clause 10 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

10.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.

10.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

10.5 The ICB must maintain a risk register in respect of its exercise of the Delegated Functions and periodically review its content. The risk register must follow such format as may be notified by NHS England to the ICB from time to time.

11. FURTHER ARRANGEMENTS

11.1 The ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under sections 65Z5 and 75 of the NHS Act.

11.2 The ICB may only make arrangements with another person (a "Sub-Delegate") concerning the exercise of the Delegated Functions ("Further Arrangements"), including without limitation arrangements under sections 65Z5 and 75 of the NHS Act, with the prior written approval of NHS England.

11.3 The approval of any Further Arrangements may:

11.3.1 include approval of the terms of the proposed Further Arrangements; and

11.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

11.4 All Further Arrangements must be made in writing.

11.5 The ICB must not:

11.5.1 terminate Further Arrangements; or

11.5.2 make any material changes to the terms of Further Arrangements;

without the prior written approval of NHS England.

11.6 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

11.7 The terms of this clause 11 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

11.8 NHS England requires the ICB to make arrangements for assistance and support in the exercise of the Delegated Functions with those persons described at SCHEDULE 6 and such other persons as NHS England may require from time to time.

11.9 Where Further Arrangements are made, any positive obligation or duty on the part of the ICB under this Agreement that is relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with that positive obligation or duty and support the ICB in doing so. In the same way, any negative duty or obligation on the part of the ICB under this Agreement that is relevant to Further Arrangement shall also require the ICB to ensure that all Sub-Delegates comply with that negative obligation or duty and support the ICB in doing so.

12. STAFFING

12.1 Subject to the terms of this Agreement, the Delegated Functions will be carried out by NHS England Staff in accordance with decisions concerning the Delegated Functions made by the ICB unless the Staff carrying out the Delegated Functions have transferred to the ICB (and/or the ICB has engaged or employed Staff for that purpose).

12.2 SCHEDULE 8 makes further provision about deployment of NHS England Staff to the ICB for the purposes of carrying out the relevant Delegated Functions.

12.3 The ICB must comply with any Mandated Guidance issued by NHS England from time to time in relation to the NHS England Staff.

12.4 For the avoidance of doubt, any breach by the ICB of the terms of this clause 12 (Staffing), including any breach of any Mandated Guidance issued in accordance with clause 12.3 above, will be a breach of the terms and conditions of this Agreement for the purposes of clauses 9.5 and 15.3.

13. BREACH

13.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

13.1.1 exercise its rights under this Agreement; and/or

13.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the ICB.

13.2 Without prejudice to clause 13.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

13.2.1 waive its rights in relation to such non-compliance in accordance with clause 13.3;

13.2.2 ratify any decision in accordance with clause 6.9;

13.2.3 revoke the Delegation and terminate this Agreement in accordance with clause 25.7 *(Termination)* below;

13.2.4 exercise the Escalation Rights in accordance with clause 14 *(Escalation Rights)*; and/or

13.2.5 exercise its rights under common law.

13.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by clause 13.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

13.4 If:

13.4.1 the ICB does not comply (or, based on the risk register maintained by the ICB in accordance with clause 10.5 or any other information available to it the ICB considers that it may not be able to comply) with this Agreement; or

13.4.2 NHS England notifies the ICB that it considers the ICB has not complied, or may not be able to comply with, this Agreement;

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB considers that it may not be able to comply with this Agreement) or such notification pursuant to clause 13.4.2 setting out:

13.4.3 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation; and

13.4.4 a plan for how the ICB proposes to remedy the non-compliance.

14. ESCALATION RIGHTS

14.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

14.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) days of NHS England becoming aware of the non-compliance; and

14.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

14.2 Nothing in clause 14 *(Escalation Rights)* will affect NHS England's right to revoke the Delegation and/or terminate this Agreement in accordance with clause 26 *(Termination)* below.

15. LIABILITY AND INDEMNITY

15.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to clause 15.3).

15.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

15.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority conferred by the Delegation) or this Agreement and, in respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to clause 9.5. The ICB shall not be liable to the extent that the Losses arose prior to the date of this Agreement.

15.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated

Function are enforceable by or against the ICB only, in accordance with s65Z5(6) of the NHS Act.

15.5 The ICB indemnifies NHS England and shall keep it indemnified on a continuing basis from and against any and all Losses which NHS England may incur by reason of any claim by any NHS England Staff:

15.5.1 arising out of a breach of duty by the ICB (whether under common law, statute or otherwise) to the extent that such claim is not met by either the ICB's or NHS England's insurance or indemnity cover;

15.5.2 under the Equality Act 2010 or Part V of the Employment Rights Act 1996 arising out of acts or omissions by the ICB (or any of its employees, directors or officers);

15.5.3 arising from any acts or omissions by the ICB resulting in the termination of their employment, including any claim arising from any instruction by the ICB to NHS England to discipline or dismiss any person.

15.6 Each Party shall co-operate with the other in making all reasonable efforts to minimise any liabilities and Losses in connection with the employment of NHS England Staff in Delegated Functions.

15.7 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

16. CLAIMS AND LITIGATION

16.1 Nothing in this clause 16 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

16.2 Except in the circumstances set out in clause **Error! Reference source not found.**16.5 and subject always to compliance with this clause 16 *(Claims and Litigation)*, the ICB shall be responsible for and shall retain the conduct of any Claim.

16.3 The ICB must:

16.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and/or the pro-active management of Claims;

16.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;

16.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;

16.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and/or

16.3.5 at the request of NHS England, take such action or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

16.4 Subject to clauses 16.3 and 16.5 and SCHEDULE 5 (Financial Provisions and Decision Making Limits) the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

16.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England. In such cases:

16.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke clause 16.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement; and

16.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim; and

16.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to clause 9.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

16.6 The ICB and NHS England shall notify each other within a reasonable time period of becoming aware of any Claim Losses.

16.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant to clause 9.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to clause 9.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to clause 9.5.3.

17. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

17.1 The Parties must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

17.2 The ICB must respond to any information governance breach in accordance with IG Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the

information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

17.3 Whether or not a Party is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Parties acknowledge that a Party may act as both a Data Controller and a Data Processor.

17.4 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).

17.5 Each Party may be statutorily required to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

17.5.1 each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

17.5.2 each Party shall consult the other regarding the possible application of exemptions in relation to the information requested; and

17.5.3 subject only to clause 16 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

17.6 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

17.7 SCHEDULE 4 makes further provision about information sharing and information governance.

18. IT INTER-OPERABILITY

18.1 NHS England and the ICB will work together to ensure that all relevant IT systems operated by NHS England and the ICB in respect of the Delegated Functions and the Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

18.2 The Parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

19. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

19.1 The ICB must and must ensure that, in delivering the Delegated Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

19.2 Without prejudice to the general obligations set out in clause 19.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

20. PROHIBITED ACTS AND COUNTER-FRAUD

20.1 The ICB must not commit any Prohibited Act.

20.2 If the ICB or its Staff commits any Prohibited Act in relation to this Agreement with or without the knowledge of NHS England, NHS England will be entitled:

20.2.1 to revoke the Delegation; and

20.2.2 to recover from the ICB the amount or value of any gift, consideration or commission concerned; and

20.2.3 to recover from the ICB any loss or expense sustained in consequence of the carrying out of the Prohibited Act.

20.3 The ICB must put in place and maintain appropriate arrangements, including without limitation Staff training, to address counter-fraud issues, having regard to any relevant Guidance (including from the NHS Counter Fraud Authority).

20.4 If requested by NHS England or the NHS Counter Fraud Authority, the ICB must allow a person duly authorised to act on behalf of the NHS Counter Fraud Authority or on behalf of NHS England to review, in line with the appropriate standards, the counter-fraud arrangements put in place by the ICB.

20.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in clause 20.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

20.6 The ICB must, on becoming aware of:

20.6.1 any suspected or actual bribery, corruption or fraud involving public funds; or

20.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources;

promptly report the matter to NHS England and to the NHS Counter Fraud Authority.

20.7 On the request of NHS England or the NHS Counter Fraud Authority, the ICB must allow the NHS Counter Fraud Authority or any person appointed by NHS England, as soon as it is reasonably practicable and in any event not later than 5 Operational Days following the date of the request, access to:

20.7.1 all property, premises, information (including records and data) owned or controlled by the ICB; and

20.7.2 all Staff who may have information to provide;

relevant to the detection and investigation of cases of bribery, fraud or corruption, or security incidents or security breaches directly or indirectly in connection with this Agreement.

21. CONFIDENTIAL INFORMATION OF THE PARTIES

21.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Party and the receiving Party has no right to use it.

21.2 Subject to clauses 21.3 to 21.5, the receiving Party agrees:

21.2.1 to use the disclosing Party's Confidential Information only in connection with the receiving Party's performance under this Agreement;

21.2.2 not to disclose the disclosing Party's Confidential Information to any third party or to use it to the detriment of the disclosing Party; and

21.2.3 to maintain the confidentiality of the disclosing Party's Confidential Information.

21.3 The receiving Party may disclose the disclosing Party's Confidential Information:

21.3.1 in connection with any Dispute Resolution;

21.3.2 in connection with any litigation between the Parties;

21.3.3 to comply with the Law;

21.3.4 to any appropriate Regulatory or Supervisory Body;

21.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Party's duty under clause 21.2;

21.3.6 to NHS Bodies for the purposes of carrying out their functions;

21.3.7 as permitted under or as may be required to give effect to clause 20 (*NHS Counter-Fraud*); and

21.3.8 as permitted under any other express arrangement or other provision of this Agreement.

21.4 The obligations in clauses 21.1 and 21.2 will not apply to any Confidential Information which:

21.4.1 is in or comes into the public domain other than by breach of this Agreement;

21.4.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party; or

21.4.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

21.5 This clause 21 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

21.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this clause 21 by the receiving Party, and in addition to any right to damages the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this clause 21.

21.7 This clause 21 will survive the termination of this Agreement for any reason for a period of 5 years.

21.8 This clause 21 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

22. INTELLECTUAL PROPERTY

22.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

22.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

22.3 The ICB must co-operate with NHS England to enable it to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as NHS England may reasonably request, and (to the extent that any IPR attaches to Best Practice), grants NHS England a fully paid-up, non-exclusive, perpetual licence for NHS England to use Best Practice IPR for the commissioning and provision of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice.

23. NOTICES

23.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars.

23.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

24. DISPUTES

24.1 This clause does not affect NHS England's right to exercise its functions for the purposes of assessing and addressing the performance of the ICB.

24.2 If a Dispute arises out of or in connection with this Agreement then the Parties must follow the procedure set out in this clause:

24.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("**Dispute Notice**"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

24.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and

24.2.3 if the people referred to in clause 24.2.2 are for any reason unable to resolve the Dispute within twenty (20) days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR Solve. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' (**ADR**) **notice**) to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR Solve. The mediation will start not later than ten (10) days after the date of the ADR notice.

24.3 If the Dispute is not resolved within thirty (30) days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) days, or the mediation terminates before the expiration of the period of thirty (30) days, the Dispute must be referred to the Secretary of State, who shall resolve the matter and whose decision shall be binding upon the Parties.

25. VARIATIONS

25.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

25.2 NHS England may notify the ICB of a Variation Proposal in respect of this Agreement.

25.3 The Variation Proposal will set out the variation proposed and the date on which NHS England requires the variation to take effect.

25.4 The ICB must respond to a Variation Proposal within thirty (30) Operational Days following the date that it is issued by serving notice on NHS England confirming either:

25.4.1 that it accepts the Variation Proposal; or

25.4.2 that it refuses to accept the Variation Proposal, and setting out reasonable grounds for that refusal.

25.5 If the ICB accepts the Variation Proposal, the ICB agrees (without delay) to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

25.6 If the ICB refuses to accept the Variation Proposal or to take such steps as are required to give effect to the variation, NHS England may terminate this Agreement in respect of some or all of the Delegated Functions.

25.7 The provisions of this clause 25 are without prejudice to the ability of NHS England to issue Contractual Notices which have the effect of varying this Agreement.

25.8 The Parties acknowledge that this Agreement is likely to require variation to take effect from 1 April 2023 as initial delegation arrangements are developed further. Accordingly, both Parties agree to engage constructively with a view to agreeing any such variation proposal in line with the provisions of this clause 25. In particular, the Parties agree to act reasonably and with the understanding that a single variation proposal will need to be accepted by all ICBs to ensure consistency across all delegation arrangements.

26. TERMINATION

26.1 The ICB may:

26.1.1 notify NHS England that it requires NHS England to revoke the Delegation; and

26.1.2 terminate this Agreement;

with effect from the end of 31 March in any calendar year, provided that:

26.1.3 on or before 30 September of the previous calendar year, the ICB sends written notice to NHS England of its requirement that NHS England revoke the Delegation and intention to terminate this Agreement; and

26.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at clause 26.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner;

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

26.2 NHS England may revoke the Delegation at the end of 31 March in any year, provided that it gives notice to the ICB of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case clause 26.4 will apply.

26.3 The Delegation may be revoked, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

26.3.1 the ICB acts outside of the scope of its delegated authority;

26.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement;

26.3.3 the ICB persistently commits non-material breaches of this Agreement;

26.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply;

26.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB;

26.3.6 failure to agree to a variation in accordance with clause 25 *(Variations)*;

26.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or

26.3.8 the ICB merges with another ICB or other body.

26.4 This Agreement will terminate upon revocation or termination of the Delegation (including revocation and termination in accordance with this clause 26 *(Termination)*) except that the provisions referred to at clause 28 (*Provisions Surviving Termination*) will continue in full force and effect.

26.5 Without prejudice to clause 13.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this clause 26 *(Termination)*. Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

26.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may alternatively terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

27. CONSEQUENCE OF TERMINATION

27.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue.

27.2 Subject to clause 27.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and if appropriate any successor delegate will:

27.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of those staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions;

27.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with clause 27.2.1 above; and

27.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

27.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

27.3.1 co-operate with NHS England and any successor delegate in order to ensure continuity and a smooth transfer of the Delegated Functions; and

27.3.2 at the reasonable request of NHS England:

(a) promptly provide all reasonable assistance and information to the extent necessary to effect an orderly assumption of the Delegated Functions by a successor delegate;

(b) deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions; and

27.3.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

27.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

28. PROVISIONS SURVIVING TERMINATION

28.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in clause 28.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

28.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

28.2.1 Clause 9 (Finance);

28.2.2 Clause 12 (Staffing);

28.2.3 Clause 15 (Liability and Indemnity);

28.2.4 Clause 16 (Claims and Litigation);

28.2.5 Clause 17 (Data Protection, Freedom of Information and Transparency);

28.2.6 Clause 24 (Disputes);

28.2.7 Clause 26 (Termination);

28.2.8 SCHEDULE 4 (Further Information Governance and Sharing Provisions).

29. COSTS

29.1 Each Party is responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

30. SEVERABILITY

30.1 If any provision or part of any provision of this Agreement is declared invalid or otherwise unenforceable, that provision or part of the provision as applicable will be

severed from this Agreement. This will not affect the validity and/or enforceability of the remaining part of that provision or of other provisions.

31. **GENERAL**

31.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

31.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

31.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1

Definitions and Interpretation

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

8. Use of the masculine includes the feminine and all other genders.

9. Use of the term “including” or “includes” will be interpreted as being without limitation.

10. The following words and phrases have the following meanings:

Additional Pharmaceutical Services	Services provided in accordance with a direction under section 127 of the NHS Act (also referred to as advanced services and enhanced services in the Pharmaceutical Regulations);
Agreement	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions and the Schedules;
Agreement Representatives	means the ICB Representative and the NHS England Representative as set out in the Particulars;
Annual Allocation	means the funds allocated to the ICB annually under section 223G of the NHS Act;
APMS Contract	means an agreement or contract for the provision of primary medical services made under section 83(2) of the NHS Act (including any arrangements which are made in reliance on a combination of that section and other powers to arrange for primary medical services);
Area	means the area described in the Particulars;

Assigned Staff	means those NHS England staff as agreed between NHS England and the ICB from time to time;
Best Practice	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software;
Caldicott Principles	means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;
Capital	shall have the meaning set out in the Capital Investment Guidance or such other replacement Mandated Guidance as issued by NHS England from time to time;
Capital Expenditure Functions	means those functions of NHS England in relation to the use and expenditure of Capital funds (but excluding the Premises Costs Directions Functions);
Capital Investment Guidance	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: - the expenditure of Capital, or investment in property, infrastructure or information and technology; and - the revenue consequences for commissioners or third parties making such investment;
CEDR	means the Centre for Effective Dispute Resolution;
Claims	means, for or in relation to the Delegated Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
Claim Losses	means all Losses arising in relation to any Claim;

Combined Authority	means a body of that name established under the provisions of the Local Democracy, Economic Development and Construction Act 2009;
Community Dental Services	means specialised dental services commissioned for patients who are unable to access treatment from Primary Dental Services due to a disability or medical condition, being a form of Prescribed Dental Service;
Community Pharmacy Contractual Framework	means the Community Pharmacy Contractual Framework as published by the Department of Health and Social Care from time to time;
Complaints Regulations	means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to an FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency;
Contractual Notice	means a contractual notice issued by NHS England to the ICB, or some or all ICBs (as the case may be), from time to time and relating to allocation of contracts for the purposes of the Delegated Functions and/or the manner in which the Delegated Functions should be exercised by the ICB;
CQC	means the Care Quality Commission;
Data Controller	shall have the same meaning as set out in the UK GDPR;
Data Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;

Data Processor	shall have the same meaning as set out in the UK GDPR;
Data Protection Legislation	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations 2003;
Data Subject	shall have the same meaning as set out in the UK GDPR;
Delegated Functions	means the functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement;
Delegated Funds	means the funds defined in paragraph 9.2;
Delegation	means the delegation of the Delegated Functions from NHS England to the ICB as described at clause 6.1;
Dental Care Services	means: (i) Primary Dental Services; and (ii) the Prescribed Dental Services;
Dental Services Contract	means: (i) a GDS Contract; (ii) a PDS Agreement (except for any Community Dental Services PDS Agreement, which constitutes a Prescribed Dental Services Contract); and (iii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 5 of the NHS Act; in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;
Dental Services Provider	means a natural or legal person who holds a Dental Services Contract;
Direct Commissioning Guidance Webpage	means the webpage maintained by NHS England at https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/;
Dispute	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement;

Effective Date of Delegation	means the Effective Date of Delegation as set out in the Particulars;
EIR	means the Environmental Information Regulations 2004;
Enhanced Services	means the nationally defined enhanced services, as set out in such directions made by the Secretary of State pursuant to his powers contained in sections 98A, 114A, 125A and 168A of the NHS Act as are in force from time to time, or which may be prescribed by NHS England under its Reserved Functions, and any other enhanced services schemes locally developed by the ICB in the exercise of its Delegated Functions (and excluding, for the avoidance of doubt, any enhanced services arranged or provided pursuant to the Section 7A Functions);
Escalation Rights	means the escalation rights as defined in clause 14 *(Escalation Rights)*;
Financial Year	shall bear the same meaning as in section 275 of the NHS Act;
FOIA	the Freedom of Information Act 2000;
Further Arrangements	means arrangements for the exercise of Delegated Functions as defined at clause 11.2;
GDS Contract	means a General Dental Services contract made under section 100 of the NHS Act;
GMS Contract	means a General Medical Services contract made under section 84(1) of the NHS Act;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance;
HSCA	means the Health and Social Care Act 2012;

ICB	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars;
ICB Deliverables	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications;
IG Guidance for Serious Incidents	IG Guidance for Serious Incidents NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013, available at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-informationgovernance/data-security-and-protection-toolkit ;
Indemnity Arrangement	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
Information Law	the UK GDPR, the Data Protection Act 2018, regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy;
IPR	means inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
Law	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body);
Local Authority	means a county council in England, a Combined Authority, a district council in England, a London borough council, the Common Council of the City of London or the Council of the Isles of Scilly;
Local Incentive Schemes	means an incentive scheme developed by the ICB in the exercise of its Delegated Functions to extend the range or quality of essential and additional services provided under a Primary Medical Services Contract and support

	national frameworks in order to meet differing local population needs;
Local Pharmaceutical Services Contract	means - a contract entered into pursuant to section 134 of the NHS Act; or - a contract entered into pursuant to Paragraph 1 of Schedule 12 to the NHS Act;
Local Terms	means the terms set out in SCHEDULE 7 *(Local Terms)*;
Losses	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law;
Managing Conflicts of Interest in the NHS	the NHS publication by that name available at: https://www.england.nhs.uk/about/board-meetings/committees/coi/ ;
Mandated Guidance	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB from time to time, in accordance with clause 7.2**;**
Need to Know	has the meaning set out in paragraph 6.2 of SCHEDULE 4 (*Further Information Governance and Sharing Provisions)*;
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 or other legislation from time to time);
NHS Business Services Authority	means the Special Health Authority established under the NHS Business Services Authority (Establishment and Constitution Order) 2005 SI 2005/2414;
NHS Counter Fraud Authority	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958;
NHS England	means the body established by section 1H of the NHS Act;
NHS England Deliverables	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement,

	including data, reports, policies, plans and specifications;
Non-Personal Data	means data which is not Personal Data;
Out of Hours Contract	means a primary medical services contract for the provision of primary medical services solely during the out of hours period (6.30pm Monday to Thursday until 8am the next day, 6.30pm Friday to 8am Monday, Christmas Day, Good Friday and bank holidays);
Operational Days	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England;
Particulars	means the Particulars of this Agreement as set out in clause 1 *(Particulars)*;
Party/Parties	means a party or both parties to this Agreement;
PDS Agreement	means a Personal Dental Services Agreement made under section 107 of the NHS Act;
Performers Lists	The lists of healthcare professionals maintained by NHS England pursuant to the National Health Service (Performers Lists) (England) Regulations 2013;
Personal Data	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate;
Personal Data Agreement	means the agreement governing Information Law issues completed further to SCHEDULE 4 (Further *Information Governance and Sharing Provisions)*;
Pharmaceutical List	means a list of persons who undertake to provide pharmaceutical services pursuant to regulation 10 of the Pharmaceutical Regulations;
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013/349;
Pharmaceutical Services	means: (i) services provided pursuant to arrangements under section 126 of the NHS Act; and (ii) Additional Pharmaceutical Services;
Pharmaceutical Services Arrangement	means an arrangement for the provision of Pharmaceutical Services, including inclusion in a Pharmaceutical List;
Pharmaceutical Services Provider	means a natural or legal person who is party to a Pharmaceutical Services Arrangement or Local Pharmaceutical Services Contract;

PMS Agreement	means an agreement made in accordance with section 92 of the NHS Act;
Premises Agreements	means tenancies, leases and other arrangements in relation to the occupation of land for the delivery of services under the Primary Medical Services Contracts;
Premises Costs Directions	means the National Health Service (General Medical Services Premises Costs) Directions 2013, as amended;
Premises Costs Directions Functions	means NHS England's functions in relation to the Premises Costs Directions;
Prescribed Dental Services	means the dental services prescribed by such regulations made pursuant to section 3B(1)(a) of the NHS Act as are in force from time to time (including, for the avoidance of doubt, services commonly known as secondary care dental services and Community Dental Services);
Prescribed Dental Services Contract	means any contract for the provision of Prescribed Dental Services;
Primary Care Contract or Arrangement (PCCA)	means: (i) a Primary Medical Services Contract; (ii) a Dental Services Contract; (iii) a Primary Ophthalmic Services Contract; (iv) a Local Pharmaceutical Services Contract; and (v) a Pharmaceutical Services Arrangement.
Primary Care Functions	means: (i) the statutory functions conferred on NHS England under Parts 4, 5, 6 and 7 of the NHS Act and secondary legislation made under those Parts; and (ii) the other statutory functions conferred on NHS England by either primary legislation, secondary legislation or by arrangement with another person in so far as they are applicable to the discharge of those functions set out at (i) above;
Primary Care Provider	means a natural or legal person who holds a Primary Care Contract, or is a Pharmaceutical Services Provider;
Primary Care Provider Personnel	means all persons (whether clinical or non-clinical) employed or engaged by a Primary Care Provider or by any Sub-Contractor (including volunteers, agency, locums, casual or seconded personnel) in the provision

	of Services or any activity related to or connected with the provision of the Services;
Primary Care Services	means the services in respect of which NHS England has a duty or power to make arrangements pursuant to the Primary Care Functions;
Primary Dental Services	means primary dental care services provided under arrangements made pursuant to Part 5 of the NHS Act, and in accordance with a Dental Services Contract;
Primary Medical Services	means primary medical services provided under arrangements made pursuant to Part 4 of the NHS Act, and in accordance with a Primary Medical Services Contract;
Primary Medical Services Contract	means: (i) a PMS Agreement; (ii) a GMS Contract; (iii) an APMS Contract; and (iv) any other contract for the provision of health services made pursuant to NHS England's functions under Part 4 of the NHS Act; in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements but excluding any Premises Agreements and excluding any Out of Hours Contracts[2];
Primary Medical Services Provider	means a natural or legal person who holds a Primary Medical Services Contract;
Primary Ophthalmic Services	means primary ophthalmic services provided under arrangements made pursuant to Part 6 of the NHS Act, and in accordance with a Primary Ophthalmic Services Contract;
Primary Ophthalmic Services Contract	means: (i) a General Ophthalmic Services Contract; and (ii) any other contract for the provision of health services made pursuant to NHS England's functions under Part 6 of the NHS Act; in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements;

[2] Arrangements for Out of Hours Contracts are dealt with under separate Directions outside of this Agreement and do not form part of any Delegated Functions.

Primary Ophthalmic Services Provider	means a natural or legal person who holds a Primary Ophthalmic Services Contract;
Principles of Best Practice	means the Mandated Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;
Prohibited Act	the ICB: (i) offering, giving, or agreeing to give NHS England (or an of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB; and (ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England; or (iii) committing an offence under the Bribery Act 2010;
QOF	means the quality and outcomes framework;
Regulatory or Supervisory Body	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) NICE; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and

(xi) the Information Commissioner;

Relevant Information	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
Reserved Functions	means the functions which are reserved to NHS England (and are therefore not delegated to the ICB under the Delegation) and as set out in detail in clause 8 and SCHEDULE 3 (Reserved Functions) of this Agreement;
Secretary of State	means the Secretary of State for Health and Social Care from time to time;
Section 7A Functions	means those functions of NHS England exercised pursuant to section 7A of the NHS Act and relating to Primary Care Services;
Section 7A Funds	shall have the meaning in clause 9.19.1;
Special Category Personal Data	shall have the same meaning as in UK GDPR;
Specified Purpose	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1 of SCHEDULE 4 *(Further Information Governance and Sharing Provisions)* to this Agreement;
Staff or Staffing	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
Staffing Model	means the employment model as defined in Appendix 2 of the NHS England and NHS Improvement operating models: HR Framework for developing Integrated Care;
Statement of Financial Entitlements Directions	means the General Medical Services Statement of Financial Entitlements Directions 2021, as amended or updated from time to time;
Sub-Delegate	shall have the meaning in clause 11.2;
Transfer Regulations	means the Transfer of Undertakings (Protection of Employment) Regulations 2006, as amended;

Triple Aim	means the duty to have regard to wider effect of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act;
UK GDPR	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
Variation Proposal	means a written proposal for a variation to the Agreement, which complies with the requirements of clause 25.3.

SCHEDULE 2

Delegated Functions

Schedule 2A: Primary Medical Services

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2A *(Primary Medical Services)* sets out further provision regarding the carrying out of those Delegated Functions relating to Primary Medical Services, being in summary:

1.1.1 decisions in relation to the commissioning and management of Primary Medical Services;

1.1.2 planning Primary Medical Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Medical Services in respect of the Area;

1.1.4 management of the Delegated Funds in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of primary medical services.

2.2 The role of the ICB includes:

2.2.1 carrying out needs assessments, and regular reviews of such assessments, to determine the needs of the population in the Area; and

2.2.2 identifying and implementing changes to meet any unmet needs which may be met through the delivery of Primary Medical Services.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, the Local Medical Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Medical Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.4.1 to manage the Primary Medical Services Contracts and perform all of NHS England's obligations under each of the Primary Medical Services Contracts

in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 actively manage the performance of the Primary Medical Services Provider in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, and avoids making any double payments under any Primary Medical Services Contracts;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Medical Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Primary Medical Services Contracts that the ICB manages setting out the following details in relation to each Primary Medical Services Contract:

2.4.6.1 name of the Primary Medical Services Provider;

2.4.6.2 the name by which the Primary Medical Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the Primary Medical Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause 9 (Finance) of the Agreement or paragraph 2.4 above, the ICB must actively manage each of the relevant Primary Medical Services Contracts including by:

2.5.1 reviewing the performance of the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.5.2 assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities);

2.5.3 managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.5 agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.6 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.5.7 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause 10 (Information, Planning and Reporting) or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual Primary Medical Services Providers in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performance of Primary Medical Services Providers;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

2.7 It should be noted that while the ICB is also required to exercise functions in respect of dispensing doctors, arrangements in respect of these functions are described in Schedule 2D (Pharmaceutical Services).

Part 2: Specific Obligations

3. Introduction

This Part 2 of Schedule 2A (Delegated Functions – Primary Medical Services) sets out further provision regarding the carrying out of each of the Delegated Functions.

4. Primary Medical Services Contract Management

The ICB must comply with any future national Mandated Guidance on equitable funding as may apply from time to time.

5. Enhanced Services

5.1 The ICB must manage the design (where applicable) and commissioning of any Enhanced Services, including re-commissioning these services annually where appropriate.

5.2 The ICB may consider any local enhanced services entered into with Primary Medical Services Providers in its Area using NHS Standard Contracts. Where these would continue to be beneficial to the Area, the ICB may manage the ongoing design and commissioning (including re-commissioning) of these services via a Local Incentives Scheme.

5.3 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of Enhanced Services.

5.4 When commissioning newly designed Enhanced Services the ICB must:

5.4.1 consider the needs of the local population in the Area;

5.4.2 develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

5.4.3 when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

5.4.4 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

5.4.5 liaise with system providers and representative bodies to ensure that the system in relation to the Directed Enhanced Services, NHS England Enhanced Services and Local Enhanced Services will be functional and secure;

5.4.6 support Data Controllers in providing 'fair processing' information as required by the UK GDPR; and

5.4.7 support Primary Medical Services Providers in entering into data processing agreements with data processors in the terms required by the UK GDPR.

6. Design of Local Incentive Schemes

6.1 The ICB may design and offer Local Incentive Schemes for Primary Medical Services Providers, sensitive to the differing needs of their particular communities. This includes in addition to or as an alternative to the national contractual frameworks (including as an alternative to QOF or Enhanced Services), provided that such schemes are voluntary, and the ICB continues to offer the national schemes.

6.2 There is no formal approvals process that the ICB must follow to develop a Local Incentive Scheme, although when designing and implementing any proposed new Local Incentive Scheme the ICB must:

6.2.1 consider the needs of the local population in the Area;

6.2.2 develop the specifications and templates for the Local Incentive Scheme;

6.2.3 consult with Local Medical Committees and other stakeholders and comply with the duty of public involvement and consultation under section 14Z45 of the NHS Act;

6.2.4 liaise with system providers and representative bodies to ensure that the system in relation to the Local Incentive Schemes will be functional and secure;

6.2.5 support Data Controllers in providing privacy information as required by the UK GDPR; and

6.2.6 support Primary Medical Services Providers in entering into data processing agreements with data processors in terms required by the UK GDPR.

6.3 The ICB must be able to:

6.3.1 demonstrate improved outcomes, reduced inequalities and value for money;

6.3.2 support ongoing national reporting requirements (where applicable); and

6.3.3 must reflect the changes agreed as part of the national PMS reviews (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/implement-pms-fund-changes.pdf) .

6.4 The ongoing assurance of any new Local Incentive Schemes will form part of the ICB's assurance process under any applicable assurance framework.

6.5 Any new Local Incentive Scheme must be implemented without prejudice to the right of Primary Medical Services Providers operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

6.6 NHS England will continue to set national standing rules, to be reviewed annually, and the ICB must comply with these rules which shall for the purposes of this Agreement be Mandated Guidance.

7. Making Decisions on Discretionary Payments or Support

7.1 The ICB must manage and make decisions in relation to any discretionary payments or discretionary support to be made to Primary Medical Services Providers in a consistent, open and transparent way.

7.2 The ICB must exercise its discretion to determine the level of payment or type of support to Primary Medical Services Providers, in accordance with any relevant Mandated Guidance.

8. Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

8.1 The ICB must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

8.2 The ICB must ensure that it complies with any Mandated Guidance in relation to the design and commissioning of these services.

8.3 For the purposes of paragraph 2.15, urgent care means the provision of primary medical services on an urgent basis.

9. Transparency and freedom of information

9.1 The ICB must:

9.1.1 Respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

9.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

10. Planning the Provider Landscape

10.1 The ICB must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

10.1.1 establishing new Primary Medical Services Providers in the Area;

10.1.2 managing Primary Medical Services Providers providing inadequate standards of patient care;

10.1.3 the procurement or award of new Primary Medical Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time);

10.1.4 closure of practices and branch surgeries;

10.1.5 dispersing the patient lists of Primary Medical Services Providers; and

10.1.6 agreeing variations to the boundaries of Primary Medical Services Providers.

10.2 In relation to any new Primary Medical Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 16 (Procurement and New Contracts) below, and paragraph 2.5 of Part 1 of this Schedule 2A:

10.2.1 consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

10.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

10.2.3 for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

11. Primary Care Networks

11.1 In managing the design and commissioning of the Network Contract Directed Enhanced Services, including re-commissioning these services annually where appropriate, the ICB must plan and manage the Primary Care Networks in the Area, complying with published specifications and Mandated Guidance, including to:

11.1.1 maintain or establish identified Network Areas to support the local population in the Area;

11.1.2 review any waived PCN list size requirements wherever possible and appropriate to best support the local population in the Area;

11.1.3 ensure that each PCN has at all times an accountable Clinical Director;

11.1.4 align each PCN with an ICB that would best support delivery of services to the local population in the Area; and

11.1.5 collaborate and work with other ICBs as appropriate to agree which ICB will be the lead ICB for the PCN.

12. Approving Primary Medical Services Provider Mergers and Closures

12.1 The ICB is responsible for approving Primary Medical Services Provider mergers and Primary Medical Services Provider closures in the Area.

12.2 The ICB must undertake all necessary consultation when taking any decision in relation to Primary Medical Services Provider mergers or Primary Medical Services Provider closures in the Area, including those set out under section 14Z45 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

12.3 Prior to making any decision in accordance with this paragraph 12 (Approving Primary Medical Services Provider Mergers and Closures), the ICB must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the Primary Medical Services Provider's registered population and that of surrounding practices. The ICB must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the Primary Medical Services Provider as to how any closure or merger will be managed.

12.4 In making any decisions pursuant to this paragraph 12 (Approving Primary Medical Services Provider Mergers and Closures), the ICB shall act in accordance with relevant Mandated Guidance and also take account of its obligations as set out in paragraph 16 *(Procurement and New Contracts)*, below, where applicable.

13. Making Decisions in relation to Management of Poorly Performing Primary Medical Services Providers

13.1 The ICB must make decisions in relation to the management of poorly performing Primary Medical Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

13.2 In accordance with paragraph 13.1 above, the ICB must:

13.2.1 ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;

13.2.2 ensure that any risks identified are managed and escalated where necessary;

13.2.3 respond to CQC assessments of Primary Medical Services Providers where improvement is required;

13.2.4 where a Primary Medical Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

13.2.5 take appropriate contractual action, including (without limitation) in response to CQC findings.

14. Premises Costs Directions Functions

14.1 The ICB must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

14.2 In particular, but without limiting paragraph 14.1, the ICB shall make decisions concerning:

14.2.1 applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

14.2.2 revisions to existing payments being made under the Premises Costs Directions.

14.3 The ICB must comply with any decision-making limits set out in Schedule 5 (Financial Provisions and Decision Making Limits) when taking decisions in relation to the Premises Costs Directions Functions.

14.4 The ICB will comply with any Guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Mandated Guidance in relation to the Premises Costs Directions.

14.5 The ICB must work to ensure that the premises estate is properly managed and maintained, including by ensuring strategic estates planning is in place, and work cooperatively with other ICBs as appropriate.

14.6 The ICB must ensure it maintains comprehensive records of the primary care estate and any changes to it.

14.7 The ICB must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

14.8 The ICB must prioritise the following measures in respect of management of the primary care estate in the Area:

14.8.1 working collaboratively with landlords and tenants to maximise the use of existing estate;

14.8.2 effective asset management practices including (without limitation) regularisation of the occupation of the estate, lease events, rent reviews and up-to-date documentation management; and

14.8.3 seeking the resolution of premises disputes in a timely manner.

15. Maintaining the Performers List

On receiving a notice from a practitioner (who is party to a Primary Medical Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

16. Procurement and New Contracts

16.1 Until any new arrangements for awarding Primary Medical Services Contracts comes into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

16.2 In discharging its responsibilities set out in this Schedule 2A, the ICB must comply at all times with Law and any relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

16.3 On the coming into force of new arrangements for awarding Primary Medical Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

16.4 When the ICB makes decisions in connection with the awarding of Primary Medical Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Primary Medical Services Contracts, including that the decision was:

16.4.1 made in the best interest of patients, taxpayers and the population;

16.4.2 robust and defensible, with conflicts of interests appropriately managed;

16.4.3 made transparently; and

16.4.4 compliant with the rules of the regime as set out in NHS England guidance.

16.5 Where the ICB wishes to develop and offer a locally designed contract, it must ensure that it has consulted with the relevant Local Medical Committees in relation to the proposal and that it can demonstrate that the scheme will:

16.5.1 improve outcomes for patients;

16.5.2 reduce inequalities in the population; and

16.5.3 provide value for money.

17. Complaints

17.1 The ICB will handle complaints made in respect of Primary Medical Services in accordance with the Complaints Regulations.

18. Commissioning ancillary support services

18.1 The ICB must procure, and undertake the management and monitoring of contracts for the provision of, such ancillary support services as are required to support the ICB in the effective discharge of the Delegated Functions, including, but not limited to the following:

18.1.1 collection and disposal of clinical waste;

18.1.2 provision of translation and interpretation services;

18.1.3 occupational health services for performers registered on the Performers List.

18.2 The arrangements for the provision of ancillary services to Primary Medical Services Providers are described in Schedule 7 (Local Terms).

19. Finance

Further requirements in respect of finance will be specified in Mandated Guidance.

20. Workforce

20.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel.

20.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

Schedule 2B: Dental Care Services

The provisions of this Schedule 2B form part of this Agreement only where indicated in the Particulars.

Part 1A: General Obligations – Primary Dental Services

1. Introduction

1.1 This Part 1A of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Primary Dental Services, being in summary:

1.1.1 decisions in relation to the commissioning and management of Primary Dental Services;

1.1.2 planning Primary Dental Services in the Area, including carrying out needs assessments;

1.1.3 undertaking reviews of Primary Dental Services in the Area;

1.1.4 management of the Delegated Funds in the Area;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for planning the commissioning of Primary Dental Services.

2.2 When planning and commissioning Primary Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.3 In respect of integrated working, the ICB must:

2.3.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, and other stakeholders;

2.3.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Dental Services generally; and

2.3.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.4 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations with regard to Dental Services Contracts:

2.4.1 to manage the Dental Services Contracts and perform all of NHS England's obligations under each of the Dental Services Contracts in accordance with the terms of the Dental Services Contracts as if it were named in the contract in place of NHS England;

2.4.2 working with other organisations, including the NHS Business Services Authority and the NHS England specialised commissioning team as appropriate, actively manage the performance of the Dental Services Provider in order to secure the needs of people who use the services,

improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.4.3 ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Dental Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local oral health needs;

2.4.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Dental Services Contracts;

2.4.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.4.6 keep a record of all of the Dental Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Dental Services Contract:

2.4.6.1 name of Dental Services Provider;

2.4.6.2 any practice or trading name by which the Dental Services Provider is known (if different to the name recorded under paragraph 2.4.6.1);

2.4.6.3 location of provision of services; and

2.4.6.4 amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.5 Without prejudice to clause 9 *(Finance)* or paragraph 2.4 above, the ICB must actively manage each of the relevant Dental Services Contracts including by:

2.5.1 reviewing and monitoring spending on services provided pursuant to Dental Services Contracts in the Area;

2.5.2 reviewing and monitoring spending on Primary Dental Services commissioned in the Area;

2.5.3 creating purchase orders, coding invoices and making appropriate amendments within the Compass contractor payments system;

2.5.4 managing the relevant Dental Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.5.5 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.5.6 managing variations to the relevant Dental Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.5.7 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.5.8 undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.5.9 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;

2.5.10 allocating sufficient resources for undertaking contract mediation; and

2.5.11 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.6 This paragraph is without prejudice to clause 10 *(Information, Planning and Reporting)* or any other provision in this Agreement. The ICB must provide NHS England with:

2.6.1 such information relating to individual providers of Primary Dental Services in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Dental Services;

2.6.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.6.3 any other data/data sets as required by NHS England; and

2.6.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 1B: General Obligations – Prescribed Dental Services (applicable only if Prescribed Dental Services are included in the Particulars)

1. Introduction

1.1 This Part 1B of Schedule 2B *(Dental Care Services)* sets out general provisions regarding the carrying out of those Delegated Functions relating to Prescribed Dental Services.

1.2 For the purposes of Paragraph 2.1 of this Part 1B of Schedule 2B *(Dental Care Services)*, the term "Population" refers to a group of people for whom the ICB has core responsibility, as established under the rules published by NHS England under section 14Z31 of the Act.

1.3 Community Dental Services are a form of Prescribed Dental Services. However, they may be governed by the terms of either an NHS Standard Contract or a PDS Agreement, as appropriate to the particular service. Accordingly:

1.3.1 where Community Dental Services are commissioned on PDS Agreement terms (or it is appropriate to commission any new PDS Agreement for such services), those contracts must be managed in accordance with the relevant provisions of Part 1A of this Schedule 2B as if they were Primary Dental Services for the purposes of that Part only. The provisions of this Part 1B of Schedule 2B also apply, with the exception of paragraphs 2.5.2 and 2.5.3; and

1.3.2 where Community Dental Services are commissioned on NHS Standard Contract terms, the provisions of this Part 1B of Schedule 2B apply in full.

2. General Obligations

2.1 NHS England may, by Contractual Notice, designate the ICB as the body responsible for commissioning Prescribed Dental Services for its Population and allocate Prescribed Dental Contracts to the ICB in accordance with clause 6.4 of this Agreement.

2.2 Each Contractual Notice referred to in paragraph 2.1 above will set out, in relation to each Prescribed Dental Services Contract, which rights, obligations and duties under that Presecribed Dental Services Contract are to be delegated to the ICB and which are to be retained by NHS England.

2.3 In respect of integrated working, the ICB must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Dental Professional Networks, Local Authorities, Healthwatch, acute and community providers, the Local Dental Committee, and other stakeholders.

2.4 When planning and commissioning Prescribed Dental Services, the ICB must comply with Mandated Guidance issued by NHS England.

2.5 In awarding any new contract for Prescribed Dental Services, the ICB must:

2.5.1 comply with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services);

2.5.2 subject to paragraph 1.3.1 of this Part 1B, use the current NHS Standard Contract published by NHS England from time to time; and

2.5.3 subject to paragraph 1.3.1 of this Part 1B, pay for the Services in accordance with the National Tariff or the NHS Payment Scheme (each as defined in the Health and Social Care Act 2012) as applicable from time to time.

Part 2: Specific Obligations – Primary Dental Services only

1. Introduction

1.1 This Part 2 of Schedule 2B *(Dental Care Services)* sets out further provision regarding the carrying out of each of the Delegated Functions in relation to Primary Dental Services.

2. Dental Services Contract Management

2.1 The ICB must:

2.1.1 comply with all current and future relevant national Mandated Guidance regarding contract reviews;

2.1.2 monitor contract performance and primary care dental spending, with a view in particular to achieving a reduction in the number of contract holders who are under-delivering, and the reallocation of unused resources to meet the oral health needs of the Area; and

2.1.3 in cooperation with the NHS Business Services Authority, monitor contract performance with a view in particular to addressing patient safety concerns and promoting patient safety.

2.2 The ICB must undertake the annual reconciliation of monies claimed by providers against the services provided under a GDS Contract, PDS Agreement and Personal Dental Services Plus Agreement procuring such ancillary support services as are required for the performance of this function.

3. Transparency and freedom of information

3.1 The ICB must:

3.1.1 respond to requests for information from members of the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

3.1.2 provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

4. Planning the Provider Landscape

4.1 The ICB must plan the provider landscape in the Area, including considering and taking decisions in relation to:

4.1.1 establishing new Dental Services Providers in the Area;

4.1.2 managing Dental Services Providers providing inadequate standards of patient care;

4.1.3 the procurement or award of new Dental Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and

4.1.4 closure of practices.

4.2 In relation to any new Dental Services Contract to be entered into, the ICB must, without prejudice to any obligation in paragraph 10 (Procurement and New Contracts), below:

4.2.1 consider and use the form of Dental Services Contract that will ensure compliance with NHS England's obligations under Law taking into account the persons to whom such Dental Services Contracts may be awarded;

4.2.2 provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

4.2.3 for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Dental Services Contracts.

5. Finance

5.1 Further requirements in respect of finance will be specified in Mandated Guidance.

6. Workforce

6.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

6.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

7. Integrating dentistry into communities at Primary Care Network level

7.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level.

8. Making Decisions in relation to Management of Poorly Performing Dental Services Providers

8.1 The ICB must make decisions in relation to the management of poorly performing Dental Services Provider including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the Performers List).

8.2 In accordance with paragraph 8.1 above, the ICB must:

8.2.1 ensure regular and effective collaboration with the CQC to ensure that information is shared and discussed in an appropriate and timely manner;

8.2.2 ensure that any risks identified are managed and escalated where necessary;

8.2.3 respond to CQC assessments of Dental Services Providers where improvement is required;

8.2.4 where a Dental Services Provider is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

8.2.5 take appropriate contractual action, including (without limitation) in response to CQC findings.

9. Maintaining the Performers List

9.1 On receiving a notice from a practitioner (who is party to a Dental Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the Performers List as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

10. Procurement and New Contracts

10.1 Until any new arrangements for awarding Dental Services Contracts comes into force, the ICB will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

10.2 In discharging its responsibilities set out in this Schedule 2B, the ICB must comply at all times with Law and all relevant Guidance (including any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services).

10.3 On the coming into force of new arrangements for awarding Dental Services Contracts, the ICB will make decisions on awarding new contracts relevant to the exercise of the Delegated Functions.

10.4 When the ICB makes decisions in connection with the awarding of Dental Services Contracts it should ensure that it is able to demonstrate compliance with requirements for the award of Dental Services Contracts, including that the decision was:

10.4.1 made in the best interest of patients, taxpayers and the population;

10.4.2 robust and defensible, with conflicts of interests appropriately managed;

10.4.3 made transparently, and

10.4.4 compliant with the rules of the regime as set out in NHS England guidance.

11. Complaints

11.1 The ICB will handle complaints made in respect of Primary Dental Services in accordance with the Complaints Regulations.

12. Commissioning Ancillary Support Services

12.1 The arrangements for the provision of ancillary services to Primary Dental Services Providers are described in Schedule 7 (Local Terms).

Schedule 2C: Primary Ophthalmic Services

The provisions of this Schedule 2C form part of this Agreement only where indicated in the Particulars.

Part 1: General Obligations

1. Introduction

1.1 This Part 1 of Schedule 2C *(Primary Ophthalmic Services)* sets out general provisions regarding the carrying out of the Delegated Functions, being, in summary:

1.1.1 decisions in relation to the management of Primary Ophthalmic Services;

1.1.2 undertaking reviews of Primary Ophthalmic Services in the Area;

1.1.3 management of the Delegated Funds in the Area;

1.1.4 co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and

1.1.5 such other ancillary activities that are necessary in order to exercise the Delegated Functions.

2. General Obligations

2.1 The ICB is responsible for managing the provision of Primary Ophthalmic Services.

2.2 When carrying out Delegated Functions in respect of Primary Ophthalmic Services, the ICB must comply with all Mandated Guidance issued by NHS England.

2.3 The role of the ICB includes identifying and seeking to address any unmet needs which may be met through the delivery of Primary Ophthalmic Services.

2.4 In respect of integrated working, the ICB must:

2.4.1 take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Eye Health Networks, Local Authorities, Healthwatch, acute and community providers, Local Optical Committees, and other stakeholders;

2.4.2 work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Primary Ophthalmic Services generally; and

2.4.3 work with NHS England to coordinate the exercise of their respective performance management functions.

2.5 In relation to the Delegated Functions, the ICB agrees to perform the following general obligations:

2.5.1 to manage the Primary Ophthalmic Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Ophthalmic Services Contracts in accordance with the terms of the Primary Care Contracts as if it were named in the contract in place of NHS England;

2.5.2 working with other organisations, including the NHS Business Services Authority and NHS England as appropriate, actively manage the performance of the Primary Ophthalmic Services Provider in order to secure the needs of people who use the services, improve the quality of services

and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches, serve notices or provide discretionary support;

2.5.3 ensure that it obtains value for money on behalf of NHS England and avoids making any double payments under any Primary Ophthalmic Services Contracts;

2.5.4 notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the ICB of its obligations to perform any of NHS England's obligations under the Primary Ophthalmic Services Contracts;

2.5.5 undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

2.5.6 keep a record of all of the Primary Ophthalmic Services Contracts that the ICB manages on behalf of NHS England setting out the following details in relation to each Primary Ophthalmic Services Contract:

2.5.6.1 name of the Primary Ophthalmic Services Provider;

2.5.6.2 any practice or trading name by which the Primary Ophthalmic Services Provider is known (if different to the name recorded under paragraph 2.5.6.1);

2.5.6.3 location of provision of services; and

2.5.6.4 amounts payable under the Primary Ophthalmic Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.6 Without prejudice to clause 9 *(Finance)* or paragraph 2.5 above, the ICB must actively manage each of the relevant Primary Ophthalmic Services Contracts including by:

2.6.1 managing the relevant Primary Ophthalmic Services Contract, including in respect of quality standards, incentives, observance of service specifications, and monitoring of activity and finance;

2.6.2 assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.6.3 managing variations to the relevant Primary Ophthalmic Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.6.4 agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

2.6.5 conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.6.6 complying with and implementing any relevant Mandated Guidance issued from time to time.

2.7 This paragraph is without prejudice to clause 10 (Information, Planning and Reporting) or any other provision in this Agreement. The ICB must provide NHS England with:

2.7.1 such information relating to individual providers of Primary Ophthalmic Services in the Area as NHS England may reasonably request, to ensure

that NHS England is able to continue to gather national data regarding the commissioning or performances of providers of Primary Ophthalmic Services;

2.7.2 such data/data sets as required by NHS England to ensure population of any national dashboards;

2.7.3 any other data/data sets as required by NHS England; and

2.7.4 the ICB shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

Part 2: Specific Obligations

3. Introduction

3.1 This Part 2 of Schedule 2C *(Primary Ophthalmic Services)* sets out further provision regarding the carrying out of each of the Delegated Functions.

4. Primary Ophthalmic Services Contract Management

4.1 The ICB must:

4.1.1 comply with all current and future relevant national Mandated Guidance regarding General Ophthalmic Contract reviews and any other contract reviews;

4.1.2 take on the responsibility for existing services provided pursuant to a Primary Ophthalmic Services Contract, and for commissioning new services;

4.1.3 assume the responsibility for the award of new Primary Ophthalmic Services Contracts; and

4.1.4 monitor contract performance with a view to achieving assurance and improvement in the delivery of services in the context of the ICB;

in each case acknowledging that the NHS Business Services Authority provides end-to-end support services in relation to these functions, as referred to in Schedule 6. The ICB accordingly agrees to co-operate with the NHS Business Services Authority in the delivery of these functions.

5. Transparency and freedom of information

5.1 The ICB must:

5.1.1 Respond to requests for information from members and the public and the media, including requests made pursuant to the FOIA, whose subject-matter relates to the performance of the Delegated Functions in the ICB's Area; and

5.1.2 Provide information and assistance as required to support NHS England in the preparation of responses to parliamentary questions in connection with the Delegated Functions.

6. Maintaining the Performers List

6.1 On receiving a notice from a practitioner (who is party to a Primary Ophthalmic Services Contract) of an amendment to information recorded about them in the Performers List, pursuant to regulation 9(1) of the National Health Service (Performers Lists) (England) Regulations 2013, the ICB must support NHS England's amendment of the performers list as soon as possible after receiving the notice using the Primary Care Support services provided by NHS England, insofar as that amendment relates to a change in contractor details.

7. Finance

7.1 Further requirements in respect of finance will be specified in Mandated Guidance.

8. Workforce

8.1 The arrangements for the provision and maintenance of sufficient and appropriately qualified, trained and experienced Staff in order for the ICB to fulfil its responsibilities for each of the Delegated Functions ("the Staffing Model"), will be communicated formally to the ICB by NHS England following recommendations made by the National Moderation Panel. Further requirements in respect of workforce will be specified in Mandated Guidance.

8.2 The ICB is not permitted to vary the Staffing Model agreed with NHS England as part of its application for delegation of the said functions however a variation can be applied for by the ICB and considered by the National Moderation Panel at any time.

9. Integrating optometry into communities at Primary Care Network level

9.1 The ICB must exercise the Delegated Functions with a view to achieving greater integration of optometrists into the Integrated Care System at the Primary Care Network level.

10. Complaints

10.1 The ICB will handle complaints made in respect of primary ophthalmic services in accordance with the Complaints Regulations.

11. Commissioning ancillary support services

11.1 The arrangements for the provision of ancillary services to Primary Ophthalmic Services Providers are described in Schedule 7 (Local Terms).

Schedule 2D: Delegated Functions – Pharmaceutical Services

The provisions of this Schedule 2D form part of this Agreement only where indicated in the Particulars.

1. In this Schedule, the following additional definitions shall apply:

Advanced Services	has the meaning given to that term by the Pharmaceutical Regulations
Conditions of Inclusion	means those conditions set out at Part 9 of the Pharmaceutical Regulations
Delegated Pharmaceutical Functions	the functions set out at paragraph 2 of this Schedule
Designated Commissioner	has the meaning given to that term at paragraph 2.3 of this Schedule
Dispensing Doctor	has the meaning given to that term by the Pharmaceutical Regulations
Dispensing Doctor Decisions	means decisions made under Part 8 of the Pharmaceutical Regulations
Dispensing Doctor Lists	has the meaning given to that term by the Pharmaceutical Regulations
Drug Tariff	has the meaning given to that term by the Pharmaceutical Regulations
Electronic Prescription Service	has the meaning given to that term by the Pharmaceutical Regulations
Enhanced Services	has the meaning given to that term by the Pharmaceutical Regulations
Essential Services	is to be construed in accordance with paragraph 3 of Schedule 4 to the Pharmaceutical Regulations
Fitness to Practise Functions	has the meaning given to that term at paragraph 2.1.10 of this Schedule
Locally Commissioned Services	means services which are not Essential Services, Advanced Services, Enhanced Services or services commissioned under an LPS Scheme
LPS Chemist	has the meaning give to that term by the Pharmaceutical Regulations
LPS Scheme	has the meaning given to that term by Paragraph 1(2) of Schedule 12 to the NHS Act
NHS Chemist	has the meaning given to that term by the Pharmaceutical Regulations

Pharmaceutical Lists	has the meaning given to that term at paragraph 2.1.1. of this Schedule and any reference to a Pharmaceutical List should be construed accordingly
Pharmaceutical Regulations	means the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and reference to a Regulation refers to a provision of the Pharmaceutical Regulations, unless otherwise stated
Rurality Decisions	means decisions made under Part 7 of the Pharmaceutical Regulations
Terms of Service	means the terms upon which, by virtue of the Pharmaceutical Regulations, a person undertakes to provide Pharmaceutical Services

Delegated Pharmaceutical Functions

2. Except in so far as they fall within the scope of the Reserved Functions, and subject to paragraphs 2.2, 2.3, 4 and 5, the ICB agrees to perform the following functions of NHS England in respect of the Area (the "Delegated Pharmaceutical Functions"), in all cases in accordance with relevant Law, Mandated Guidance and other Guidance:

2.1.1. preparing, maintaining and submitting for publication by NHS England lists of persons, other than medical practitioners or dental practitioners, who have undertaken to provide pharmaceutical services from premises situated within the Area[3], specifically:

2.1.1.1. lists of persons who have undertaken to provide pharmaceutical services in particular by way of the provision of drugs;

2.1.1.2. lists of persons who have undertaken to provide pharmaceutical services only by way of the provision of appliances; and

2.1.1.3. lists of persons participating in the Electronic Prescription Service[4]

collectively referred to in this Schedule as the "Pharmaceutical Lists". In doing so, it is sufficient for the lists referred to at paragraphs 2.1.1.1 and 2.1.1.2 to include a marker showing which persons are also participating in the Electronic Prescription Service, rather than preparing a separate list for the purposes of paragraph 2.1.1.3.

2.1.2. managing and determining applications by persons for inclusion in a Pharmaceutical List[5];

[3] Including (without limitation) updates to those lists following any removal under regulation 115 of the Pharmaceutical Regulations
[4] Regulation 10 of the Pharmaceutical Regulations
[5] Schedule 2 of the Pharmaceutical Regulations

2.1.3. managing and determining applications by persons included in a Pharmaceutical List;

2.1.4. responsibilities for financial resources related to the Delegated Pharmaceutical Functions as described in Mandated Guidance issued by NHS England;

2.1.5. overseeing the compliance of those included in the Pharmaceutical Lists with:

2.1.5.1. their Terms of Service and identifying and investigating breaches, including possible breaches, of those terms;

2.1.5.2. relevant Conditions of Inclusion; and

2.1.5.3. requirements of the Community Pharmacy Contractual Framework.

2.1.6. exercising powers in respect of Performance Related Sanctions and Market Exit[6];

2.1.7. exercising all other rights, and complying with all other obligations, of NHS England in respect of the Terms of Service and Conditions of Inclusion of those included in the Pharmaceutical Lists;

2.1.8. communicating to those included in the Pharmaceutical Lists any announcement made by NHS England modifying Terms of Service of any person included in the Pharmaceutical Lists as a consequence of a disease being, or in anticipation of a disease being imminently:

2.1.8.1. pandemic; and

2.1.8.2. a serious risk or potentially a serious risk to human health[7];

2.1.9. communicating to those included in the Pharmaceutical Lists any other matters which NHS England may require the ICB to communicate from time to time;

2.1.10. performing functions in respect of the disqualification of practitioners, and related measures concerning a practitioners inclusion in the Pharmaceutical Lists, set out in Chapter 6 of Part 7 to the NHS Act and the provisions of the Pharmaceutical Regulations made under that Chapter ("the Fitness to Practise Functions");

2.1.11. performing functions in respect of enforcement, reviews and appeals relating to the Fitness to Practise Functions[8];

2.1.12. making LPS Schemes[9], subject to the requirements of paragraph 5;

2.1.13. overseeing the compliance of those who are party to Local Pharmaceutical Services Contracts with the terms of those contracts and identifying and investigating breaches, including possible breaches, of the terms of those contracts;

2.1.14. exercising all rights, and complying with all obligations, of NHS England under Local Pharmaceutical Services Contracts;

2.1.15. determining LPS matters[10] in respect of LPS Schemes;

2.1.16. determining Rurality Decisions and other rurality matters[11];

2.1.17. determining Dispensing Doctor Decisions[12];

[6] Part 10 of the Pharmaceutical Regulations
[7] Regulation 11(3) of the Pharmaceutical Regulations
[8] Part 11 of the Pharmaceutical Regulations
[9] Section 134 NHS Act and Part 13 of the Pharmaceutical Regulations.
[10] Part 13 of the Pharmaceutical Regulations
[11] Part 7 of the Pharmaceutical Regulations
[12] Part 8 of the Pharmaceutical Regulations

2.1.18. preparing and maintaining Dispensing Doctor Lists[13];

2.1.19. making arrangements for the provision of adequate pharmaceutical service delivery across the ICB area;

2.1.20. making arrangements for the delivery of Essential Services, Advanced Services and Enhanced Services;

2.1.21. supporting implementation and delivery of all elements of the Community Pharmacy Contractual Framework;

2.1.22. consulting with patients, the public and other stakeholders to the extent required by the duty of public involvement and consultation under section 14Z45 of the NHS Act;

2.1.23. responding to Appeals to the Secretary of State and First Tier Tribunal in respect of the Delegated Pharmaceutical Functions[14];

2.1.24. responding to Claims in respect of the Delegated Pharmaceutical Functions;

2.1.25. recovering overpayments from NHS Chemists, LPS Chemists, Dispensing Doctors and Primary Medical Services Providers[15];

2.1.26. bringing any legal proceedings in respect of the Delegated Pharmaceutical Functions;

2.1.27. making any notifications to, and consulting with, third parties in respect of the Delegated Pharmaceutical Functions;

2.1.28. recognising one or more Local Pharmaceutical Committees which it considers are representative of Pharmaceutical Services Providers in the ICB's Area and liasing with and consulting such Local Pharmaceutical Committees as required by the Pharmaceutical Regulations;

2.1.29. commissioning the provision of NHS Smartcards to Pharmaceutical Services Providers and their staff by registration authorities;

2.1.30. making any payments due to NHS Chemists suspended from a Pharmaceutical List in accordance with the determination made by the Secretary of State in respect of such payments; and

2.1.31. undertaking any investigations relating (among other things) to whistleblowing claims (relating to a superintendent pharmacist, a director or the operation of a pharmacy contractor), infection control and patient complaints.

2.2. Where the Area comprises the areas of two or more Health and Wellbeing Boards in their entirety:

2.2.1. the Delegated Pharmaceutical Functions shall be exercised so as to maintain separately in respect of each Health and Wellbeing Board area:

2.2.1.1. Pharmaceutical Lists in respect of premises in that Health and Wellbeing Board area;

2.2.1.2. a list of LPS Chemists providing local pharmaceutical services at or from premises in that Health and Wellbeing Board area[16]; and

2.2.1.3. a Dispensing Doctor List (together the "Relevant Lists"); and

[13] Regulation 46 of the Pharmaceutical Regulations
[14] Schedule 3 of the Pharmaceutical Regulations
[15] Regulation 94 of the Pharmaceutical Regulations
[16] Regulation 114 of the Pharmaceutical Regulations

2.2.2. the ICB shall comply with such Contractual Notices as NHS England may issue from time to time concerning the arrangements for the exercise of the Delegated Pharmaceutical Functions across two or more Health and Wellbeing Board areas.

2.3. Where the Area comprises part of the area of a Health and Wellbeing Board (the "Relevant Health and Wellbeing Board"):

2.3.1. NHS England shall by Contractual Notice designate:

2.3.1.1. the ICB;

2.3.1.2. another ICB whose area comprises in part the area of the Relevant Health and Wellbeing Board; or

2.3.1.3. NHS England;

as the body responsible for maintaining the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board ("the Designated Commissioner");

2.3.2. the ICB shall exercise the Delegated Pharmaceutical Functions in respect of that part of the Relevant Health and Wellbeing Board's area that falls within the Area but in doing so shall liaise with any Designated Commissioner for the purposes of maintaining the accuracy of the Relevant Lists (as defined in paragraph 2.2.1 of this Schedule 2D) in respect of the Relevant Health and Wellbeing Board; and

2.3.3. the ICB shall comply with all Contractual Notices issued by NHS England for the purposes of determining responsibilities in the circumstances described in this paragraph 3.3.

Prescribed Support

3. Notwithstanding the inclusion of the following within the Delegated Functions, the ICB shall discharge the functions set out at:
   3.1. Paragraph 3.1.1 (maintaining Pharmaceutical Lists)
   3.2. Paragraph 3.1.2 (managing applications for inclusion)
   3.3. Paragraph 3.1.3 (managing applications from those included in a list)
   3.4. Paragraph 3.1.5 (overseeing compliance with Terms of Service and Conditions of Inclusion)
   3.5. Paragraph 3.1.10 (Fitness to Practise)
   3.6. Paragraph 3.1.18 (maintaining and publishing Dispensing Doctors Lists)
   3.7. Paragraph 3.1.25 (recovery of overpayments)

   with the assistance and support of the NHS Business Services Authority, Primary Care Support England or such other person as NHS England shall designate by Contractual Notice for these purposes from time to time and in accordance with the allocation of operational responsibilities described by NHS England in Mandated Guidance.

LPS Schemes

4. The ICB shall not without the prior written consent of NHS England make any new LPS Schemes.

Barred Persons

5. The ICB must ensure that persons barred from involvement in specific elements of the Delegated Functions are excluded from such involvement in accordance with the Pharmaceutical Regulations.

Other Services

6. The provisions of this schedule are without prejudice to the ability of the ICB to make arrangements for the provision of Locally Commissioned Services for the purposes of the NHS in accordance with its own commissioning functions and using its own financial resources.

Payments

7. In exercising the Delegated Pharmaceutical Functions, the ICB must ensure that:

    7.1. all payments to which the Drug Tariff applies are made solely in accordance with the Drug Tariff; and

    7.2. any other payments for services (including without limitation those relating to LPS Schemes and Enhanced Services) are made in accordance with recognised contractual mechanisms intended to apply to those services.

Flu vaccinations

8. The Parties acknowledge and agree that:

    8.1. responsibility for arranging any national scheme for flu vaccinations remains with NHS England as part of its Section 7A Functions; and

    8.2. where any such national scheme is arranged by NHS England, the ICB is required to commission flu vaccines as Advanced Services. For the purposes of this Agreement, this forms part of the ICB's responsibilities under clause 9.20.

Integration

9. In respect of integrated working, the ICB must:

    9.1.1. take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Authorities, Healthwatch, acute and community providers, professional representative groups, contractor representative groups and other stakeholders;

    9.1.2. work with NHS England and other ICBs to co-ordinate a common approach to the commissioning of Pharmaceutical Services generally; and

    9.1.3. work with NHS England to coordinate the exercise of their respective performance management functions.

Integrating pharmacy into communities at Primary Care Network level

10. The ICB must exercise the Delegated Functions with a view to achieving greater integration of community pharmacy into the Integrated Care System at the Primary Care Network level including participation in network governance arrangements.

Complaints

11. The ICB will handle complaints made in respect of Pharmaceutical Services and Local Pharmaceutical Services in accordance with the Complaints Regulations.

Commissioning ancillary support services

12. The arrangements for the provision of ancillary services to Pharmaceutical Services Providers are described in Schedule 7 (Local Terms).

13. **Finance**

    13.1. Further requirements in respect of finance will be specified in Mandated Guidance.

14. **Workforce**

    14.1. Further requirements in respect of workforce will be specified in Mandated Guidance.

SCHEDULE 3

Reserved Functions

1. Introduction

1.1 In accordance with clause 8.4 of this Agreement, all functions of NHS England other than those defined as Delegated Functions are Reserved Functions.

1.2 This SCHEDULE 3 (Reserved Functions) sets out further provision regarding the carrying out of the Reserved Functions.

1.3 The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

2. Management of the national performers list

2.1 Subject to Paragraph 2.2, NHS England will continue to perform its functions under the National Health Service (Performers Lists) (England) Regulations 2013.

2.2 The ICB will carry out administrative tasks in respect of the Performers Lists as described at:

2.2.1 Paragraph 9 of Part 2, Schedule 2A;

2.2.2 Paragraph 9 of Part 2, Schedule 2B; and

2.2.3 Paragraph 6 of Part 2, Schedule 2C.

2.3 NHS England's functions in relation to the management of the national performers list include:

2.3.1 considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

2.3.2 identifying, managing and supporting primary care performers where concerns arise; and

2.3.3 managing suspension, imposition of conditions and removal from the national performers list.

2.4 NHS England may hold local Performance Advisory Group ("PAG") meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

2.5 NHS England may notify the ICB of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the ICB to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.

2.6 The ICB must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The ICB will comply with any Mandated Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

3. Management of the revalidation and appraisal process

3.1 NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

3.2 All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

3.2.1 the funding of GP appraisers;

3.2.2 quality assurance of the GP appraisal process; and

3.2.3 the responsible officer network.

3.3 Funding to support the GP appraisal is incorporated within the global sum payment to Primary Medical Services Provider.

3.4 The ICB must not remove or restrict the payments made to Primary Medical Services Provider in respect of GP appraisal.

3.5 Appraisal arrangements in respect of all other primary care practitioner groups shall also be Reserved Functions.

4. Administration of payments and related performers list management activities

4.1 NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

4.2 NHS England may continue to pay practitioners who are suspended from the national performers list in accordance with relevant determinations made by the Secretary of State.

4.3 For the avoidance of doubt, the ICB is responsible for any ad hoc or discretionary payments to Primary Medical Services Providers (including those under section 96 of the NHS Act) in accordance with SCHEDULE 2 (Delegated Functions) Part 1 paragraphs 7.1 and 7.2 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

5. Section 7A and Capital Expenditure Functions

5.1 In accordance with clause 9.18, NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

5.2 In accordance with clauses 9.20 and 9.21, the ICB will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

5.3 In accordance with clause 9.14**Error! Reference source not found.**, NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

5.4 In accordance with clauses 9.16 and 9.17, the ICB will provide certain management and/or administrative services to NHS England in relation to the Capital Expenditure Functions.

6. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

6.1 NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.2 The ICB must assist NHS England's controlled drug accountable officer ("CDAO") to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.3 The ICB must nominate a relevant senior individual within the ICB (the "ICB CD Lead") to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

6.4 The ICB CD Lead must, in relation to the Delegated Functions:

6.4.1 on request provide NHS England's CDAO with all reasonable assistance in any investigation involving the Delegated Functions;

6.4.2 report all complaints involving controlled drugs to NHS England's CDAO;

6.4.3 report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England's CDAO;

6.4.4 analyse the controlled drug prescribing data available; and

6.4.5 on request supply (or ensure organisations from whom the ICB commissions services involving the regular use of controlled drugs supply) periodic self–declaration and/or self-assessments to NHS England's CDAO.

7. Reserved Functions – Primary Medical Services

7.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Medical Services Functions"):

7.1.1 determining the outcomes expected from Primary Medical Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes and the Department of Health and Social Care mandate;

7.1.2 designing and delivering national transformation programmes in support of national priorities;

7.1.3 the negotiation and agreement of matters concerning General Medical Services contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary medical services nationally;

7.1.4 the development of national standard Primary Medical Service contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Medical Services providers;

7.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties;

7.1.6 the provision of nationally contracted services delivering digital, logistical and support services for Primary Medical Services in England (including but not limited to):

7.1.6.1 Payments;

7.1.6.2 Pensions;

7.1.6.3 Patient Registration;

7.1.6.4 Medical Records;

7.1.6.5 Performer List;

7.1.6.6 Supplies;

7.1.6.7 Call and Recall for Cervical screening (CSAS); and

7.1.6.8 Pharmacy Market Management.

7.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

8. Reserved Functions – Primary Dental Services

8.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Primary Dental Services Functions"):

8.1.1 determining the outcomes expected from Primary Dental Services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes; designing and delivering national transformation programmes in line with any applicable commissioning policies and guidance;

8.1.2 the negotiation and agreement of matters concerning Dental Services Contracts with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of primary dental services nationally;

8.1.3 the development of national standard Dental Service Contracts and national contract variations and guidance to ensure an equitable approach to applying nationally agreed changes to all Primary Dental Services providers;

8.1.4 the provision of all dental commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

8.1.5 the provision of nationally contracted services delivering digital, logistical and support services for Primary Dental Services in England (including but not limited to):

8.1.5.1 Payments;

8.1.5.2 Pensions;

8.1.5.3 Performer List; and

8.1.5.4 Market Management.

8.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

9. Reserved Functions – Primary Ophthalmic Services

9.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Ophthalmic Functions"):

9.1.1 the Primary Ophthalmic Services Contracts policy and associated documentation;

9.1.2 the negotiation and agreement of matters concerning Primary Ophthalmic Services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Ophthalmic Services nationally; and

9.1.3 the provision of nationally contracted services delivering digital, logistical and support services for Primary Ophthalmic Services in England (including but not limited to):

9.1.3.1 Payments;

9.1.3.2 Performers List;

9.1.3.3 Market Management/Entry; and

9.1.3.4 Contract management, assurance and post-payment verification.

9.2 The ICB will work collaboratively with NHS England, and will support and assist those nationally contracted services to carry out their services.

10. Reserved Functions – Pharmaceutical Services and Local Pharmaceutical Services

10.1 The following functions and related activities shall continue to be exercised by NHS England (the "Reserved Pharmaceutical Functions"):

10.1.1 publication of Pharmaceutical Lists;

10.1.2 functions of NHS England as a determining authority in relation to pharmaceutical remuneration under Part 12 of the Pharmaceutical Regulations;

10.1.3 functions in respect of lists of performers of pharmaceutical services and assistants, noting that as at the date of this Agreement regulations for the purposes of these functions have not been made[17];

10.1.4 the negotiation and agreement of matters concerning NHS pharmaceutical services with national stakeholders including, without limitation, the Department of Health and Social Care and bodies representing providers of Pharmaceutical Services nationally;

10.1.5 the provision of commissioning and contracting policy and guidance to support ICBs to meet their delegated duties; and

10.1.6 administration of the pharmacist pre-registration training grant scheme.

[17] Part 7, Chapter 4A of the NHS Act (not currently in force)

SCHEDULE 4

Further Information Governance and Sharing Provisions

1. Introduction

1.1. The purpose of this Schedule 4 *(Further Information Governance and Sharing Provisions)* and the Personal Data Agreement at the Annex is to set out the scope for the secure and confidential sharing of information between the Parties on a **Need To Know** basis, in order to enable the Parties to exercise their functions in pursuance of this Agreement.

1.2. References in this Schedule 4 *(Further Information Governance and Sharing Provisions)* to the **Need to Know** basis or requirement (as the context requires) should be taken to mean that the Data Controllers' personnel will only have access to Personal Data or Special Category Personal Data if it is lawful for such personnel to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3. This Schedule and the Personal Data Agreement is designed to:

1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Parties;

1.3.2. describe the purposes for which the Parties have agreed to share Relevant Information;

1.3.3. set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;

1.3.4. describe roles and structures to support the exchange of Relevant Information between the Parties;

1.3.5. apply to the sharing of Relevant Information relating to

1.3.5.1. Primary Care Providers and Primary Care Provider Personnel; and

1.3.5.2. Dental Services Providers and their personnel;

1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8. apply to the activities of the Parties' personnel; and

1.3.9. describe how complaints relating to Personal Data sharing between the Parties will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as described in this Agreement.

2.2. Specific and detailed purposes are set out in the Personal Data Agreement annexed to this Schedule.

3. Benefits of information sharing

3.1. The benefits of sharing information are the achievement of the Specified Purpose set out above, with benefits for service users and other stakeholders in terms of the improved local delivery of Primary Care Services and Primary Dental Services.

4. Lawful basis for Sharing

4.1. Each Party shall comply with all relevant Information Law requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Parties shall identify the lawful basis for sharing Relevant Information for each purpose and data flow, and document these in the Personal Data Agreement annexed to this Schedule.

5. Relevant Information to be shared

5.1. The Relevant Information to be shared is set out in the Personal Data Agreement annexed to this Schedule.

6. Restrictions on use of the Shared Information

6.1. Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose, and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

6.2. Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Information Law requirements, and the parties' personnel should only have access to Personal Data on a justifiable **Need to Know** basis.

6.3. Neither the provisions of this Schedule 4 *(Further Information Governance and Sharing Provisions)* nor the Personal Data Agreement annexed to this Schedule should be taken

to permit unrestricted access to data held by any Party. It lays the parameters for the safe and secure sharing and processing of information on a justifiable **Need to Know** basis.

6.4. Neither Party shall subcontract any processing of the Relevant Information without the prior written consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

6.5. Neither Party shall cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

6.6. Any particular restrictions on use of certain Relevant Information are included in the Personal Data Agreement annexed to this Schedule.

7. Ensuring fairness to the Data Subject

7.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Parties will take the following measures:

7.1.1. amendment of internal guidance to improve awareness and understanding among personnel;

7.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

7.1.3. ensuring that information and communications relating to the processing of data is easily accessible and easy to understand, and that clear and plain language be used; and

7.1.4. giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

7.2. Each Party shall procure that its notification to the Information Commissioner's Office and record of processing maintained for the purposes of Article 30 UK GDPR reflects the flows of information under this Agreement.

7.3. Each Party shall reasonably cooperate with the other in undertaking any Data Protection Impact Assessment associated with the processing of data further to this Agreement, , and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

7.4. Further provision in relation to specific data flows is included in the Personal Data Agreement annexed to this Schedule.

8. Governance: personnel

8.1. Each Party must take reasonable steps to ensure the suitability, reliability, training and competence, of any personnel who have access to the Personal Data (and Special Category Personal Data) including reasonable background checks and evidence of completeness should be available on request by each Party.

8.2. The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Parties' personnel are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing Parties must procure that personnel operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

8.3. Each Party shall ensure that all personnel required to access the Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data and each Party shall include appropriate confidentiality clauses in employment/service contracts of all personnel that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Information Law requirements, or causes damage to or loss of the Relevant Information.

8.4. Each Party shall provide evidence (further to any reasonable request) that all personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Information Law and this Agreement.

8.5. Each Party shall ensure that:

8.5.1. only those personnel involved in delivery of the Agreement use or have access to the Relevant Information; and

8.5.2. that such access is granted on a strict **Need to Know** basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller. These access controls are set out in the Personal Data Agreement annexed to this Schedule; and

8.5.3. specific limitations on the personnel who may have access to the Information are set out in the Personal Data Agreement annexed to this Schedule.

9. Governance: Protection of Personal Data

9.1. At all times, the Parties shall have regard to the requirements of Information Law and the rights of Data Subjects.

9.2. Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by Parties, without the need to share easily identifiable Personal Data. The Parties shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data/Special Category Personal Data.

9.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a **Need to Know** basis. If either Party:

9.3.1. becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

9.3.2. becomes aware of any security vulnerability or breach,

in respect of the Relevant Information it shall promptly (and within 48 hours) notify the other Party. The Parties shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Information Law.

9.4. In processing any Relevant Information further to this Agreement, each Party shall:

9.4.1. process the Personal Data (including Special Category Personal Data) only in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

9.4.2. process the Personal Data (including Special Category Personal Data) only to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

9.4.3. process the Personal Data (including Special Category Personal Data) only in accordance with Information Law requirements and shall not perform its obligations under this Agreement in such a way as to cause any other Data Controller to breach any of their applicable obligations under Information Law; and

9.4.4. process the Personal Data in accordance with the requirements of Information Law and in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR.

9.5. Each Party shall act generally in accordance with Information Law requirements, and in particular shall implement, maintain and keep under review appropriate technical and organisational measures to ensure and to be able to demonstrate that the processing of Personal Data is undertaken in accordance with Information Law, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised

or unlawful processing and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

9.5.1. Take account of the nature, scope, context and purposes of processing as well as the risks of varying likelihood and severity for the rights and freedoms of Data Subjects; and

9.5.2. Be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data (and Special Category Personal Data) and having regard to the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

9.6. In particular, each Party shall:

9.6.1. ensure that only personnel authorised under this Agreement have access to the Personal Data (and Special Category Personal Data);

9.6.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

9.6.3. obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party;

9.6.4. permit the other Party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

9.6.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

9.7. Each Party shall adhere to the specific requirements as to information security set out in the Personal Data Agreement.

9.8. Each Party shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

9.9. The Parties' Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below will be the persons who, in the first instance, will have oversight of third party security measures.

10. Governance: Transmission of Information between the Parties

10.1. This paragraph supplements paragraph 9 *(Governance: Protection of Personal Data)* of this Schedule.

10.2. Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net / gcsx) email.

10.3. Wherever possible, Personal Data should be transmitted (and held) in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record / data is identified.

10.4. Any other special measures relating to security of transfer are specified in the Personal Data Agreement annexed to this Schedule.

10.5. Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

10.6. The Parties' Single Point of Contact notified pursuant to paragraph 14 *(Governance: Single Points of Contact)* will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

11. Governance: Quality of Information

11.1. The Parties will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11.2. Special measures relating to ensuring quality are set out in the Personal Data Agreement annexed to this Schedule.

12. Governance: Retention and Disposal of Shared Information

12.1. The non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

12.2. Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, if requested by the other Party and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

12.3. If either Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy under this paragraph 12 *(Governance: Retention and Disposal of Shared Information)*, it shall notify the other Party in writing of that retention, giving details of the documents or materials that it must retain.

12.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

12.5. Any special retention periods are set out in the Personal Data Agreement annexed to this Schedule.

12.6. Each Party shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

12.7. Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

12.8. Electronic records will be considered for deletion once the relevant retention period has ended.

12.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

13. Governance: Complaints and Access to Personal Data

13.1. Each Party shall assist the other in responding to any request made under Information Law made by persons who wish to access copies of information held about them ("**Subject Access Requests**"), as well as any other purported exercise of a Data Subject's rights under Information Law or complaint to or investigation undertaken by the Information Commissioner.

13.2. Complaints about information sharing shall be routed through each Party's own complaints procedure but reported to the Single Points of Contact set out in paragraph 14 *(Governance: Single Points of Contact)* below.

13.3. The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Agreement or any data processing carried out further to it.

13.4. Basic details of the Agreement shall be included in the appropriate log under each Party's Publication Scheme.

14. Governance: Single Points of Contact

14.1. The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance. Details of the single points of contact shall be set out in the Personal Data Agreement.

15. Monitoring and review

15.1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Information Law and best practice. Specific monitoring requirements are set out in the Personal Data Agreement annexed to this Agreement.

Annex

Template Personal Data Agreement

Data flow subject matter: [Description]
Data flow duration: *The duration of the delegation arrangement* **[OR Insert alternative period]**
Nature and purpose of processing: *Described in the Delegation Agreement at Schedule 4 paragraph 2.1 above*

Description of information flow and Single Points of Contact for parties involved

Originating Data Controller	[Insert:]			
Contact details for Single Point of Contact for Originating Data Controller	**Name of point of contact**	**Title**	**Contact (email)**	**Contact (phone)**
Recipient Data Controller	[Insert:]			
Contact details for Single Point of Contact of Recipient Data Controller	**Name of point of contact**	**Title**	**Contact (email)**	**Contact (phone)**

Description of information to be shared

Comprehensive description of Relevant Information to be shared – including the type(s) of personal data to be shared and categories of personal data	[Insert:]
Anonymised / not information about individual persons	**Yes / No**
Strongly pseudonymised	**Yes / No**

Weakly pseudonymised	**Yes / No**
Person -identifiable data	**Yes / No**
Justification for the level of identifiability required	[Insert or N/A:]

Legal basis for disclosure and use

GDPR Article 6 Legitimising Condition/s	[Insert or N/A:]	
GDPR Article 9 Exemption/s	[Insert or N/A:]	
Confidentiality	**Explicit consent**	Yes / No [If yes, how documented?:]
	Implied Consent	Yes / No [If yes, how have you implied consent?:]
	Statutory required/permitted disclosure	[Insert statutory basis:]
	Public interest disclosure	[Insert how the public interest favours use/disclosure of the information:]
	Other legal basis	[Insert:]
s. 13Z3 / 14Z61 NHS Act 2006 justification	**S. 13Z3 condition(s) to permit disclosure**	[Insert:]
	S. 14Z23 condition(s) to permit disclosure	[Insert:]
Other specific legal considerations		

Restrictions on use of information

[Insert:]

Governance arrangements

Specific measures to ensure fairness to the Data Subject, including privacy impact assessments undertaken	[Insert:]
Access controls on use of information	[Insert:]
Specific limitations on Personnel who may access information	[Insert:]
Other specific security requirements (transmission)	[Insert:]
Other specific security requirements (general)	[Insert:]
Specific requirements as to ensuring quality of information	[Insert:]
Specific requirements for retention and destruction of information	[Insert:]
Specific monitoring and review arrangements	[Insert:]

SCHEDULE 5

Financial Provisions and Decision Making Limits

Financial Limits and Approvals

1. The ICB shall ensure that any decisions in respect of the Delegated Functions and which exceed the financial limits set out below are only taken:

    1.1 by the following persons and/or individuals set out in column 2 of Table 1 below; and

    1.2 following the approval of NHS England (if any) as set out in column 3 of the Table 1 below.

2. NHS England may, from time to time, update Table 1 by sending a notice to the ICB of amendments to Table 1.

Table 1 – Financial Limits		
Decision	**Person/Individual**	**NHS England Approval**
General		
Taking any step or action in relation to the settlement of a Claim, where the value of the settlement exceeds £100,000	ICB Chief Executive Officer or Chief Finance Officer or Chair	NHS England Head of Legal Services and Local NHS England Team Director or Director of Finance
Any matter in relation to the Delegated Functions which is novel, contentious or repercussive	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance or NHS England Region Director or Director of Finance or NHS England Chief Executive or Chief Financial Officer
Revenue Contracts		
The entering into of any Primary Care Contract or Arrangement which has or is capable of having a term which exceeds five (5) years	ICB Chief Executive Officer or Chief Finance Officer or Chair	Local NHS England Team Director or Director of Finance
Capital Note: As at the date of this Agreement, the ICB will not have delegated or directed responsibility for decisions in relation to Capital expenditure (and these decisions are retained by NHS England) but the ICB may be required to carry out certain administrative services in relation to Capital expenditure under paragraph 13 *(Financial Provisions and Liability).*		

SCHEDULE 6

Mandated Assistance and Support

1. Primary Dental Services

2.1 NHS Business Services Authority has existing agreements with NHS England to support its delivery of the following services:

2.1.1 Contract management – end-to-end administration of contract variations and other regional team/ICB support activities;

2.1.2 Performance management - provide mid and end of year administration process to support regional teams and ICBs and undertake risk based assurance reviews - PPV can also be instigated by the ICS or Counter Fraud;

2.1.3 Clinical assurance reviews – provide clinical assurance of quality of dental services delivered, working in collaboration with regional teams/ICBs to identify and seek to address any concerns;

2.1.4 Provide data reports to teams defining quantity and service delivery at a contractor level.

3. Primary Ophthalmic Services

3.1 NHS Business Services Authority have existing agreements with NHS England to support its delivery of the following services:

3.1.1 Contract management. End-to-end administration of new contract applications, contract variations and contract terminations.

3.1.2 Contract assurance. Administration of the annual contractor assurance declaration and additional in-depth assurance declaration where appropriate. Provision of assurance reports at ICS and contractor level, supporting further assurance decisions.

3.1.3 GOS complaints. Administration of the annual GOS complains survey.

3.1.4 Post-Payment Verification (PPV). End-to-end process for identifying and verifying GOS claims as part of the national PPV framework. This includes obtaining and reviewing claims and carrying out a financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

3.1.5 GOS 4 pre-authorisation of repair or replacement glasses.

4 **Pharmaceutical Services and Local Pharmaceutical Services**

4.1 NHS Business Services Authority has existing agreements with NHS England to support ICBs to discharge their assurance responsibilities by the delivery of the following services to ICBs:

4.1.1 Performance management – direct support to commissioners and community pharmacy contractors to implement corrective and preventative intervention;

4.1.2 Contract assurance – administration of the annual contractor assurance declaration and additional in-depth assurance declaration where appropriate, provision of assurance reports at ICS and contractor level supporting further assurance decisions by the ICB;

4.1.3 Post-Payment Verification (PPV) – end-to-end process for identifying and verifying claims as part of the national PPV framework to support ICBs to play their part in ensuring compliance with contractual requirements and delivery of quality and value for money. This includes obtaining and reviewing claims, investigation of outliers and other potential inappropriate claims, along with referrals and investigatory reports to the ICB to consider and decide overpayment recoveries, and carrying out the financial recovery where appropriate. PPV can also be instigated by the ICS or Counter Fraud.

5 Support Services directed by DHSC

5.1 NHS Business Services Authority is directed by DHSC to undertake specific activities as well as having existing agreements with NHS England to support its delivery of primary care services. These include (without limitation):

5.1.1 The administration of national payment platforms for primary care services to dentists, pharmacy contractors, appliance contractors, oxygen contractors and special school eye care providers;

5.1.2 The calculation of payment for covid-19 and flu vaccinations to PCNs and GP practices as well as payments to Dispensing Doctors and prescribing only doctors for personal administration claims and sharing this information accurately and in a timely manner;

5.1.3 Clinical advisory support;

5.1.4 Administration functions;

5.1.5 Assurance services - performance and contract management of primary care providers;

5.1.6 The provision of information to primary care organisations for all contractor groups via standardised reporting (eg. ePACT2, eDEN and eOPS);

5.1.7 Working with NHS England and ICB Counter Fraud Teams to reduce loss across the system.

SCHEDULE 7

Local Terms

[*Note – Local terms may only be agreed between the ICB and NHS England on an exceptional basis and must not derogate from the terms and conditions of this Agreement. Please note that Local Terms may include:*

- *details of any pooled funds of NHS England and the ICB;*
- *resourcing arrangements between NHS England and the ICB;*
- *details of ancillary services provided to Primary Care Providers such as clinical waste;*
- *details of any particular services that the Assigned Staff will provide to the ICB under SCHEDULE 8**Error! Reference source not found.**; and*
- *Staffing arrangements.*

If there are no Local Terms, state "None" in this SCHEDULE 7.]

SCHEDULE 8

Deployment of NHS England Staff to the ICB

Note:
This schedule relates to the Deployment of Staff who are employed by NHS England only.

Deployment of NHS England Staff

1. NHS England may deploy Staff to the ICB for the purposes of carrying out the Delegated Functions.

2. The Parties have agreed that arrangements for the provision of NHS England Staff and the associated employment model envisaged by section 5.9 of the HR Framework **https://www.england.nhs.uk/wp-content/uploads/2021/06/B1427-Human-resources-framework-for-developing-integrated-care-boards-version-2-March-2022.pdf**) will be determined by the National Moderation Panel convened for this purpose and endorsed by NHS England's Executive Group.

3. The Parties agree and acknowledge that the Staffing Models will be developed in conjunction with the ICB and are subject to the decision of the National Moderation Panel and cannot be varied without the express agreement of NHS England.

4. A proposal for a variation to any Staffing Model must be made by means of a formal submission to the National Moderation Panel which will determine the proposal, following which the proposal if approved, will be endorsed by NHS England's Executive Group.

5. Subject to any variation made in accordance with paragraphs 3 and 4 above, a Staffing Model determined in accordance with paragraph 2 will apply for the duration of this Agreement.

Availability of NHS England Staff

1. In addition to any Staff deployed in any communicated Staffing Model arrangement, NHS England may deploy additional Staff to the ICB to perform administrative and management support services together with such other services specified in SCHEDULE 7 (Local Terms) (the "Services") so as to facilitate the ICB in undertaking the Delegated Functions pursuant to the terms of this Agreement.

2. NHS England will take all reasonable steps to ensure that the NHS England Staff deployed for the purposes of carrying out the Delegated Functions shall:

   2.1 faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

   2.2 perform all duties assigned to them pursuant to this Schedule 8.

3. The ICB shall notify NHS England if the ICB becomes aware of any act or omission by any NHS England Staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the NHS England Staff.

4. NHS England shall use all reasonable efforts to make its Staff available for the purposes of this Schedule 8 whilst the NHS England Staff are absent:

   4.1 by reason of industrial action;

4.2 as a result of the suspension or exclusion of employment or secondment of any Staff by NHS England;

4.3 in accordance with the NHS England Staff's respective terms and conditions of employment and policies, including, but not limited to, by reason of training, holidays, sickness, injury, trade union duties, paternity leave or maternity or where absence is permitted or required by Law;

4.4 if making the NHS England Staff available would breach or contravene any Law;

4.5 as a result of the cessation of employment of any individual NHS England Staff; and/or

4.6 at such other times as may be agreed between NHS England and the ICB.

Employment of the NHS England Deployed Staff

1. NHS England shall employ their Staff and shall be responsible for the employment of their Staff at all times on whatever terms and conditions as NHS England and their Staff may agree from time to time.

2. NHS England shall pay their Staff their salaries and benefits and make any deductions for income tax liability and national insurance or similar contributions it is required to make from the Staff's salaries and other payments.

3. NHS England shall not, and shall procure that the NHS England Staff shall not, hold themselves out as employees of the ICB.

Management of NHS England staff

1. NHS England where appropriate, shall in consultation with the ICB, make arrangements to ensure the day-to-day control of the activities of their Staff is shared with the ICB and deal with any relevant management issues concerning their Staff including, without limitation, performance appraisal, discipline and leave requests.

2. The ICB agrees to provide all such assistance and co-operation that NHS England may reasonably request from time to time to resolve grievances raised by NHS England Staff and to deal with any disciplinary allegations made against NHS England Staff arising out of or in connection with the provision of the Services which shall include, without limitation, supplying NHS England with all information and the provision of access to all documentation and NHS England Staff as NHS England requires for the purposes of considering and dealing with such issues and participating promptly in any action which may be necessary.

Conduct of Claims

1. If the ICB becomes aware of any matter that may give rise to a claim by or against a member of NHS England Staff, notice of that fact shall be given as soon as possible to NHS England. NHS England and the ICB shall co-operate in relation to the investigation and resolution of any such claims or potential claims.

2. No admission of liability shall be made by or on behalf of the ICB and any such claim shall not be compromised, disposed of or settled without the consent of NHS England.

Confidential Information and Property

1. For the avoidance of doubt, this paragraph 17 (Confidential Information and Property) is without prejudice to any other provision of this Agreement in relation to confidential information.

2. It is acknowledged that to enable the NHS England Staff to provide the Services, the Parties may share Confidential Information.

3. The Parties agree to adopt all such procedures as the other party may reasonably require and to keep confidential all Confidential Information.

Intellectual Property

1. All IPR made, written, designed, discovered or originated by Staff (People Resources) deployed by NHS England, shall be the property of NHS England to the fullest extent permitted by Law and NHS England shall be the absolute beneficial owner of the copyright in any such IPR.

SCHEDULE 9

Mandated Guidance

Primary Medical Care

- Primary Medical Care Policy and Guidance Manual.
- The 'Principles of Best Practice' and any other guidance relating to *the Premises Cost Directions 2013.*
- Guidance relating to the Minimum Practice Income Guarantee.
- Guidance relating to Primary Medical Care discretionary payments.
- Guidance for Commissioners: Interpreting and Translation Services in Primary Care.
- Framework for Patient and Public Participation in Primary Care Commissioning.
- NHS England National Primary Care Occupational Health Service Specification.
- Guidance relating to list cleansing in relation to Primary Medical Care providers.
- Guidance relating to mergers and closures of GP practices and/or Primary Medical Care providers.
- Guidance relating to Primary Medical Care and POD contract reviews.
- Guidance relating to the escalation of complaints from a named 'performer'.
    - Including: *Framework for Managing Performer Concerns.*

Pharmaceutical Services and Local Pharmaceutical Services

- Pharmacy Manual.

Primary Ophthalmic Services

- Policy Book for Eye Health.

Primary and Prescribed Dental Services

- Policy Book for Primary Dental Services.
- Securing Excellence in Commissioning NHS Dental Services.
- Securing Excellence in Commissioning NHS Dental Services: Key facts.
- Securing Excellence in Commissioning NHS Dental Services: FAQs.
- Quick Guide: Best use of unscheduled dental care services.
- How to update NHS Choices for Dental Practices.
- Flowchart for managing patients with a dental problem/pain.
- Guidance on NHS 111 Directory of Services for dental providers.
- Definitions – Unscheduled Dental Care.
- Introductory Guide for Commissioning Dental Specialties.
- Guide for Commissioning Dental Specialties: Orthodontics.
- Guide for Commissioning Dental Specialties: Oral Surgery and Oral Medicine.
- Guide for Commissioning Dental Specialties: Special Care Dentistry.
- Guide for Commissioning Service Standards: Conscious Sedation in a Primary Care Setting.
- Commissioning Standard for Dental Specialties: Paediatric Dentistry.
- Commissioning Standard for Urgent Dental Care.
- Commissioning Standard for Restorative Dentistry.
- Commissioning Standard for Dental Care for People with Diabetes.
- Accreditation of Performers and Providers of Level 2 Complexity Care.

Finance

- Guidance on NHS System Capital Envelopes.
- Finance and Payments Guidance for Community Pharmacy, Dental and Primary Care Ophthalmology Services Delegated to ICBs from 2022.
- Managing Public Money (HM Treasury).
- Guidance relating to Personal Service Medical Reviews.
    - Including: *Implementing Personal Medical Services Reviews.*

Workforce

- Guidance on the Employment Commitment.

Other Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- IG Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable guidance relating to the use of data and data sets for reporting.
- Any applicable guidance relating to the commissioning and management of clinical waste in primary care e.g.
    - Including: Management and disposal of healthcare waste

Dated 2023

(1) **NHS ENGLAND**

- and -

(2) **NHS LINCOLNSHIRE INTEGRATED CARE BOARD**

- and -

(3) **NHS NOTTINGHAM AND NOTTINGHAMSHIRE INTEGRATED CARE BOARD**

- and -

(4) **NHS LEICESTER, LEICESTERSHIRE, AND RUTLAND INTEGRATED CARE BOARD**

- and -

(5) **NHS NORTHAMPTONSHIRE INTEGRATED CARE BOARD**

- and -

(6) **NHS DERBY AND DERBYSHIRE INTEGRATED CARE BOARD**

Agreement in relation to the establishment and operation of joint working arrangements

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THIS AGREEMENT is made on the_____ day of _____2023

BETWEEN[1]**:**

(1) **NHS England** of Quarry House, Quarry Hill, Leeds LS2 7UE (acting under the name NHS England) ("**NHS England"**); and

(2) **NHS Lincolnshire Integrated Care Board** of Bridge House, The Point, Lions Way, Sleaford, NG34 8GG ("**Lincolnshire ICB"**); and

(3) **NHS Nottingham & Nottinghamshire Integrated Care Board** of Sir John Robinson House, Sir John Robinson Way, Arnold, Nottingham, NG5 6DA ("**Nottingham & Nottinghamshire ICB"**); and

(4) **NHS Leicester, Leicestershire & Rutland Integrated Care Board** of Room G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB ("**Leicester, Leicestershire & Rutland ICB"**); and

(5) **NHS Northamptonshire Integrated Care Board** of Francis Crick House, 6 Summerhouse Road, Northampton, Northamptonshire, NN3 6BF ("**Northamptonshire ICB"**); and

(6) **NHS Derby & Derbyshire Integrated Care Board** of Cardinal Square, 10 Nottingham Road, Derby, Derbyshire, DE1 3QT ("**Derby & Derbyshire ICB"**).

each a "Partner" and together the “Partners”.

Lincolnshire ICB, **Nottingham & Nottinghamshire ICB, Leicester, Leicestershire & Rutland ICB, Northamptonshire ICB** and **Derby & Derbyshire ICB** are together referred to in this Agreement as the **“ICBs”,** and **“ICB”** shall mean any of them.

BACKGROUND

(A) NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.

(B) The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their areas, apart from those commissioned by NHS England.

(C) Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs are able to establish and maintain joint arrangements in respect of the discharge of their commissioning functions.

(D) NHS England and the ICBs agree to jointly exercise the Joint Functions through the decisions of the Joint Committee under section 65Z5 of the NHS Act and as set out in this Agreement and the Terms of Reference.

(E) NHS England and the ICBs acknowledge and agree that making arrangements to involve the ICBs in the exercise of NHS England’s Commissioning Functions is likely to lead to an improvement in the way the Commissioning Functions of all Partners are exercised.

(F) This Agreement sets out the arrangements that will apply between NHS England and the ICBs in relation to the joint commissioning of Specialised Services for the ICBs’ Populations. These arrangements are intended to give the ICBs greater involvement in the commissioning of Specialised Services to better align and transform pathways of care around the needs of local populations.

(G) NHS England and the ICBs have entered into this Agreement to define their arrangements for

[1] Complete Partners' names as appropriate.

joint working. To avoid doubt, none of the Partners are delegating the exercise of any of their Commissioning Functions or any other functions to any other Partner under this Agreement.

(H) This Agreement is intended for use in the 2023/24 financial year, to govern what are envisaged to be transitional joint working arrangements prior to the delegation of specialised commissioning functions from NHS England to ICBs, effective from 2024.

NOW IT IS HEREBY AGREED as follows:

1. **COMMENCEMENT AND DURATION**

1.1 This Agreement has effect from the date of this Agreement and will remain in force for the Initial Term unless terminated in accordance with Clause 20 (Leaving the Joint Committee) below.

1.2 The Partners may extend this Agreement beyond the Initial Term for a further period, by written agreement prior to the expiry of the Initial Term.

2. **PRINCIPLES AND AIMS**

2.1 The Partners acknowledge that, in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act and must:

2.1.1 consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

2.1.2 consider how, in performing its obligations, it can address health inequalities;

2.1.3 at all times exercise functions effectively, efficiently and economically; and

2.1.4 act at all times in good faith towards each other.

2.2 The Partners agree:

2.2.1 that successfully implementing this Agreement will require strong relationships and an environment based on trust and collaboration;

2.2.2 to seek to continually improve whole pathways of care including Specialised Services and to design and implement effective and efficient integration;

2.2.3 to act in a timely manner;

2.2.4 to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks and reduce cost;

2.2.5 to act at all times in accordance with the scope of their statutory powers; and

2.2.6 to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any Specialised Services and, as far as is reasonably practicable, take such needs and views into account.

2.3 The Partners' primary aim is to maximise the benefits to patients of integrating the Joint Functions with the ICBs' Commissioning Functions through designing and commissioning the Joint Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

3. SCOPE OF JOINT WORKING ARRANGEMENTS

3.1 This Agreement sets out the arrangements through which the Partners will work together to exercise the Joint Functions as set out in Schedule 4, including:

3.1.1 the establishment of a Joint Committee;

3.1.2 the participation by all Partners in the work of the Joint Committee;

3.1.3 the development of leadership and expertise in respect of the Joint Specialised Services;

collectively referred to as the "Joint Working Arrangements".

4. JOINT COMMITTEE

4.1 NHS England shall together with the ICBs establish a Joint Committee which will operate in accordance with the Terms of Reference set out in Schedule 2 (Joint Committee – Terms of Reference). The Joint Committee (and each member of the Joint Committee) will act at all times in accordance with the Terms of Reference.

4.2 The Partners shall nominate Authorised Officers to the Joint Committee in accordance with Schedule 2.

4.3 Subject to Clauses 4.4 and 8.1 and the terms of the Schedules, NHS England shall exercise the Joint Functions collaboratively with the ICBs in accordance with this Agreement and must reach decisions in relation to the Joint Functions through discussion and agreement. Where in exceptional cases consensus cannot be reached between the members of the Joint Committee in respect of matters under consideration, the voting arrangements set out in the Terms of Reference will apply.

4.4 NHS England may at any time exercise the Joint Functions outside of the Joint Working Arrangements where, in its view, that is necessary for reasons of urgency, and in such circumstances it shall inform the Partners of such action at the earliest reasonable opportunity.

4.5 The Partners may establish sub-groups or sub-committees of the Joint Committee with such terms of reference as may be agreed between them from time to time. Any such sub-groups or sub-committees that are in place at the commencement of this Agreement may be documented in the Local Terms (Schedule 9).

4.6 The ICBs shall ensure that their Authorised Officers have appropriate delegated authority, in accordance with each ICB's internal governance arrangements, to represent the interests of each ICB in the Joint Committee and any other sub-groups or sub-committees established by the Joint Committee.

4.7 The Partners recognise the need to ensure that any potential conflicts of interest on the part of any Partner, including its representatives, in respect of this Agreement and the establishment or operation of the Joint Committee and any sub-group or sub-committee of the Joint Committee must be appropriately identified, recorded and managed.

5. JOINT FUNCTIONS

5.1 This Agreement shall include such Joint Functions as identified in Schedule 4 in respect of the Joint Specialised Services.

5.2 The Joint Committee must establish effective, safe, efficient and economic arrangements for the discharge of the Joint Functions.

5.3 The Joint Committee must exercise the Joint Functions in accordance with:

5.3.1 the terms of this Agreement;

5.3.2 all applicable Law;

5.3.3 Guidance;

5.3.4 the Terms of Reference; and

5.3.5 Good Practice.

5.4 In exercising the Joint Functions, the Joint Committee must comply with the Mandated Guidance set out in Schedule 8, or otherwise referred to in this Agreement, and such further Mandated Guidance as may be issued by NHS England from time to time, including on the NHS England or FutureNHS websites.

5.5 The Joint Committee must perform the Joint Functions:

5.5.1 in such a manner as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Joint Functions and to enable NHS England to fulfil its Reserved Functions; and

5.5.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Joint Functions and Reserved Functions.

6. THE RESERVED FUNCTIONS

6.1 NHS England will exercise the Reserved Functions, including but not limited to those set out in Schedules 5 (Retained Services) and 6 (Reserved Functions).

6.2 The Reserved Functions include all of NHS England's Specialised Commissioning Functions other than the Joint Functions.

6.3 The Partners acknowledge that NHS England may ask the ICBs to provide certain administrative and management services to NHS England in relation to Reserved Functions.

7. FURTHER COLLABORATIVE WORKING

7.1 An ICB may, at its discretion, table for discussion at any Joint Committee meeting an item relating to any ICB Function, where such ICB Function relates to Specialised Commissioning Functions, in order to facilitate engagement and promote integration and collaborative working. Decision-making in respect of such discussions will remain with the relevant ICB. For the avoidance of doubt, the Joint Committee will not have any authority to take decisions in respect of ICB Functions.

7.2 NHS England may, at its discretion, table for discussion at any Joint Committee meeting an item relating to a Reserved Function (including but not limited to the Part A Retained Services) or any such other of NHS England's Functions that it considers appropriate in order to facilitate engagement and promote integration and collaborative working. For the avoidance of doubt, the Joint Committee will only have authority to take decisions in respect of the Joint Functions. The decision-making will remain with NHS England for all other NHS England Functions.

8. FINANCE

8.1 For the Initial Term, NHS England shall hold the Specialised Commissioning Budget and shall be responsible for paying for the Joint Specialised Services from the Specialised Commissioning Budget pursuant to the Specialised Services Contracts. NHS England will establish and maintain the financial and administrative support necessary to meet any auditing regulations applicable to NHS England. The Joint Committee shall ensure full compliance with the Finance Guidance and any other relevant Mandated Guidance.

8.2 For the avoidance of doubt, in the Initial Term, the ICBs are not required to financially contribute to the Specialised Commissioning Budget and the Partners do not intend to create a pooled fund or joint budget for the purpose of this Agreement. The NHS England Standing Financial Instructions shall apply in respect to the commissioning of all Joint Specialised Services.

8.3 Each Partner shall bear its own costs as they are incurred, unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners. Such costs may include, but will not be limited to, costs of attendance at Joint Committee meetings and costs in complying with each Partner's relevant obligations in this Agreement.

8.4 Prior to the end of the first year of the Term, the Partners will review the financial arrangements described in this Clause 8 (Finance) and consider whether alternative arrangements should be put in place for any extended Term. Any changes to this Agreement to effect such new arrangements will be made in accordance with Clause 10 (Variations).

9. STAFFING

9.1 During the Initial Term the Specialised Services Staff shall be employed by NHS England.

9.2 The Partners must comply with any Mandated Guidance issued by NHS England from time to time in relation to any NHS England Staff.

10. VARIATIONS

10.1 The Partners acknowledge that the scope of the Joint Working Arrangements, including the scope of the Joint Functions, may be reviewed and amended from time to time.

10.2 This Agreement may be varied by the agreement of the Partners at any time in writing in accordance with the Partners' internal decision-making processes.

11. DATA PROTECTION

11.1 The Partners must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Joint Working Arrangements is processed in accordance with the relevant Partner's obligations under Data Protection Legislation and Data Guidance, and the Partners must assist each other as necessary to enable each other to comply with these obligations.

11.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis. If any Partner:

11.2.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

11.2.2 becomes aware of any security breach,

in respect of the Relevant Information it shall promptly notify the Joint Committee and NHS England. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.

11.3 In processing any Relevant Information further to this Agreement, each Partner shall at all times comply with all NHS England policies and guidance on the handling of data.

11.4 Any information governance breach must be responded to in accordance with Data Security and the Protection Incident Reporting tool. If any Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant Partner must fully inform NHS England and the Joint Committee of the information governance breach. This clause does not require the relevant Partner to provide information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

11.5 Whether or not a Partner is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Partners acknowledge that a Partner may act as both a Data Controller and a Data Processor.

11.6 The Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of law, including in particular the Data Protection Legislation in respect of any Personal Data.

11.7 Other than in compliance with judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any other Partners save as agreed by the Partners in writing.

11.8 Schedule 7 makes further provision about information sharing and information governance.

12. IT INTER-OPERABILITY

12.1 The Partners will work together to ensure that all relevant IT systems operated by the Partners in respect of the Joint Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

12.2 The Partners will use their respective reasonable endeavours to help develop initiatives to further this aim.

13. FURTHER ARRANGEMENTS

13.1 The Partners must give due consideration to whether any of the Joint Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The Partners must comply with any Guidance around the commissioning of Joint Specialised Services by means of arrangements under section 65Z5 or 75 of the NHS Act.

14. FREEDOM OF INFORMATION

14.1 Each Partner acknowledges that the others are a public authority for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).

14.2 Each Partner may be statutorily required to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

14.2.1 each Partner shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

14.2.2 each Partner shall consult the other regarding the possible application of exemptions in relation to the information requested; and

14.2.3 each Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the Partner to whom the request is addressed.

14.3 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Joint Working Arrangements. The Joint Committee and each Partner shall comply with such FOIA or EIR protocols.

15. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

15.1 The Partners must and must ensure that, in delivering the Joint Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

15.2 Without prejudice to the general obligations set out in Clause 5 (Joint Functions), each ICB must maintain a register of interests in respect of all persons involved in decisions concerning the Joint Functions. This register must be publicly available. For the purposes of this clause, an ICB may rely on an existing register of interests rather than creating a further register.

15.3 Where any member of the Joint Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Joint Committee, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed or make a recommendation in relation to the relevant matter. The relevant appointing body may send an alternative representative to take the place of the conflicted member in relation to that matter.

16. CONFIDENTIALITY

16.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Partner and the receiving Partner has no right to use it.

16.2 Subject to Clause 16.3, the receiving Partner agrees:

16.2.1 to use the disclosing Partner's Confidential Information only in connection with the receiving Partner's performance under this Agreement;

16.2.2 not to disclose the disclosing Partner's Confidential Information to any third party or to use it to the detriment of the disclosing Partner; and

16.2.3 to maintain the confidentiality of the disclosing Partner's Confidential Information.

16.3 The receiving Partner may disclose the disclosing Partner's Confidential Information:

16.3.1 in connection with any Dispute Resolution Procedure;

16.3.2 to comply with the Law;

16.3.3 to any appropriate Regulatory or Supervisory Body;

16.3.4 to its staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Partner's duty under Clause 16.2;

16.3.5 to NHS Bodies for the purposes of carrying out their functions;

16.3.6 as permitted under any other express arrangement or other provision of this Agreement.

16.4 The obligations in Clause 16 will not apply to any Confidential Information which:

16.4.1 is in or comes into the public domain other than by breach of this Agreement;

16.4.2 the receiving Partner can show by its records was in its possession before it received it from the disclosing Party; or

16.4.3 the receiving Partner can prove it obtained or was able to obtain from a source other than the disclosing Partner without breaching any obligation of confidence.

16.5 This Clause 16 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.

16.6 This Clause 16 will survive the termination of this Agreement for any reason for a period of 5 years.

16.7 This Clause 16 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

17. LIABILITIES

17.1 Nothing in this Agreement shall affect:

17.1.1 the liability of NHS England to any person in respect of NHS England's Commissioning Functions; or

17.1.2 the liability of any of the ICBs to any person in respect of that ICB's Commissioning Functions.

17.2 NHS England shall be responsible for and shall retain the conduct of any Claim in relation to the Joint Functions and Reserved Functions.

17.3 Each ICB must:

17.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims;

17.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;

17.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;

17.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and/or

17.3.5 at the request of NHS England, take such action or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

18. DISPUTE RESOLUTION

18.1 Where any dispute arises within the Joint Committee in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute within the Joint Committee in accordance with the Terms of Reference.

18.2 Where any dispute is not resolved under Clause 18.1 on an informal basis, any Authorised Officer may convene a special meeting of the Joint Committee to attempt to resolve the dispute.

19. BREACHES OF THE JOINT WORKING AGREEMENT

19.1 If any Partner does not comply with the terms of this Agreement, then NHS England may:

19.1.1 exercise its rights under this Agreement; and

19.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the Partner.

19.2 Without prejudice to Clause 19.1, if any Partner does not comply with the terms of this Agreement (including if the Joint Committee or any Partner exceeds its authority under this Agreement), NHS England may (at its sole discretion):

19.2.1 waive its rights in relation to such non-compliance in accordance with Clause 19.3;

19.2.2 ratify any decision;

19.2.3 terminate this Agreement in accordance with Clause 20 (Leaving the Joint Committee*)* below;

19.2.4 exercise the dispute resolution procedure in accordance with Clause 18 *(Dispute Resolution Procedure)*; and/or

19.2.5 exercise its rights under common law.

19.3 NHS England may waive any non-compliance by a Partner with the terms of this Agreement provided that the Partner provides a written report to the Joint Committee as required by Clause 19.4 and, after considering the Partner's written report, NHS England is satisfied that the waiver is justified.

19.4 If:

19.4.1 a Partner does not comply with this Agreement; or

19.4.2 NHS England notifies a Partner that it considers the Partner has not complied, or may not be able to comply with, this Agreement;

then that Partner must provide a written report to the NHS England within ten (10) Operational Days of the non-compliance (or the date on which the relevant Partner considers that it may not be able to comply with this Agreement) or such notification pursuant to Clause 25 setting out:

19.4.3 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement; and

19.4.4 if the non-compliance is capable of remedy, a plan for how the Partner proposes to remedy the non-compliance.

20. LEAVING THE JOINT COMMITTEE

20.1 If an ICB wishes to exit the Joint Committee and end its participation in this Agreement, the relevant ICB must provide at least six (6) months' notice to NHS England of its intention to exit the Joint Committee and end its participation in this Agreement. Such notification shall only take effect from the end of 31 March in any calendar year.

20.2 NHS England and the ICBs will work together to ensure that there are suitable alternative arrangements in place in relation to the exercise of the Joint Functions.

20.3 The ICB(s) acknowledge that the exercise of the Joint Functions remains the responsibility of NHS England.

20.4 NHS England may terminate this Agreement forthwith where it considers it necessary or expedient to terminate the Joint Working Arrangements, but in reserving this power NHS England anticipates that this will only be used in exceptional circumstances and that in all instances it will use its reasonable endeavours to seek an orderly termination of the Joint Working Arrangements.

21. CONSEQUENCES OF TERMINATION

21.1 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the following shall apply:

21.1.1 the Partners agree that they will work together and co-operate to ensure that the winding down of these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

21.1.2 termination of this Agreement shall have no effect on the liability of any rights or remedies of any Partner already accrued, prior to the date upon which such termination takes effect.

21.2 The provisions of Clauses 11 (Data Protection), 14 (Freedom of Information), 16 (Confidentiality), 17 (Liabilities) and 21 (Consequences of Termination) shall survive termination or expiry of this Agreement.

22. PUBLICITY

22.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement.

23. EXCLUSION OF PARTNERSHIP OR AGENCY

23.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners, or render any Partner directly liable to any third party for the debts, liabilities or obligations of any Partner.

23.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

24. THIRD PARTY RIGHTS

24.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

25. NOTICES

25.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

25.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

26. ASSIGNMENT AND SUBCONTRACTING

26.1 This Agreement, and any right and conditions contained in it, may not be assigned or transferred by a Partner, without the prior written consent of the other Partners, except to any statutory successor to the relevant function.

27. SEVERABILITY

27.1 If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

28. WAIVER

28.1 No failure or delay by a Partner to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

29. STATUS

29.1 The Partners acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

30. **ENTIRE AGREEMENT**

30.1 This Agreement constitutes the entire agreement and understanding of the Partners and supersedes any previous agreement between the Partners relating to the subject matter of this Agreement.

31. **GOVERNING LAW AND JURISDICTION**

31.1 Subject to the provisions of Clause 18 (Dispute Resolution) and Clause 29 (Status), this Agreement shall be governed by and construed in accordance with English Law, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

32. **FAIR DEALINGS**

32.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that, if in the course of the performance of this Agreement, unfairness to either of them does or may result, then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

33. **COMPLAINTS**

33.1 Any complaints received by the Partners shall be dealt with in accordance with the statutory complaints procedure of the Partner to whose Commissioning Function(s) the complaint relates. For the avoidance of doubt, NHS England shall manage all complaints in respect of the Joint Specialised Services and Retained Services.

34. **COUNTERPARTS**

34.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the date stated at the beginning of it.

SIGNED by Dale Bywater .....

for and on behalf of NHS England (Signature)

.....

(Date)

SIGNED by John Turner .....

for and on behalf of NHS Lincolnshire Integrated Care Board (Signature)

.....

(Date)

SIGNED by Amanda Sullivan .....

for and on behalf of NHS Nottingham & Nottinghamshire Integrated Care Board (Signature)

.....

(Date)

SIGNED by Andy Williams .....

for and on behalf of NHS Leicester, Leicestershire & Rutland Integrated Care Board (Signature)

.....

(Date)

SIGNED by Toby Sanders .....

for and on behalf of NHS Northamptonshire Integrated Care Board (Signature)

.....

(Date)

SIGNED by Chris Clayton .....

for and on behalf of NHS Derby & Derbyshire Integrated Care Board (Signature)

.....

(Date)

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

DEFINITIONS AND INTERPRETATION

1. In this Agreement, unless the context otherwise requires, the following words and expressions shall have the following meanings:

“Agreement"	this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
“Area”	means the geographical area covered by the ICBs;
“Assurance Processes”	has the meaning in Paragraph 8 of Schedule 4 (Oversight and Assurance);
"Authorised Officer"	the individual(s) appointed as Authorised Officer in accordance with Schedule 2 (Terms of Reference);
"Change in Law"	a change in Law that is relevant to the arrangements made under this Agreement, which comes into force after the Commencement Date;
“Claim”	means for or in relation to the Joint Functions and Reserved Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
“Clinical Commissioning Policies”	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;
“Clinical Reference Groups”	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
“Collaborative Commissioning Agreement”	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commencement Date"	means 1 April 2023
"Commissioning Functions"	the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
"Confidential Information"	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or arrangements made pursuant to it and: (a) which comprises Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner; or

(c) which is a trade secret;

"Contracting Standard Operating Procedure"	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Joint Specialised Services;
"Core Membership"	means the voting membership of the Joint Committee as set out in the Terms of Reference;
"Data Controller"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Security and Protection Incident Reporting tool"	the incident reporting tool for data security and protection incidents, which forms part of the Data Security and Protection Toolkit available at https://www.dsptoolkit.nhs.uk/;
"**Delegated Commissioning Group**" **"DCG"**	means a group hosted by NHS England whose terms shall include providing an assurance role in compliance with the Assurance Processes;
"Dispute Resolution Procedure"	the procedure set out in Clause 18 (Dispute Resolution);
"Finance Guidance"	guidance, rules and operating procedures produced by NHS England that relate to these Joint Working Arrangements, including but not limited to the following:

- Commissioning Change Management Business Rules;

- Contracting Standard Operating Procedure;
- Cashflow Standard Operating Procedure;
- Finance and Accounting Standard Operating Procedure;
- Service Level Framework Guidance;

"FOIA"	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
"Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Partners have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified by any relevant Regulatory or Supervisory Body;
"High Cost Drugs"	Means medicines not reimbursed though national prices and identified on the NHS England high cost drugs list;
"ICB Functions"	the Commissioning Functions of the ICB;
"Information"	has the meaning given under section 84 of FOIA;
"Indemnity Arrangement"	mean either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Information Sharing Agreement"	any information sharing agreement entered into in accordance with Schedule 7 (Further Information Governance and Sharing Provisions);
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Initial Term"	the period of one year from 1 April 2023;
"Joint Committee"	means the joint committee of NHS England and the ICBs, established under this Agreement on the terms set out in the Terms of Reference;
"Joint Working Arrangements"	means the arrangements for joint working as set out in Clause 3 (Scope of Joint Working Arrangements);
"Joint Functions"	those aspects of the NHS England Specialised Commissioning Functions, as set out in Schedule 4, that shall be jointly exercised by NHS England and the ICBs through the decisions of the Joint Committee in accordance with the Terms of Reference;
"Joint Specialised Services"	means those Specialised Services listed in Schedule 3 (Joint Specialised Services);
"Law"	means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(c) any judgment of a relevant court of law which is a binding precedent in England;

"Mandated Guidance" means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Joint Functions and issued by NHS England from time to time as mandatory in respect of the Joint Working Arrangements. At the Commencement Date the Mandated Guidance in respect of the Joint Functions shall be as set out in Schedule 8;

"National Standards" means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;

"National Specifications" the service specifications published by NHS England in respect of Specialised Services;

"Need to Know" has the meaning set out in Schedule 7;

"NHS Act" the National Health Service Act 2006;

"NHS England Functions" NHS England's statutory functions exercisable under or by virtue of the NHS Act;

"Non-Personal Data" means data which is not Personal Data;

"**Oversight Framework**" means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England;

"Part A Retained Services" means those services listed in Part A of Schedule 5;

"Part B Retained Services" means those services listed in Part B of Schedule 5;

"Partners" the parties to this Agreement;

"Personal Data" has the meaning set out in the Data Protection Legislation;

"Population" means the population for which an ICB or all of the ICBs have the responsibility for commissioning health services;

"Provider Collaborative" a group of Specialised Service Providers who have agreed to work together to improve the care pathway for one or more Specialised Services;

"Provider Collaborative Arrangements"	Means the contracting arrangements entered into in respect of a Provider Collaborative;
"Provider Collaborative Guidance"	Means the guidance published by NHS England in respect of Provider Collaboratives;
"Regional Quality Group"	A group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) NICE; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;
"Relevant Information"	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*);
"Request for Information"	has the meaning set out in the FOIA;
"Reserved Functions"	those aspects of the Specialised Commissioning Functions that are not Joint Functions, including but not limited to those set out in Schedule 6;
"**Relevant Clinical Networks"**	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out in Schedule 5 and being the Part A Retained Services and the Part B Retained Services;

“Shared Care Arrangements”	these arrangements support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification;
“Single Point of Contact”	the member of Staff appointed by each relevant Partner in accordance with Paragraph 14 of Schedule 7;
“Special Category Personal Data”	has the meaning set out in the Data Protection Legislation;
“Specialised Commissioning Budget”	means the budget identified by NHS England for the purpose of exercising the Joint Functions;
"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
“Specified Purpose”	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Functions and Reserved Functions as specified in Schedule 7 *(Further Information Governance and Sharing Provisions)* to this Agreement;
“Specialised Services”	means the services commissioned in exercise of the Specialised Commissioning Functions;
“Specialised Services Contract”	a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions;
“Specialised Services Provider”	a provider party to a Specialised Services Contract;
“Specialised Services Staff”	means the Staff carrying out the Joint Specialised Services Functions immediately prior to the date of this Agreement;
“Staff”	means the Partners’ employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors’ and their sub-contractors’ personnel;
“System quality group”	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;
"Term"	the Initial Term, as may be varied by: (a) any extensions to this Agreement that are agreed under Clause 1.1 (Commencement and Duration); or

	(b) the earlier termination of this Agreement in accordance with its terms;
“Terms of Reference”	means the Terms of Reference for the Joint Committee agreed between NHS England and the ICBs at the first meeting of the Joint Committee, a draft of which is included at Schedule 2 (Joint Committee – Terms of Reference);
“Triple Aim”	the duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to: (a) the health and well-being of the people of England; (b) the quality of services provided to individuals by the NHS; (c) efficiency and sustainability in relation to the use of resources by the NHS;
“UK GDPR”	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
"Working Day"	any day other than Saturday, Sunday, a public or bank holiday in England.

2. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

3. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are Clauses in this Agreement.

4. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.

5. References to a person or body shall not be restricted to natural persons and shall include a company, corporation or organisation.

6. Words importing the singular number only shall include the plural.

7. Use of the masculine includes the feminine and all other genders.

8. Where anything in this Agreement requires the mutual agreement of the Partners, then unless the context otherwise provides, such agreement must be in writing.

9. Any reference to the Partners shall include their respective statutory successors, employees and agents.

10. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

11. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

SCHEDULE 2: JOINT COMMITTEE – TERMS OF REFERENCE

Document name:		[Insert]	
Senior Responsible Owner (SRO):		[Insert]	
Lead:		[Insert]	
Version	[Insert]	**Date:**	27/02/2023

Document management

Revision history

Version	Date	Summary of changes

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version

Related documents

Title	Owner	Location

Document control

The controlled copy of this document is maintained by NHS England. Any copies of this document held outside of that area, in whatever format (e.g. paper, e-mail attachment), are considered to have passed out of control and should be checked for currency and validity.

Introduction and purpose	From April 2023, Integrated Care Boards (ICBs) entering joint working agreements with NHS England will become jointly responsible, with NHS England, for commissioning the Joint Specialised Services set out in Schedule 3 of the Agreement, and for any associated Joint Functions set out in Schedule 4. NHS England and ICBs will form a statutory joint committee to collaboratively make decisions on the planning and delivery of the Joint Specialised Services, to improve health and care outcomes and reduce health inequalities. Joint Committees are intended as a transitional mechanism prior to ICB taking on full delegated commissioning responsibility. Subject to Clauses 7.1 and 7.2 of this Agreement (Further Collaborative Working), the Partners may, to such extent that they consider it desirable, table an item at the Joint Committee relating to any other of their functions that is not a Joint Specialised Service or a Joint Function to facilitate engagement, promote integration and collaborative working. The Partners may, from time to time, establish sub-groups or sub-committees of the Joint Committee, with such terms of reference as may be agreed between them. Any such sub-groups or sub-committees that are in place at the commencement of this Agreement may be documented in the Local Terms (Schedule 9).
The Terms of Reference	These Terms of Reference provide a template to support effective collaboration between NHS England and ICBs acting through Joint Committees in 2023/24. The Terms of Reference set out the role, responsibilities, membership, decision-making powers, and reporting arrangements of the Joint Committee in accordance with the Agreement between the ICB and NHS England. It is acknowledged that Joint Working Arrangements aim to give ICBs greater involvement in the commissioning of Specialised Services to better align and transform pathways of care around the needs of local populations. The Joint Committee will operate as the decision-making forum for exercising the agreed Joint Functions in accordance with the Agreement. By agreement, the Partners may use an alternative title for the Joint Committee that reflects local arrangements, for example, ‘Commissioning Committee.’

Statutory Framework	The Partners have arranged to exercise the Functions jointly pursuant to section 65Z5 of the NHS Act 2006. The Joint Committee is established pursuant to section 65Z6 of the NHS Act 2006. Apart from as set out in the Agreement, the Joint Committee does not affect the statutory responsibilities and accountabilities of the Partners.
Role of the Joint Committee	The role of the Joint Committee is to provide strategic decision-making, leadership and oversight for the Joint Specialised Services and any associated activities. The Joint Committee will safely, effectively, efficiently and economically discharge the Joint Functions and deliver these Joint Specialised Services through the following key responsibilities: ▪ Determining the appropriate structure of the Joint Committee; ▪ Making joint decisions in relation to the planning and commissioning of the Joint Specialised Services, and any associated commissioning or statutory functions, for the population,for example, through undertaking population needs assessments; ▪ Making recommendations on the population-based Specialised Services financial allocation and financial plans; ▪ Oversight and assurance of the Joint Specialised Services in relation to quality, operational and financial performance, including co-ordinating risk and issue management and escalation, and developing the approach to intervention with Specialised Services Providers where there are quality or contractual issues; ▪ Identifying and setting strategic priorities and undertaking ongoing assessment and review of Joint Specialised Services within the remit of the Joint Committee, including tackling unequal outcomes and access; ▪ Supporting the development of partnership and integration arrangements with other health and care bodies that facilitate population health management and providing a forum that enables collaboration to integrate service pathways, improve population health and services and reduce health inequalities. This includes establishing links and working effectively with Provider Collaboratives and cancer alliances, and working closely with other ICBs, Joint Committees and NHS England where there are cross-border patient flows to providers;

	▪ Ensuring the Joint Committee has effective engagement with stakeholders, including patients and the public, and involving them in decision-making; ▪ Ensuring the Joint Committee has appropriate clinical advice and leadership, including through Clinical Reference Groups and Relevant Clinical Networks; ▪ Commencing longer-term planning, particularly in view of the ICB(s) receiving full delegated commissioning responsibility in future; ▪ Discussing any matter which any member of the Joint Committee believes to be of such importance that it should be brought to the attention of the Joint Committee; ▪ Where agreed by the Partners, overseeing the Collaborative Commissioning Agreements set out in the Joint Working Arrangement; ▪ Otherwise ensuring that the roles and responsibilities set out in the Agreement between the Partners are discharged. The Partners must implement such arrangements as are necessary to demonstrate good decision-making and compliance with all statutory duties, guidance and good practice, including ensuring that the Joint Committee has sufficient independent scrutiny of its decision-making and processes. The Joint Committee must adhere to these Terms of Reference and will operate the meeting in in two parts, these being PART A – NHSE & ICB NHS England will be a Partner for the commissioning of Specialised Services defined under a separate Joint Working Agreement. ICB and NHSE under that agreement will make joint decisions for the benefit of the population PART B – ICB Only ICBs defined in the Tier One Joint Committee of the East Midlands will make decisions regarding all services outlined in Schedule 4 and will act as a forum for discussion and make recommendations to ICBs on issues where further joint action or working between ICBs would be of benefit outside the arrangements delegated to it.
Accountability and reporting	The Joint Committee will be formally accountable to the Board of NHS England through the relevant NHS England regional governance structure for specialised services. Regional Directors of Commissioning Regional Director of Specialised Services

	Regional Director of Primary Care and Public Health The Joint Committee may report to the Delegated Commissioning Group (DCG) for Specialised Services on its proceedings and decisions. The Joint Committee's Chair(s) or, at the Chair's discretion, another member of the Joint Committee, may attend the DCG and report to the DCG on its proceedings. Where the DCG requests that the Joint Committee provides information or reports on its proceedings or decisions, the Partners must comply with that request within a reasonable timescale.
Membership	<u>Core Membership</u> Each of the Partners must nominate one Authorised Officer to be their representative at meetings of the Joint Committee. The Authorised Officers nominated by the Partners and present at a meeting of the Joint Committee comprise the voting membership of the Joint Committee. Each of the Partners may nominate a named substitute to attend meetings of the Joint Committee if its Authorised Officer is unavailable or unable to attend or because they are conflicted. Each of the Partners must ensure that its Authorised Officer (and any named substitute) is of a suitable level of seniority and duly authorised to act on its behalf and to agree to be bound by the final position or decision taken at any meeting of the Joint Committee. The Authorised Officers (or any substitute(s) appointed) form the Core Membership of the Joint Committee. <u>Discretionary Membership</u> Each of the Partners may be represented at meetings of the Joint Committee by representatives (who may be officers or, in the case of an ICB, non-executive members of the ICB) who may observe proceedings and contribute to the Joint Committee's deliberations as required, but these representatives will not have the right to vote. The Partners may identify individuals or representatives of other organisations that may be invited to observe proceedings and contribute to the Joint Committee's deliberations as required. These representatives will not have the right to vote. <u>Term of membership</u> Each member of the Core Membership (and any substitute appointed) will hold their appointment for a term of [one year]. The term of appointment of each member expires on the [first] anniversary of the first Joint Committee meeting at which the

	member is in attendance. Members will be eligible to be reappointed for further terms at the discretion of the Partners. <u>Membership lists</u> The Chair (or in the absence of a Chair, the Partners themselves) shall ensure that there is prepared (and updated from time to time) a list of the members and that this list is made available to the Partners.
Chair	At the first meeting of the Joint Committee, the Core Membership shall select a Chair, or joint Chairs, from among the membership. The Chair(s) shall hold office for a period of [one year] and be eligible for re-appointment for [1] further term. At the first scheduled Joint Committee meeting after the expiry of the Chair's term of office, the Core Membership will select a Chair, or joint Chairs, who will assume office at that meeting and for the ensuing term. If the Chair(s) is/are not in attendance at a meeting, the Core Membership will select one of the members to take the chair for that meeting.
Remuneration	The Partners shall prepare a scheme for the remuneration of any external members and for meeting the reasonable expenses incurred by other classes of membership of the Joint Committee. The scheme shall be reviewed on an [annual] basis.
Meetings	The Joint Committee shall meet [12] times per year, as a minimum. At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Joint Committee shall prepare a schedule of meetings for the forthcoming year ("the Schedule"). The Chair(s) (or in the absence of a Chair, the Partners themselves) shall see that the Schedule is notified to the members. Either: ▪ NHS England, or ▪ The ICBs acting collectively, may call for a special meeting of the Joint Committee outside of the Schedule as they see fit, by giving notice of their request to the Chair. The Chair(s) may, following consultation with the Partners, confirm the date on which the special meeting is to be held and then issue a notice giving not less than [4 weeks'] notice of the special meeting.

Quorum	A Joint Committee meeting is quorate if the following are in attendance: ▪ the Authorised Officers (or substitute) nominated by NHS England; ▪ each of the Authorised Officers (or substitutes) appointed by the ICBs.
Decisions and voting arrangements	
Conduct and conflicts of interest	Members of the Joint Committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and relevant organisational policies. The NHS Standards of Business Conduct policy is available from: https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/ Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life). See: https://www.gov.uk/government/publications/the-7-principles-of-public-life. Members should refer to and act consistently with the NHS England guidance: *Managing Conflicts of Interest in the NHS: Guidance for staff and organisations*. See: https://www.england.nhs.uk/ourwork/coi/. Where any member of the Joint Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Joint Committee, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed, either by participating in discussion or by voting. A Partner whose Authorised Officer is conflicted in this way may secure that their appointed substitute attend the meeting (or part of meeting) in the place of that member.
Confidentiality of proceedings	The Joint Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings of the Joint Committee is at the discretion of the Partners. All members in attendance at a Joint Committee are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners.

Publication of notices, minutes and papers	The Partners shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Joint Committee. The Chair(s) (or in the absence of a Chair, the Partners themselves) shall see that notices of meetings of the Joint Committee, together with an agenda listing the business to be conducted and supporting documentation, is issued to the Partners [1 week] (or, in the case of a special meeting, [1 week]) prior to the date of the meeting. The proceedings and decisions taken by the Joint Committee shall be recorded in minutes, and those minutes circulated in draft form within [2 weeks] of the date of the meeting. The Joint Committee shall confirm those minutes at its next meeting.
Review of the Terms of Reference	These Terms of Reference will be reviewed [annually].

CHEDULE 3: JOINT SPECIALISED SERVICES

The following are the Specialised Services that NHS England has determined as being suitable and ready for greater ICB involvement:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease
		29S	Severe asthma
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Transcatheter Aortic Valve Replacement (TAVI)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08E	Neurosurgery - Low Volume Procedures (National)
		08F	Neurosurgery - Low Volume Procedures (Regional)
		08G	Neurosurgery - Low Volume Procedures (Neuroscience Centres)
		08O	Neurology
		08P	Neurophysiology
		08R	Neuroradiology
		08S	Neurosurgery
		08T	Mechanical Thrombectomy
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery
		34R	Orthopaedic revision
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection
72	Major trauma services (adults and children)	34T	Major trauma services
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer
		01K	Malignant mesothelioma
		01M	Head and neck cancer
		01N	Kidney, bladder and prostate cancer
		01Q	Rare brain and CNS cancer
		01U	Oesophageal and gastric cancer
		01V	Biliary tract cancer
		01W	Liver cancer
		01Y	Cancer Outpatients
		01Z	Testicular cancer
		04F	Gynaecological cancer
		19V	Pancreatic cancer
		24Y	Skin cancer
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence
		33B	Complex inflammatory bowel disease
		33C	Transanal endoscopic microsurgery
		33D	Distal sacrectomy for advanced and recurrent rectal cancer
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	23X(b)	Specialist paediatric surgery services - Gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics
135	Specialist paediatric surgery services	23X(a)	Specialist paediatric surgery services - General Surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Complex termination of pregnancy
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 4: JOINT FUNCTIONS

1. Introduction

1.1 This Schedule sets out in further detail the functions which are to be exercised jointly by the Partners, being, in summary:

1.1.1 decisions in relation to the commissioning and management of Joint Specialised Services;

1.1.2 planning Joint Specialised Services for the Population, including carrying out needs assessments;

1.1.3 undertaking reviews of Joint Specialised Services in respect of the Population;

1.1.4 supporting the management of the Specialised Commissioning Budget;

1.1.5 co-ordinating a common approach to the commissioning and delivery of Joint Specialised Services with other health and social care bodies in respect of the Population where appropriate; and

1.1.6 such other ancillary activities that are necessary in order to exercise the Specialised Commissioning Functions.

2. General Obligations

2.1 The Partners are jointly responsible for planning the commissioning of the Joint Specialised Services in accordance with this Agreement, the Finance Guidance and the Mandated Guidance.

2.2 The role of the Joint Committee shall include:

2.2.1 planning the commissioning of the Joint Specialised Services;

2.2.2 assurance and oversight of the Joint Specialised Services, including compliance with the National Specifications and relevant Clinical Commissioning Policies;

2.2.3 identifying and setting strategic priorities for the Joint Specialised Services;

2.2.4 development of local commissioning expertise and advice structures.

2.3 The Joint Committee must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Services Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification where one exists in relation to the relevant Specialised Service.

Specific Obligations

3. Procurement and Contract Management

3.1 The Joint Committee will make procurement decisions and support NHS England to carry out any procurement processes in accordance with the Contracting Standard Operating Procedure.

3.2 In discharging these responsibilities, the Joint Committee must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any

applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services.

3.3 When the Joint Committee makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it is able to demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

3.3.1 made in the best interest of patients, taxpayers and the population;

3.3.2 robust and defensible, with conflicts of interests appropriately managed;

3.3.3 made transparently; and

3.3.4 compliant with relevant Guidance and Legislation.

3.4 The Joint Committee shall be consulted on contracting decisions relevant to the exercise of the Joint Commissioning Functions and shall ensure the performance of the following general obligations:

3.4.1 oversee the management of the Specialised Services Contracts and, except in relation to payment, performance of the obligations of the commissioner in accordance with the relevant terms;

3.4.2 support the active management of the performance of the Specialised Services Providers in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services, including, as appropriate, by ensuring that timely action is taken to enforce contractual breaches, serve notices or work with Specialised Services Providers to address any issues;

3.4.3 review expenditure and collectively discuss how to obtain value for money in order to obtain value for money on behalf of NHS England;

3.4.4 where required, support NHS England to undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;

3.4.5 collectively assess quality and outcomes including but not limited to clinical effectiveness, clinical governance, patient safety and the patient safety incident response framework, risk management, patient experience, and addressing health inequalities;

3.4.6 consider any necessary variations (to be managed by NHS England) to the relevant Specialised Services Contract or services in accordance with Clinical Commissioning Policies, National Specifications, service user needs and clinical developments, including, where necessary, developing and implementing a service development improvement plan with Specialised Service Providers where they are not in position to meet any new National Standard or amendment to a National Specification or Clinical Commissioning Policy that is published in the future;

3.4.7 agree information and reporting requirements to support NHS England to manage information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

3.4.8 conduct review meetings and support NHS England to undertake contract management, including the issuing of contract queries and agreeing any remedial action plan or related contract management processes.

3.5 Where NHS England considers that it is necessary for the effective commissioning of the Joint Specialised Services, it may take any such decision that it considers necessary and appropriate and shall report such decision to the next Joint Committee.

4. Finance

4.1 Without prejudice to Clause 8 (Finance) of this Agreement, the Joint Committee must support NHS England to manage each of the relevant Specialised Services Contracts, including by:

4.1.1 ensuring proper financial management and governance for Joint Specialised Services in accordance with the Finance Guidance;

4.1.2 supporting the move towards management of population-based budgets for Joint Specialised Services; and

4.1.3 considering and inputting into local price agreements, managing agreements or proposals for local variations and local modifications to be implemented by NHS England.

5. Service Planning and Strategic Priorities

5.1 The Joint Committee is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Joint Specialised Services.

5.2 In planning, commissioning and managing the Joint Specialised Services, the Partners must have processes in place to assess and monitor equitable patient access, in accordance with the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

5.3 The Joint Committee must ensure that the Partners work with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Joint Specialised Services.

5.4 The Joint Committee shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Part A Retained Services should be delegated the Joint Committee or ICB.

6. Commissioning of High Cost Drugs

6.1 The Joint Committee must support the effective and efficient commissioning of High Cost Drugs for Joint Specialised Services.

6.2 The Joint Committee must develop and implement Shared Care Arrangements across the Area of the Joint Committee.

6.3 The Joint Committee must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs. This includes supporting the Specialised Service Provider pharmacy services and each Partner in the development access to medicine strategies, and minimising barriers that may exacerbate health inequalities.

6.4 The Joint Committee must ensure:

6.4.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies;

6.4.2 effective introduction of new medicines;

6.4.3 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored; and

6.4.4 consistency of prescribing and unwarranted prescribing variation are addressed.

6.5 The Joint Committee must have in place appropriate monitoring mechanisms, including prescribing analysis, to support the financial management of High Cost Drugs.

6.6 The Joint Committee must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.

6.7 The Joint Committee must provide support to prescribing networks and forums, including but not limited to: immunoglobulin assessment panels, HIV prescribing networks and high cost drugs pharmacy networks.

7. Innovation and New Treatment

7.1 The Joint Committee shall support local implementation of innovative treatments for Joint Specialised Services.

8. Oversight and Assurance

8.1 The Joint Committee must at all times operate in accordance with:

8.1.1 the Oversight Framework published by NHS England;

8.1.2 any national oversight and assurance guidance in respect of Specialised Services and/or joint working arrangements; and

8.1.3 any other relevant NHS oversight and assurance guidance;

collectively known as the “Assurance Processes”.

8.2 The Joint Committee must develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes.

8.3 The Partners must provide any information and comply with specific actions in relation to the Joint Specialised Services, as required by NHS England, including metrics and detailed reporting in accordance with the Terms of Reference.

9. Mental Health, Learning Disabilities and Autism NHS-led Provider Collaboratives

9.1 The Joint Committee shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative Arrangements where tabled by NHS England as an item for discussion under Clause 7.2.

10. Service Standards, National Specifications and Clinical Commissioning Policies

10.1 The Joint Committee shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

10.2 The Joint Committee shall support local and national groups including Relevant Clinical Networks and Clinical Reference Groups that are involved in developing Clinical Commissioning Policies, National Specifications, National Standards and knowledge around Specialised Services.

10.3 The Joint Committee must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Commissioning Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification, where one exists in relation to the relevant Joint Specialised Service.

10.4 The Joint Committee must co-operate with any NHS England activities relating to the assessment of compliance against National Standards, including through the Assurance Processes.

10.5 The Joint Committee must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

10.6 Where any Partner has identified that a Specialised Services Provider may not be complying with the National Standards set out in the relevant National Specification, the Joint Committee shall consider the action to take to address this in line with the Assurance Processes.

11. Networks

11.1 The Joint Committee shall participate in the planning, governance and oversight of the Relevant Clinical Networks, including involvement in agreeing the annual plan for each Relevant Clinical Network. The Partners shall seek to align the network priorities with system priorities and to ensure that the annual plan for the Relevant Clinical Network reflects local needs and priorities.

11.2 The Joint Committee shall actively support and participate in dialogue with Relevant Clinical Networks and shall ensure that there is a clear and effective mechanism in place for giving and receiving information with the Relevant Clinical Networks including network reports.

11.3 The Joint Committee shall support NHS England in the management of Relevant Clinical Networks.

11.4 The Partners shall actively engage and promote Specialised Service Provider engagement in appropriate Relevant Clinical Networks.

11.5 Where a Relevant Clinical Network identifies any concern, the Joint Committee shall seek to consider and review that concern as soon as is reasonably practicable and take such action, if any, as it deems appropriate.

11.6 The Joint Committee shall ensure that network reports are considered where relevant as part of exercising the Joint Functions.

12. Transformation

12.1 The Joint Committee must provide such support as may be requested by NHS England with transformational programmes which encompass the Joint Specialised Services.

12.2 The Joint Committee shall identify the pathways and services that are priorities for transformation according to the needs of their Population.

12.3 The Joint Committee shall oversee local implementation of transformation programmes in respect of the Joint Specialised Services for the Population.

13. Quality

13.1 The Joint Committee must ensure that appropriate arrangements for quality oversight are in place. This must include the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

13.2 The Joint Committee must establish a plan to ensure that quality of the Specialised Services is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.

13.3 The Joint Committee must ensure that the oversight of the quality of the Specialised Services is integrated with wider quality governance in the local system and aligns with NHS England quality escalation processes.

13.4 The Joint Committee must ensure that there is a System Quality Group to identify and manage concerns across the local system.

13.5 The Joint Committee must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

13.6 The Joint Committee must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

14. Individual Funding Requests

14.1 The Partners shall provide any support required by NHS England in respect of determining an Individual Funding Request and implementing the decision of the Individual Funding Request panel.

15. Data Management and Analytics

15.1 The Joint Committee shall:

15.1.1 lead on standardised collection, processing, and sharing of data for Joint Specialised Services, in line with broader NHS England, Department of Health and Social Care and government data strategies;

15.1.2 lead on the provision of data and analytical service to support commissioning of Joint Specialised Services;

15.1.3 ensure collaborative working across the Partners on agreed programmes of work focusing on provision of pathway analytics.

15.2 The Partners shall:

15.2.1 share expertise, and, existing reporting tools, and shall ensure interpretation of data is made available to Joint Committees and other Partners to support the commissioning of the Joint Specialised Services;

15.2.2 work collaboratively with subject matter experts to ensure Partners are able to access data sources available to support the commissioning of the Joint Specialised Services.

15.3 The Joint Committee must ensure that the data reporting and analytical frameworks, as set out in Mandated Guidance or otherwise required by NHS England, are in place to support the commissioning of the Joint Specialised Services.

16. Incident Response

16.1 The Joint Committee shall:

16.1.1 support local incident management for Joint Specialised Services as appropriate to stated incident level; and

16.1.2 support national and regional incident management relating to Joint Specialised Services.

16.2 In the event that an incident is identified that has an impact on the Joint Specialised Services (such as potential failure of a Specialised Services Provider), the Joint Committee shall fully support the implementation of any requirements set by NHS England around the management of such incident and shall provide full co-operation to NHS England to enable a co-ordinated national approach to incident management. NHS England retains the right to take decisions at a national level where it determines this is necessary for the proper management and resolution of any such incident and the Joint Committee shall be bound by any such decision.

17. Freedom of Information and Parliamentary Correspondence

17.1 The Partners shall provide timely support in relation to the handling, management and response to all freedom of information and parliamentary correspondence relating to Joint Specialised Services.

SCHEDULE 5: RETAINED SERVICES

Part A Retained Services

The following are Retained Services that NHS England has determined are suitable but not yet ready for greater ICS leadership:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
4	Adult specialist respiratory services	29E	Management of central airway obstruction
		29V	Complex home ventilation
15	Adult specialist renal services	11T	Renal transplantation
29	Haematopoietic stem cell transplantation services (adults and children)	02Z	Blood and marrow transplantation services
		ECP	Extracorporeal photopheresis service
45	Cystic fibrosis services (adults and children)	10Z	Cystic fibrosis services
55	Gender dysphoria services (children and adolescents)	22A	Gender identity development service for children and adolescents
56	Gender dysphoria services (adults)	22Z	Gender identity services
		42A	Gender dysphoria: genital surgery (trans feminine)
		42B	Gender dysphoria - genital surgery (trans masculine)
		42C	Gender dysphoria: chest surgery (trans masculine)
		42D	Gender dysphoria - non-surgical services
		42E	Gender dysphoria: other surgical services
58	Specialist adult gynaecological surgery and urinary surgery services for females	04K	Specialised services for women with complications of mesh inserted for urinary incontinence and vaginal prolapse (16 years and above)
		04L	Reconstructive surgery and congenital anomalies of the female genital tract
65	Specialist services for adults with infectious diseases	18T	Tropical Disease
82	Paediatric and perinatal post mortem services	F23	Paediatric and perinatal post mortem services
87	Positron emission tomography-computed tomography services (adults and children)	01P	Positron emission tomography-computed tomography services (PETCT)
89	Primary malignant bone tumours service (adults and adolescents)	01O	Primary malignant bone tumours service (adults and adolescents)
101	Severe intestinal failure service (adults)	12Z	Severe intestinal failure service
103A	Specialist adult haematology services	03C	Castleman disease
105	Specialist cancer services (adults)	01L	Soft tissue sarcoma
		01X	Penile cancer
111	Clinical genomic services (adults and children)	20G	Genomic laboratory testing services
		20H	Pre-Implantation genetic diagnosis and associated in-vitro fertilisation services
		20Z	Specialist clinical genomics services
		MOL	Molecular diagnostic service
114	Specialist haemoglobinopathy services (adults and children)	38S (DPC)	Sickle cell anaemia -direct patient care
		38T (DPC)	Thalassemia - direct patient care
		38X (HCC)	Haemoglobinopathies coordinating centres (HCCs)
		38X (SHT)	Specialist Haemoglobinopathies Teams (SHTs)
115	Specialist immunology services for adults with deficient immune systems	16X	Specialist immunology services for adults with deficient immune systems
115A	Specialist immunology services for children with deficient immune systems	16Y	Specialist immunology services for children with deficient immune systems

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05C	Specialist augmentative and alternative communication aids
		05E	Specialist environmental controls
137	Spinal cord injury services (adults and children)	06A	Spinal cord injury services (adults and children)
6	Adult secure mental health services	22S(a)	Secure and specialised mental health services (adult) (Medium and low) -including LD / ASD / WEMS / ABI / DEAF
		22S(b)	Secure and specialised mental health services (adult) (Medium and low) - Excluding LD / ASD / WEMS / ABI / DEAF
		22S(c)	Secure and specialised mental health services (adult) (Medium and low) - ASD
		22S(d)	Secure and specialised mental health services (adult) (Medium and low) - LD
		22S(e)	Secure and specialised mental health services (adult) Medium Secure Female WEMS
		22S(f)	Secure and specialised mental health services (adult) (Medium and low) - ABI
		22S(g)	Secure and specialised mental health services (adult) (Medium and low) - DEAF
		YYY	Specialised mental health services exceptional packages of care
8	Adult specialist eating disorder services	22E	Adult specialist eating disorder services
32	Children and young people's inpatient mental health service	22C	Tier 4 CAMHS (MSU)
		24E	Tier 4 CAMHS (children's service)
		23K	Tier 4 CAMHS (general adolescent inc eating disorders)
		23L	Tier 4 CAMHS (low secure)
		23O	Tier 4 CAMHS (PICU)
		23U	Tier 4 CAMHS (LD)
		23V	Tier 4 CAMHS (ASD)
98	Specialist secure forensic mental health services for young people	24C	FCAMHS
102	Severe obsessive compulsive disorder and body dysmorphic disorder service (adults and adolescents)	22F	Severe obsessive compulsive disorder and body dysmorphic disorder service
116	Specialist mental health services for Deaf adults	22D	Specialist mental health services for Deaf adults
124	Specialist perinatal mental health services (adults and adolescents)	22P	Specialist perinatal mental health services
133	Specialist services for severe personality disorder in adults	22T	Specialist services for severe personality disorder in adults

Part B Retained Services

The following are Retained Services that NHS England has determined will remain nationally commissioned:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
1	Adult ataxia telangiectasia services	23G	Adult ataxia telangiectasia services
2A	Adult oesophageal gastric services in the form of gastro-electrical stimulation for patients with intractable gastroparesis	39A	Gastro-electrical stimulation for patients with intractable gastroparesis
4	Adult specialist respiratory services	29G	Primary ciliary dyskinesia management (adult)
11	Adult specialist neurosciences services	08U	Transcranial magnetic resonance guided focused ultrasound (TcMRgFUS)
		43A	Inherited white matter disorders diagnostic and management service for adults
12	Adult specialist ophthalmology services	37D	Retinal Gene Therapy
		37E	Limbal Cell Treatment (Holoclar)
14	Adult specialist pulmonary hypertension services	13G	Adult specialist pulmonary hypertension services
15	Adult specialist renal services	36E	Cystinosis
19	Alkaptonuria service (adults)	20A	Alkaptonuria service (adults)
19A	Alpha 1 antitrypsin services (adults)	29H	Alpha 1 antitrypsin services
20	Alström syndrome service (adults and children)	H23	Alström syndrome service (adults and children)
21	Ataxia telangiectasia service for children	23J	Ataxia telangiectasia service for children
21A	Atypical haemolytic uraemic syndrome services (adults and children)	11A	Atypical haemolytic uraemic syndrome services (adults and children)
22	Autoimmune paediatric gut syndromes service	16A	Autoimmune paediatric gut syndromes service
23	Autologous intestinal reconstruction service for adults	12A	Autologous intestinal reconstruction service for adults
24	Bardet-Biedl syndrome service (adults and children)	20B	Bardet-Biedl syndrome service (adults and children)
25	Barth syndrome service (adults and children)	36A	Barth syndrome service (male adults and children)
26	Beckwith-Wiedemann syndrome with macroglossia service (children)	36B	Beckwith-Wiedemann syndrome with macroglossia service (children)
27	Behçet's syndrome service (adults and adolescents)	16B	Behçet's syndrome service (adults and adolescents)
28	Bladder exstrophy service (children)	D23	Bladder exstrophy service (children)
31	Pain-related complex cancer late effects rehabilitation service (adults)	01A	Breast radiotherapy injury rehabilitation service
33	Choriocarcinoma service (adults and adolescents)	01I	Choriocarcinoma service (adults and adolescents)
34	Chronic pulmonary aspergillosis service (adults)	29Q	Chronic pulmonary aspergillosis service (adults)
37	Complex childhood osteogenesis imperfecta service	K23	Complex childhood osteogenesis imperfecta service
38	Complex Ehlers Danlos syndrome service (adults and children)	M23	Complex Ehlers Danlos syndrome service (adults and children)
39	Complex neurofibromatosis type 1 service (adults and children)	08A	Complex neurofibromatosis type 1 service (adults and children)
41	Complex tracheal disease service (children)	B23	Complex tracheal disease service (children)
42	Congenital hyperinsulinism service (children)	N23	Congenital hyperinsulinism service (children)
43	Craniofacial service (adults and children)	15A	Craniofacial service (adults and children)
44	Cryopyrin associated periodic syndrome service (adults and children)	02A	Cryopyrin associated periodic syndrome service (adults and children)
46	Diagnostic service for amyloidosis (adults and children)	02B	Diagnostic service for amyloidosis (adults and children)
47	Diagnostic service for primary ciliary dyskinesia (adults and children)	29D	Diagnostic service for primary ciliary dyskinesia (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
48	Diagnostic service for rare neuromuscular disorders (adults and children)	08B	Diagnostic service for rare neuromuscular disorders (adults and children)
49	Encapsulating peritoneal sclerosis treatment service (adults)	11D	Encapsulating peritoneal sclerosis treatment service (adults)
50	Epidermolysis bullosa service (adults and children)	24A	Epidermolysis bullosa service (adults and children)
51	Extra corporeal membrane oxygenation service for adults with respiratory failure	29F	Extra corporeal membrane oxygenation service for adults with respiratory failure
52	Extra corporeal membrane oxygenation service for neonates, infants and children with respiratory failure	R23	Extra corporeal membrane oxygenation service for neonates, infants and children with respiratory failure
53	Ex-vivo partial nephrectomy service (adults)	01D	Ex-vivo partial nephrectomy service (adults)
56A	Hand and upper limb transplantation service (adults)	40A	Hand and upper limb transplantation service (adults)
56ZA	Ovarian and testicular tissue cryopreservation for patients receiving gonadotoxic treatment who are at high risk of infertility and cannot store mature eggs or sperm	44A	Gonadal tissue cryopreservation services for children and young people at high risk of gonadal failure due to treatment or disease
57	Heart and lung transplantation service (including mechanical circulatory support) (adults and children)	13N	Heart and lung transplantation
		13V	Ventricular Assist Devices
58	Specialist adult gynaecological surgery and urinary surgery services for females	04J	Urinary Fistula
61	Specialist dermatology services (adults and children)	43S	Stevens-Johnson syndrome and toxic epidermal necrolysis (SJS-TEN)
62	Specialist metabolic disorder services (adults and children)	36F	CLN2 Disease
65	Specialist services for adults with infectious diseases	18D	Human T- Cell Lymphotropic Virus Type 1 and 2
		18J	Adult high consequence infectious airborne disease service
		18L	Adult high consequence infectious contact disease service
		18U	Infectious disease isolation units
66	Hyperbaric oxygen treatment services (adults and children)	28Z	Hyperbaric oxygen treatment services (adults and children)
67	Insulin-resistant diabetes service (adults and children)	27A	Insulin-resistant diabetes service (adults and children)
68	Islet transplantation service (adults)	27B	Islet transplantation service (adults)
69	Liver transplantation service (adults and children)	19T	Liver transplantation service (adults and children)
70	Lymphangioleiomyomatosis service (adults)	29C	Lymphangioleiomyomatosis service (adults)
71	Lysosomal storage disorder service (adults and children)	36C	Lysosomal storage disorder service (adults and children)
73	McArdle's disease service (adults)	26A	McArdle's disease service (adults)
75	Mitochondrial donation service	20D	Mitochondrial donation service
76	NF2-schwannomatosis service (adults and children)	08C	Neurofibromatosis type 2 service (adults and children)
77	Neuromyelitis optica service (adults and adolescents)	08D	Neuromyelitis optica service (adults and adolescents)
79	Ocular oncology service (adults)	01H	Ocular oncology service (adults)
80	Ophthalmic pathology service (adults and children)	37A	Ophthalmic pathology service (adults and children)
81	Osteo-odonto-keratoprosthesis service for corneal blindness (adults)	37B	Osteo-odonto-keratoprosthesis service for corneal blindness (adults)
84	Paediatric intestinal pseudo-obstructive disorders service	12B	Paediatric intestinal pseudo-obstructive disorders service
85	Pancreas transplantation service (adults)	27C	Pancreas transplantation service (adults)
86	Paroxysmal nocturnal haemoglobinuria service (adults and adolescents)	03A	Paroxysmal nocturnal haemoglobinuria service (adults and adolescents)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
88	Primary ciliary dyskinesia management service (adults and children)	29P	Primary ciliary dyskinesia management service (adults and children)
90	Proton beam therapy service (adults and children)	01B	Proton beam therapy service (adults and children)
91	Pseudomyxoma peritonei service (adults)	01F	Pseudomyxoma peritonei service (adults)
92	Pulmonary hypertension service for children	13J	Pulmonary hypertension service for children
93	Pulmonary thromboendarterectomy service (adults and adolescents)	13M	Pulmonary thromboendarterectomy service (adults and adolescents)
95	Rare mitochondrial disorders service (adults and children)	36D	Rare mitochondrial disorders service (adults and children)
97	Retinoblastoma service (children)	01G	Retinoblastoma service (children)
99	Severe acute porphyria service (adults and children)	27D	Severe acute porphyria service (adults and children)
100	Severe combined immunodeficiency and related disorders service (children)	16C	Severe combined immunodeficiency and related disorders service (children)
103	Small bowel transplantation service (adults and children)	12D	Small bowel transplantation service (adults and children)
103A	Specialist adult haematology services	03T	Thrombotic thrombocytopenic purpura (TTP)
104	Specialist burn care services (adults and children)	09A	Specialist burn care services (adults)
		09C	Specialist burn care services (children)
106A	Specialist colorectal surgery services (adults)	33E	Cytoreductive surgery and hyperthermic intraperitoneal chemotherapy for colorectal cancer
108	Specialist ear, nose and throat services for children	32E	Auditory brainstem implants for children
114	Specialist haemoglobinopathy services (adults and children)	38S (NHP)	National haemoglobinopathy panel (NHP)
119	Specialist neuroscience services for children	08M	Spinal muscular atrophy: gene therapy
		43C	Inherited white matter disorders diagnostic and management service for children
		73M	Children's Epilepsy Surgery Service
		T23	Multiple Sclerosis Management service for children
		U23	Open Fetal surgery to treat fetuses with open spina bifida
123	Specialist paediatric liver disease service	C23	Specialist paediatric liver disease service
130	Specialist services for children with infectious diseases	14C	Specialist services for children with infectious diseases: HIV
		18K	High consequence infectious airborne disease services for children
		18M	High consequence infectious contact disease services for children
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19A	Total pancreatectomy with islet auto transplant
138	Stem cell transplantation service for juvenile idiopathic arthritis and related connective tissue disorders (children)	P23	Stem cell transplantation service for juvenile idiopathic arthritis and related connective tissue disorders (children)
139	Stickler syndrome service (adults and children)	20C	Stickler syndrome diagnostic service (adults and children)
139B	Uterine transplantation services (adults)	04U	Uterine transplantation services
140	Vein of Galen malformation service (adults and children)	A23	Vein of Galen malformation service (adults and children)
142	Wolfram syndrome service (adults and children)	Q23	Wolfram syndrome service (adults and children)
143	DNA Nucleotide Excision Repair Disorders Service (adults and children)	24D	DNA Nucleotide Excision Repair Disorders Service
6	Adult secure mental health services	22O	Offender personality disorder
		22U(a)	Secure and specialised mental health service (adult) (High) - Excluding LD
		22U(b)	Secure and specialised mental health service (adult) (High) - LD
74	Mental health service for deaf children & adolescents	22B	Mental health service for deaf children & adolescents

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
91A	Psychological medicine inpatient services for severe and complex presentations of medically unexplained physical symptoms (adults)	22V	Psychological medicine inpatient services for severe and complex presentations of medically unexplained physical symptoms
141	Integrated veterans' mental health and wellbeing service	22G	Veterans' mental health complex treatment service
		05V	Veterans' prosthetic service

SCHEDULE 6: RESERVED FUNCTIONS

1. Introduction

1.1 In accordance with Clause 6.2 of this Agreement, all functions of NHS England other than those defined as Joint Functions, are Reserved Functions.

1.2 This Schedule sets out further provision regarding the carrying out of the Reserved Functions as they relate to the Joint Functions.

1.3 The ICB Partners will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

1.4 The following functions and related activities shall continue to be exercised by NHS England.

2. Retained Services

2.1 NHS England shall commission the Retained Services set out in Schedule 5.

3. Reserved Specialised Service Functions

3.1 In addition to the commissioning of Retained Services set out in Schedule 5, NHS England shall also carry out the functions set out in this Schedule 6 in respect of the Joint Specialised Services.

4. Oversight and Assurance

4.1 NHS England shall be responsible for developing national oversight and assurance guidance on joint working arrangements for Specialised Services.

4.2 NHS England shall be responsible for assuring the Joint Working Arrangements. Such assurance shall be undertaken in accordance with the Assurance Processes.

4.3 NHS England shall host a Delegated Commissioning Group that will undertake an assurance role in compliance with the Assurance Processes. This assurance role shall include monitoring and suggesting solutions to mitigate systemic risk to Joint Specialised Service provision.

5. Clinical Leadership and Clinical Reference Groups

5.1 NHS England shall be responsible for the following:

5.1.1 providing clinical leadership, advice and guidance to the Joint Committee in relation to the Joint Specialised Services;

5.1.2 supporting ICB Partners to develop clinical leadership for Joint Specialised Services; and

5.1.3 providing clinical and public health leadership for Specialised Services.

5.2 NHS England will host Clinical Reference Groups, which will lead on the development and publication of the following for Specialised Services:

5.2.1 Clinical Commissioning Policies;

5.2.2 National Specifications, including National Standards for each of the Specialised Services.

6. Clinical Networks

6.1 Unless otherwise agreed between the Partners, NHS England shall put in place contractual arrangements and funding mechanisms for the commissioning of the Relevant Clinical Networks.

6.2 NHS England shall be responsible for the following in respect of the Relevant Clinical Networks:

6.2.1 developing national policy for the Relevant Clinical Networks;

6.2.2 developing and approving the national specifications for the Relevant Clinical Networks;

6.2.3 maintaining links with other NHS England national leads for clinical networks not focused on Specialised Services;

6.2.4 convening or supporting national networks of the Relevant Clinical Networks;

6.2.5 agreeing the annual plan for each Relevant Clinical Network with the involvement of the Joint Committee and Relevant Clinical Network, ensuring these reflect national and regional priorities;

6.2.6 managing Relevant Clinical Networks jointly with the Joint Committee; and

6.2.7 agreeing and commissioning the hosting arrangements of the Relevant Clinical Networks.

7. Complaints

7.1 NHS England shall manage all complaints in respect of the Joint Specialised Services and Reserved Services.

8. Procurement

8.1 In relation to procurement, NHS England shall be responsible for:

8.1.1 setting standards and agreeing frameworks and processes for provider selections and procurements for Specialised Services;

8.1.2 monitoring and providing advice, guidance and expertise on the overall provider market in relation to Specialised Services;

8.1.3 running provider selection and procurement processes for Specialised Services.

9. Contracting

9.1 NHS England shall retain the following obligations in relation to contracting:

9.1.1 except where 9.1.2 applies, entering into Specialised Commissioning Contracts with Specialised Service Providers as Co-ordinating Commissioner including negotiation of the Specialised Services Contracts and creating all contract documents (including indicative activity plans) and

schedules for inclusion in the Specialised Services Contracts, including the process of negotiation;

9.1.2 where NHS England in its absolute discretion agrees to enter into Specialised Commissioning Contracts with Specialised Service Providers as Associate Commissioner and perform all contracting duties required of an associate as well as ensure oversight of the relevant Specialised Commissioning Contracts through the Joint Committee;

9.1.3 setting, publishing or making otherwise available the Contracting Standard Operating Procedure and other Mandated Guidance detailing contracting strategy and policy for Specialised Services; and

9.1.4 providing and distributing contracting support tools and templates to the Partners.

9.2 NHS England shall keep a record of all of the Specialised Services Contracts setting out the following details in relation to each Specialised Services Contract

9.2.1 name of the Specialised Services Provider;

9.2.2 the name by which the Specialised Services Provider is known;

9.2.3 commissioner name;

9.2.4 Specialised Services Contract start date and end date;

9.2.5 description of Specialised Services;

9.2.6 location of provision of services; and

9.2.7 amounts payable under the Specialised Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

10. Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

10.1 NHS England shall commission and design Provider Collaborative Arrangements for mental health, learning disabilities and autism services. Where it considers appropriate, NHS England shall seek the input of the Joint Committee in relation to relevant Provider Collaborative Arrangements.

11. Finance

11.1 NHS England shall be responsible for:

11.1.1 Performing all necessary financial transactions associated with Specialised Services unless expressly agreed and set out in Local Terms;

11.1.2 Setting financial policy and frameworks and developing the support tools necessary to enable commissioners to plan and deliver against a population-based allocation;

11.1.3 Setting financial allocations for Specialised Services, including the move from historic actual to population-based allocations and including growth, inflation and efficiency targets;

11.1.4 Consolidating and reporting plans and in-year financial delivery against the Specialised Services Budget;

11.1.5 Developing financial impact assessments for National Specifications;

11.1.6 Overseeing dispute escalation and resolution where there are material changes to out-of-area cross-border flows;

11.1.7 Supporting the Joint Committee to ensure the financial delivery of the Joint Specialised Services according to financial business rules and financial frameworks including but not limited to:

11.1.7.1 financial planning;

11.1.7.2 investment and commissioning decision-making;

11.1.7.3 budgetary control and delivery of efficiency targets;

11.1.7.4 financial reporting and accounting;

11.1.7.5 system financial oversight.

12. Individual Funding Requests (IFRs)

12.1 NHS England shall be responsible for the following:

12.1.1 Leading on IFR policy, supporting IFR governance and managing the IFR process; and

12.1.2 Providing pharmacy activity input and public health medicines expertise into IFR decisions.

13. Data Management and Analytics

13.1 NHS England shall:

13.1.1 Lead on data collection, data acquisition and reporting;

13.1.2 Provide leadership of data management and analytics to support the Partners, including professional network development, workforce development and information dissemination;

13.1.3 Set Specialised Services data strategy and ensure alignment with broader NHS England, Department of Health and Social Care and government data strategies;

13.1.4 Secure appropriate resource to support a national service for data processing and analytics for Specialised Services;

13.1.5 Oversee standardised collection, processing and sharing of data used to support Specialised Services commissioning across the Partners, in line with national data strategy;

13.1.6 Work collaboratively with all Partners to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services; and

13.1.7 Support ICB data and analytic functions and wider data and analytic networks to develop, deploy locally and utilise business intelligence tools.

14. Pharmacy and Optimisation of High Cost Drugs

14.1 In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:

14.1.1 support the Joint Committee on strategy for access to medicines, minimising barriers to health inequalities;

14.1.2 provide financial management of High Cost Drugs spend, including prescribing analysis, to identify, scope, engage, deliver and record better value medicines strategy and initiatives;

14.1.3 commission High Cost Drugs for Retained Services and of High Cost Drugs for Joint Specialised Services working jointly with Joint Committee;

14.1.4 ensure consistency of prescribing in line with Clinical Commissioning Policies, introduction of new medicines, and addressing unwarranted prescribing variation;

14.1.5 set medicines commissioning policy and criteria for access to certain medicines commissioned by Specialised Services including developing any necessary support tools;

14.1.6 provide expert medicines advice and input into all Specialised Services activities; and

14.1.7 provide direction and support to medicines leads at ICB level to support discharge of duties and delivery of strategic objectives and National Standards.

15. Quality

15.1 In respect of quality, NHS England shall:

15.1.1 work with the Joint Committee to ensure oversight of Specialised Services through quality oversight and risk management;

15.1.2 ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group, or other appropriate forums, as necessary;

15.1.3 ensure that the Joint Specialised Services are aligned and integrated with broader clinical quality governance and processes;

15.1.4 when quality issues relating to Specialised Services are identified, facilitate improvement through programme support, and mobilise intensive support when required on specific quality issues;

15.1.5 facilitate review of Specialised Services where concerns arise, utilising peer reviews or clinical assessment, as appropriate;

15.1.6 ensure all relevant intelligence is shared appropriately for quality and safety monitoring, including between organisations and at system quality groups or appropriate alternative forums;

15.1.7 identify and act upon issues and concerns that cross multiple ICBs, coordinating response and management as necessary;

15.1.8 provide guidance on quality and clinical governance matters and benchmark available data;

15.1.9 support Joint Committees to identify key themes and trends across their Area and utilise data and intelligence to respond and monitor as necessary; and

15.1.10 facilitate and support the national quality governance infrastructure (Specialised Commissioning Quality and Governance Group).

16. Service standards

16.1 NHS England shall carry out the following:

16.1.1 development, engagement and approval of National Standards for Specialised Services (including National Specifications, Clinical Commissioning Policies, quality and data standards);

16.1.2 production of national commissioning products and tools to support commissioning of Specialised Services; and

16.1.3 maintenance and publication of the 'Manual' of prescribed Specialised Services and engagement with the Department of Health and Social Care on policy matters.

17. Transformation

17.1 NHS England shall be responsible for:

17.1.1 providing leadership for transformation programmes and projects that have been identified as priorities for national coordination and support, and / or are national priorities for the NHS, including supporting delivery of commitments in the NHS Long Term Plan;

17.1.2 co-production and co-design of transformation programmes with the Joint Committee and wider stakeholders; and

17.1.3 supporting Joint Committees in co-ordinating and enabling Specialised Services transformation programmes for Joint Specialised Services where necessary.

18. Incident Response

18.1 NHS England shall, lead on incident management for Specialised Services.

18.2 NHS England shall lead on monitoring, planning and support for service and operational resilience and provide support to the Joint Committee to develop its oversight of these arrangements.

18.3 NHS England shall respond to specific service interruptions; for example. supplier, workforce challenges and provide support to the Joint Committee in any response to interruptions.

19. Innovation and New Treatment

19.1 NHS England shall ensure the implementation of innovative treatments for Joint Specialised Services and Retained Services such as Advanced Medicinal Therapy Products (ATMPs), recommended by NICE technology appraisals within statutory requirements.

19.2 NHS England shall provide national leadership for innovative treatments with significant service impacts including liaison with NICE.

SCHEDULE 7: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

1. Introduction

1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Partners on a Need To Know basis, in order to enable the Partners to exercise their functions in pursuance of this Agreement.

1.2. References in this Schedule *(Further Information Governance and Sharing Provisions)* to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3. This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:

1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Partners;

1.3.2. describe the purposes for which the Partners have agreed to share Relevant Information;

1.3.3. set out the lawful basis for the sharing of information between the Partners, and the principles that underpin the exchange of Relevant Information;

1.3.4. describe roles and structures to support the exchange of Relevant Information between the Partners;

1.3.5. apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff;

1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8. apply to the activities of the Partners' Staff; and

1.3.9. describe how complaints relating to Personal Data sharing between the Partners will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Functions and NHS England's Reserved Functions.

2.2. Each Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant Legislation and Guidance.

3. Benefits of information sharing

3.1. The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Joint Specialised Services.

4. Lawful basis for sharing

4.1. The Partners shall comply with all relevant Data Protection Legislation requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Partners shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.

4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5. Restrictions on use of the Shared Information

5.1. Each Partner shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

5.2. Access to, and processing of, the Relevant Information provided by a Partner must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Partners' Staff should only have access to Personal Data on a justifiable Need to Know basis.

5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Partners.

5.4. Neither Partner shall subcontract any processing of the Relevant Information without the prior consent of the other Partner. Where a Partner subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

5.5. The Partners shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

5.6. Any particular restrictions on use of certain Relevant Information should be included in a Personal Data Agreement.

6. Ensuring fairness to the Data Subject

6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Partners will take the following measures as reasonably required:

6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering

the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and

6.1.4. giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

6.2. Each Partner shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.

6.3. The Partners shall reasonably cooperate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

6.4. Further provision in relation to specific data flows may be included in a Personal Data Agreement between the Partners.

7. Governance: Staff

7.1. The Partners must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.

7.2. The Partners agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Partners' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing Partners must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

7.3. The Partners shall ensure that all Staff required to access Personal Data (including Special Category Personal Data are informed of the confidential nature of the Personal Data. The Partners shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

Each Party shall provide evidence (further to any reasonable request) that all personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

7.4. The Partners shall ensure that:

7.4.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information; and

7.4.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and

7.4.3. specific limitations on the Staff who may have access to the Information are set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8. Governance: Protection of Personal Data

8.1. At all times, the Partners shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.

8.2. Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Partners. The Partners shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.

8.4. If any Partner

8.4.1. becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

8.4.2. becomes aware of any security vulnerability or breach in respect of the Relevant Information,

it shall promptly, within 48 hours, notify the other Partners. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

8.5. In processing any Relevant Information further to this Agreement, the Partners shall process the Personal Data and Special Category Personal Data only:

8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.

8.6. The Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protected the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

8.6.1. take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and

8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

8.7. In particular, teach Partner shall:

8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;

8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

8.7.3. obtain prior written consent from the originating Partner in order to transfer the Relevant Information to any third party;

8.7.4. permit any other Partner or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Partner to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

The Partners shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8.8. The Partners shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.9. The Partners' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third party security measures.

9. Governance: Transmission of Information between the Partners

9.1. This paragraph supplements paragraph 8 of this Schedule.

9.2. Transfer of Personal Data between the Partners shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record / data is identified.

9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered into in accordance with this Schedule.

9.5. Each Partner shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

9.6. The Partners' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Partners.

10. Governance: Quality of Information

10.1. The Partners will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11. Governance: Retention and Disposal of Shared Information

11.1. A non-originating Partner shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Partner they came from.

11.2. Each Partner shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3. If a Partner is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Partners in writing of that retention, giving details of the documents or materials that it must retain.

11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

11.5. The Partners shall set out any special retention periods in a Data Sharing Agreement where appropriate.

11.6. The Partners shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

11.7. Each Partner shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

11.8. Electronic records will be considered for deletion once the relevant retention period has ended.

11.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Partner shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

12.1. The Partners shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("**Subject Access Requests**"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2. Complaints about information sharing shall be reported to the Single Points of Contact and the Joint Committee. Complaints about information sharing shall be routed through each Partners' own complaints procedure unless otherwise provided for in the Joint Working Arrangements or determined by the Joint Committee.

12.3. The Partners shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4. Basic details of the Agreement shall be included in the appropriate log under each Partner's Publication Scheme.

13. Governance: Single Points of Contact

13.1. The Partners each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

14.1. The Partners shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 8: MANDATED GUIDANCE

Generally applicable Mandated Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- IG Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable guidance relating to the use of data and data sets for reporting.

Workforce

- Guidance on the Employment Commitment.

Finance

- Guidance on NHS System Capital Envelopes.
- Managing Public Money (HM Treasury).

Specialised Services Mandated Guidance

- Commissioning Change Management Business Rules.
- Cashflow Standard Operating Procedure.
- Finance and Accounting Standard Operating Procedure.
- Provider Collaborative Guidance.
- Clinical Commissioning Policies.
- National Specifications.
- National Standards.
- The ‘Manual’ for Specialised Commissioning.

SCHEDULE 9: LOCAL TERMS

General

Where there is a dispute as to the content of this Schedule, the Partners should follow the Disputes Resolution procedure set out at Clause 18.

Following signature of the Agreement, this Schedule can be amended by the Partners using the Variations procedure at Clause 10.

Part 1 – Further Governance Arrangements

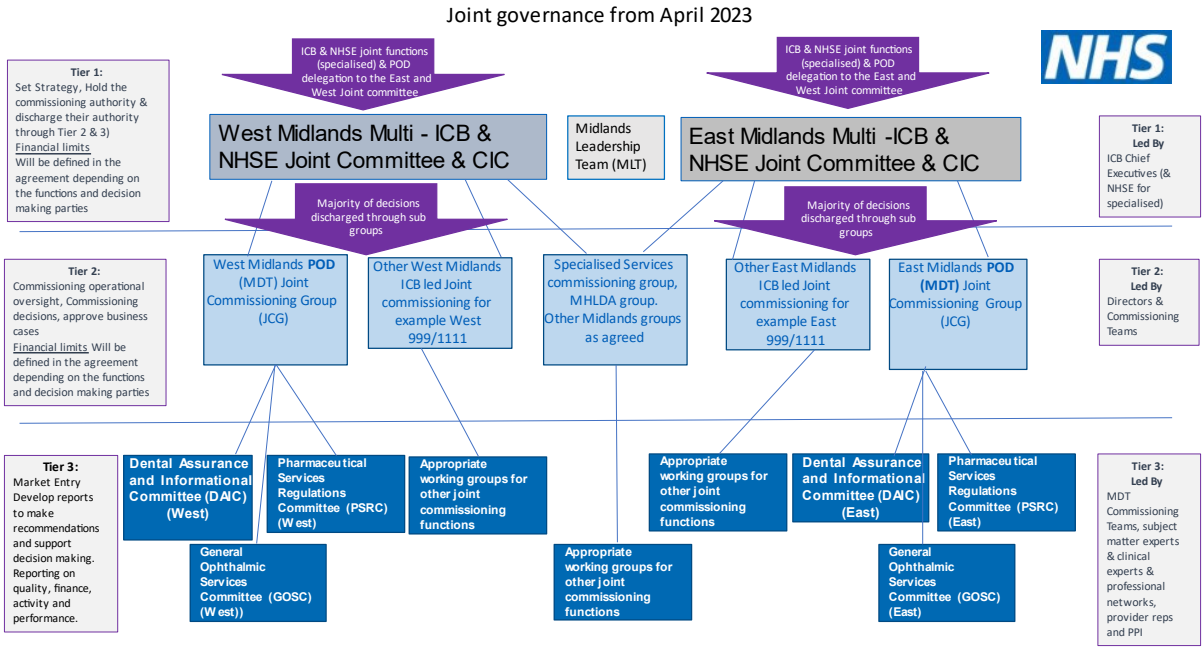
1.1 The Joint Committee wil operate in 2 parts, these being,

- Part 1: Functions of NHSE that are not yet delegated to ICB's which are designated for formal joint working.
- Part 2: Functions and services delegated to it from the individual ICBs.

1.2 All delegated decisions will be made at the Joint Committee in line with the scheme of delegation outlined below.

1.3 Figure 1 below illustrates the decision-making Tiers, with Tier 1 forming the Joint Committee.

1.4 The Terms of Reference for any sub groups operating on behalf of the Joint Committee must be formally approved by Partners



DRAFT Schemes of Financial Delegation

TIER ONE - Function, Decision or Purpose	Value	Who Transacts
JOINT COMMITTEES – East & West		
To jointly discharge joint working (pre-delegation) and joint commissioning (once delegated) responsibilities through an East & West Joint Committees decision-making structure; including scope to receive	23/24 will be as per NHSE SFIs ceilings (as with Midlands Commissioning Group now, but with ICB input) until Spec	

future delegations (either further from NHSE, or from ICBs to each other, to work together for services they wish to collaborate on)	Comm is part-delegated April-24, then the Joint Committee will be empowered to commit resources to the ceilings determined by the decision to be taken.
Part A and Part B to provide strategic decision-making, leadership and oversight for the Joint Working / Joint Commissioning of services and any associated activities. PART A – NHSE & ICBs: NHSE will be a Partner for the commissioning of Specialised Services defined under this Joint Working Agreement. ICBs and NHSE under this agreement will make joint decisions for the benefit of the population. PART B – ICBs Only: ICBs defined in the Tier One Joint Committee of the East Midlands will make decisions regarding all services outlined in Schedule 4 of a separate joint working agreement between ICBs and will act as a forum for discussion and make recommendations to ICBs on issues where further joint action or working between ICBs would be of benefit outside the arrangements delegated to it. This might include but would not be limited to: - Joint Policy development / Links to other regional structures such as Academic Health Science Networks and Clinical networks and Joint Commissioning between ICBs on POD services as delegated from NHSE by 1st April 2023 (see Tiers 2 & 3 below)]	

TIER TWO - Function, Decision or Purpose	Value	Who Transacts
JOINT COMMISSIONING SUB-GROUPS – East & West for Specialised Services		
Midlands Acute Specialised Commissioning Group	23/24 will be as per NHSE SFIs ceilings (as with Midlands Commissioning Group now, but with ICB input) until Spec Comm is part-delegated April-24, then the Joint Committee will be empowered to commit resources to the ceilings determined by the decision to be taken.	
JOINT COMMISSIONING SUB-GROUPS – East & West for Quality and Finance		
DETAILS TBC		
JOINT COMMISSIONING SUB-GROUPS – East & West for POD Services		
Details contained within separate joint working agreement for POD and other services which ICB wish to joint work on.		

TIER THREE - Function, Decision or Purpose	Value	Who Transacts
To be confirmed through Midlands Acute Specialised Commissioning Group		

Part 2 – Workforce Arrangements

In 2023/24, NHS England will retain the relevant specialised commissioning workforce which will support the arrangements described in this Agreement. During 2023/24, NHSE will make arrangements to transfer the specialised commissioning workforce to a host ICB on 01/04/2024 to coincide with the delegation of specialised services.

Dated 2023

East Midlands Integrated Care Boards

NHS Derby and Derbyshire Integrated Care Board

NHS Leicester, Leicestershire and Rutland Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Northamptonshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Agreement in relation to the establishment and operation of joint working arrangements –

“Tier One”: Joint Committee East Midlands

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Clause heading and number — Page number

THIS AGREEMENT is made on the_____ day of _____2023

BETWEEN[1]:

(1) **Integrated Care Board** of **NHS Derby and Derbyshire ("ICB"**);

(2) **Integrated Care Board** of **NHS Leicester, Leicestershire and Rutland** ("{●} **ICB"**);

(3) **Integrated Care Board** of **NHS Lincolnshire** ("{●} **ICB"**).

(4) **Integrated Care Board** of **NHS Northamptonshire** ("{●} **ICB"**).

and

(5) **Integrated Care Board** of **NHS Nottingham and Nottinghamshire** ("{●} **ICB"**).

each a "Partner" and together the "Partners".

{●} **ICB**, {●} **ICB** and {●} **ICB** are together referred to in this Agreement as the **"ICBs",** and **"ICB"** shall mean any of them.

BACKGROUND

(A) The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their areas, apart from those commissioned by NHSE.

(B) Pursuant to section 65Z5 of the NHS Act, NHSE and the ICBs are able to establish and maintain joint arrangements in respect of the discharge of their commissioning functions.

(C) ICBs agree to exercise decisions of the Joint Committee(s) under section 65Z5 of the NHS Act and as set out in this Agreement and the Terms of Reference.

(D) ICBs acknowledge and agree that making joint arrangements to exercise ICB Commissioning Functions is likely to lead to an improvement in the way the Commissioning Functions of all Partners are exercised.

(E) This Agreement sets out the arrangements that will apply the ICBs in relation to the joint exercising of the Joint Working / Joint Commissioning Functions for the ICBs' populations. These arrangements are intended to better align and transform pathways of care around the needs of local populations.

(F) ICBs have entered into this Agreement to define their arrangements for joint working. To avoid doubt, none of the Partners are delegating the exercise of any of their Commissioning Functions or any other functions to any other Partner under this Agreement.

(G) This Agreement is intended for use in the 2023/24 financial year, to govern defined Services; ICBs will:

- Govern the joint working between ICBs in relation to the commissioning functions delegated to the Joint Committee by the ICBs and as defined in Schedule 4 of this agreement. The Joint Committee will discharge the delegated functions through its subgroups and in accordance with the Scheme of Reservation and Delegation defined by the joint committee

NOW IT IS HEREBY AGREED as follows:

1. **COMMENCEMENT AND DURATION**

1.1 This Agreement has effect from the date of this Agreement and will remain in force for the Initial Term unless terminated in accordance with Clause 20 (Leaving the Joint Committee) below.

1.2 The Partners may extend this Agreement beyond the Initial Term for a further period, by written agreement prior to the expiry of the Initial Term.

2. **PRINCIPLES AND AIMS**

2.1 The Partners acknowledge that, in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act and must:

2.1.1 consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;

2.1.2 consider how, in performing its obligations, it can address health inequalities;

2.1.3 at all times exercise functions effectively, efficiently and economically; and

2.1.4 act at all times in good faith towards each other.

2.2 The Partners agree:

2.2.1 that successfully implementing this Agreement will require strong relationships and an environment based on trust and collaboration;

2.2.2 to seek to continually improve whole pathways of care pertinent to the Joint Working / Joint Commissioning services and to design and implement effective and efficient integration;

2.2.3 to act in a timely manner;

2.2.4 to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks and reduce cost;

2.2.5 to act at all times in accordance with the scope of their statutory powers; and

2.2.6 to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any Joint Working and Joint Commissioning services and, as far as is reasonably practicable, take such needs and views into account.

2.3 The Partners' primary aim is to maximise the benefits to patients of integrating the Joint Functions with the ICBs' Commissioning Functions through designing and commissioning the Joint Working / Joint Commissioning services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

3. **SCOPE OF JOINT WORKING ARRANGEMENTS**

3.1 This Agreement sets out the arrangements through which the Partners will work together to exercise the Joint Functions as set out in Schedule 4, including:

3.1.1 the establishment of a Joint Committee;

3.1.2 the participation by all Partners in the work of the Joint Committee;

3.1.3 the development of leadership and expertise in respect of the Joint Working / Joint Commissioning services, collectively referred to as the "Joint Working Arrangements".

4. JOINT COMMITTEE

4.1 The Partner ICBs shall together establish a Joint Committee which will operate in accordance with the Terms of Reference set out in Schedule 3.

4.2 The Joint Committee may establish sub-groups or sub-committees of the Joint Committee, which will operate in accordance with the relevant Terms of Reference agreed by the Joint Committee.

4.3 The Partners shall nominate Authorised Officers to the Joint Committee in accordance with Schedule 3.

4.4 Subject to Clauses 17.1 to 17.4 and the terms of the Schedules, ICBs in accordance with this Agreement must reach decisions in relation to the Joint Functions through discussion and agreement. Where in exceptional cases consensus cannot be reached between the members of the Joint Committee in respect of matters under consideration, any voting arrangements set out in the Terms of Reference will apply.

4.5 The ICBs shall ensure that their Authorised Officers have appropriate delegated authority, in accordance with each ICB's internal governance arrangements, to represent the interests of each ICB in the Joint Committee and any other sub-groups or sub-committees established by it.

4.6 The Partners recognise the need to ensure that any potential conflicts of interest on the part of any Partner, including its representatives, in respect of this Agreement and the establishment or operation of the Joint Committee and any sub-group or sub-committee of it must be appropriately identified, recorded and managed.

5. JOINT FUNCTIONS

5.1 This Agreement shall include functions that the ICBs delegate to it as outlined in Schedule 4 in respect of the Joint Working / Joint Commissioning services.

5.2 The Partners must establish effective, safe, efficient and economic arrangements for the discharge of the Joint Functions.

5.3 Partners must exercise the Joint Functions outline in the Joint Committee in accordance with:

5.3.1 the terms of this Agreement;

5.3.2 all applicable Law;

5.3.3 Guidance;

5.3.4 the Terms of Reference; and

5.3.5 Good Practice.

5.4 In exercising the Joint Functions, the Joint Committee must comply with the Mandated Guidance set out in Schedule 6, or otherwise referred to in this Agreement, and such further Mandated Guidance as may be issued by NHSE from time to time, including on NHSE or FutureNHS websites.

5.5 The Joint Committee must perform the Joint Functions:

5.5.1 in such a manner as to ensure ICBs compliance with its statutory duties in respect of the Joint Functions;

5.5.2 having regard to NHSE's accountability to the Secretary of State and Parliament in respect of any NHSE delegated Functions.

6. FURTHER COLLABORATIVE WORKING

6.1 An ICB may, at its discretion, table for discussion at any Joint Committee meeting an item relating to any ICB Function, in order to facilitate engagement and promote integration and collaborative working. Decision-making in respect of such discussions will remain with the relevant ICB. For the avoidance of doubt, the Joint Committee will not have any authority to take decisions in respect of ICB Functions, outside of services defined in Schedule 4

6.2 NHSE may table for discussion at any Joint Committee meeting an item relating to NHSE's accountability to the Secretary of State and Parliament in respect of any NHSE delegated Functions or any such other of NHSE's Functions that it considers appropriate in order to facilitate engagement and promote integration and collaborative working.

7. FINANCE

7.1 The Joint Committee shall ensure full compliance with Finance Guidance and any other relevant Mandated Guidance.

7.2 Each Partner shall bear its own costs as they are incurred, unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners. Such costs may include, but will not be limited to, costs of attendance at Joint Committee meetings and costs in complying with each Partner's relevant obligations in this Agreement.

7.3 Prior to the end of the first year of the Term, the Partners will review the financial arrangements described for the joint commissioning of services outlined in Schedule 4 and consider whether alternative arrangements should be put in place for any extended Term. Any changes to this Agreement to effect such new arrangements will be made in accordance with Clause 9 (Variations).

7.4 Any costs relating to the operation of the Joint Committee shall be shared equally by each Partner

7.5 Financial arrangements for costs associated with the joint commissioning of Services in Schedule 4 will be defined in the relevant Hosting agreement for the services

8. STAFFING

8.1 Staff employed to carry out the functions for commissioning and its associated functions for all services outlined in Schedule 4 and for the management for the Joint Committee will be defined in the relevant hosting agreement for the services

8.2 Any costs associated with the staffing for the Joint Commissioning of services will be met equally by each partner

9. **VARIATIONS**

9.1 The Partners acknowledge that the scope of the Joint Working Arrangements, including the scope of the Joint Functions, may be reviewed and amended from time to time.

9.2 This Agreement may be varied by the agreement of the Partners at any time in writing in accordance with the Partners' internal decision-making processes.

10. **DATA PROTECTION**

10.1 The Partners must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Joint Working Arrangements is processed in accordance with the relevant Partner's obligations under Data Protection Legislation and Data Guidance, and the Partners must assist each other as necessary to enable each other to comply with these obligations.

10.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis. If any Partner:

10.2.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

10.2.2 becomes aware of any security breach,

in respect of the Relevant Information it shall promptly notify the Joint Committee. The Partners shall fully co-operate with one another to remedy the issue as soon as reasonably practicable.

10.3 In processing any Relevant Information further to this Agreement, each Partner shall at all times comply with all NHSE policies and guidance on the handling of data.

10.4 Any information governance breach must be responded to in accordance with Data Security and the Protection Incident Reporting tool. If any Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant Partner must fully inform the Joint Committee of the breach. This clause does not require the relevant Partner to provide information which identifies any individual affected by the breach where doing so would breach Data Protection Legislation.

10.5 Whether or not a Partner is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Partners acknowledge that a Partner may act as both a Data Controller and a Data Processor.

10.6 The Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of law, including in particular the Data Protection Legislation in respect of any Personal Data.

10.7 Other than in compliance with judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any other Partners save as agreed by the Partners in writing.

10.8 Schedule 5 makes further provision about information sharing and information governance.

11. IT INTER-OPERABILITY

11.1 The Partners will work together to ensure that all relevant IT systems operated by the Partners in respect of the Joint Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

11.2 The Partners will use their respective reasonable endeavours to help develop initiatives to further this aim.

12. FURTHER ARRANGEMENTS

12.1 The Partners must give due consideration to whether any of the Joint Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The Partners must comply with any Guidance around the commissioning of Joint Specialised Services by means of arrangements under section 65Z5 or 75 of the NHS Act.

13. FREEDOM OF INFORMATION

13.1 Each Partner acknowledges that the others are a 'Public Authority' for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).

13.2 Each Partner may be statutorily required to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

13.2.1 each Partner shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

13.2.2 each Partner shall consult the other regarding the possible application of exemptions in relation to the information requested; and

13.2.3 each Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the Partner to whom the request is addressed.

13.3 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Joint Working Arrangements. The Joint Committee and each Partner shall comply with such FOIA or EIR protocols.

14. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

14.1 The Partners must and must ensure that, in delivering the Joint Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality / other inducements and actual or potential conflicts of interest.

14.2 Without prejudice to the general obligations set out in Clause 5 (Joint Functions), each ICB must maintain a register of interests in respect of all persons involved in decisions concerning the Joint Functions. This register must be publicly available. For the purposes of this clause, an ICB may rely on an existing register of interests rather than creating a further register.

14.3 Where any member of the Joint Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Joint Committee, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed or make a recommendation in relation to the relevant matter. The relevant appointing body

may send an alternative representative to take the place of the conflicted member in relation to that matter.

15. CONFIDENTIALITY

15.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Partner and the receiving Partner has no right to use it.

15.2 Subject to Clause 16.3, the receiving Partner agrees:

15.2.1 to use the disclosing Partner's Confidential Information only in connection with the receiving Partner's performance under this Agreement;

15.2.2 not to disclose the disclosing Partner's Confidential Information to any third party or to use it to the detriment of the disclosing Partner; and

15.2.3 to maintain the confidentiality of the disclosing Partner's Confidential Information.

15.3 The receiving Partner may disclose the disclosing Partner's Confidential Information:

15.3.1 in connection with any Dispute Resolution Procedure;

15.3.2 to comply with the Law;

15.3.3 to any appropriate Regulatory or Supervisory Body;

15.3.4 to its staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Partner's duty under Clause 16.2;

15.3.5 to NHS Bodies for the purposes of carrying out their functions;

15.3.6 as permitted under any other express arrangement or other provision of this Agreement.

15.4 The obligations in Clause 16 will not apply to any Confidential Information which:

15.4.1 is in or comes into the public domain other than by breach of this Agreement;

15.4.2 the receiving Partner can show by its records was in its possession before it received it from the disclosing Party; or

15.4.3 the receiving Partner can prove it obtained or was able to obtain from a source other than the disclosing Partner without breaching any obligation of confidence.

15.5 This Clause 16 does not prevent an ICB making use of or disclosing any Confidential Information disclosed any other ICB where necessary for the purposes of exercising its functions in relation to that ICB.

15.6 This Clause 16 will survive the termination of this Agreement for any reason for a period of 5 years.

15.7 This Clause 16 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

16. **LIABILITIES**

16.1 Nothing in this Agreement shall affect:

16.1.1 the liability of any of the ICBs to any person in respect of that ICB's Commissioning Functions.

16.2 Partner ICBs shall be responsible for and shall retain the conduct of any Claim in relation to the Joint Functions.

16.3 Each ICB must:

16.3.1 comply with any agreed policy issued by Partners from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims;

16.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify the Joint Committee and send to them all copies of such correspondence;

16.3.3 co-operate fully with Partners in relation to such Claim and the conduct of such Claim;

16.3.4 provide, at its own cost, to Partners all documentation and other correspondence that Partners requires for the purposes of considering and/or resisting such Claim; and/or

16.3.5 at the request of Partners, take such action or step or provide such assistance as may in Partners discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

17. **DISPUTE RESOLUTION**

17.1 Where any dispute arises within the Joint Committee in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute within the Joint Committee in accordance with the Terms of Reference.

17.2 Where any dispute is not resolved under Clause 18.1 on an informal basis, any Authorised Officer may convene a special meeting of the Joint Committee to attempt to resolve the dispute

17.3 Where any dispute is not resolved under Clause 18.1 or 18.2 the Joint Committee can appoint an independent mediator to attempt to resolve the dispute. The cost of mediation will be borne in equal shares between parties involved in the dispute.

17.4 Where any dispute is remains resolved The Joint Committee will commissioning an independent review. The Joint Committee will abide by the independent review findings. The cost will be borne in equal shares between parties involved in the dispute.

18. **BREACHES OF JOINT WORKING**

18.1 If any Partner does not comply with the terms of this agreement in relation to services delegated by ICBs then Patners may:

18.1.1 exercise its rights under this Agreement; and

18.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the Partner.

18.2 Without prejudice to Clause 19.1, if any Partner does not comply with the terms of this Agreement (including if the Joint Committee or any Partner exceeds its authority under this Agreement), Partners may (at their discretion):

18.2.1 waive its rights in relation to such non-compliance in accordance with Clause 19.3;

18.2.2 ratify any decision;

18.2.3 terminate this Agreement in accordance with Clause 20 (Leaving the Joint Committee*)* below;

18.2.4 exercise the dispute resolution procedure in accordance with Clause 18 *(Dispute Resolution Procedure)*; and/or

18.2.5 exercise its rights under common law.

18.3 Partner may waive any non-compliance by another Partner with the terms of this Agreement provided that the Partner provides a written report to the Joint Committee as required by Clause 19.4 and, after considering the Partner's written report, Partner is satisfied that the waiver is justified.

18.4 If:

18.4.1 a Partner does not comply with this Agreement; or

18.4.2 Partners notifies a Partner that it considers the Partner has not complied, or may not be able to comply with, this Agreement;

then that Partner must provide a written report to Partners within ten (10) Operational Days of the non-compliance (or the date on which the relevant Partner considers that it may not be able to comply with this Agreement) or such notification pursuant to Clause 25 setting out:

18.4.3 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement; and

18.4.4 if the non-compliance is capable of remedy, a plan for how the Partner proposes to remedy the non-compliance.

19. LEAVING THE JOINT COMMITTEE

19.1 If any Partner wishes to exit the Joint Committee and end its participation in this Agreement, the relevant ICB must provide at least six (6) months notification to the Joint Committee of its intention to exit the Joint Committee and end its participation in this Agreement. Such notification shall only take effect from the end of 31 March in any calendar year.

19.2 Partners will work together to ensure that there are suitable alternative arrangements in place in relation to the exercise of the Joint Functions.

19.3 The exercise of the Joint Functions does not alter accountability any partner

20. CONSEQUENCES OF TERMINATION

20.1 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the following shall apply:

20.1.1 the Partners agree that they will work together and co-operate to ensure that the winding down of these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

20.1.2 termination of this Agreement shall have no effect on the liability of any rights or remedies of any Partner already accrued, prior to the date upon which such termination takes effect.

20.2 The provisions of Clauses 11 (Data Protection), 14 (Freedom of Information), 16 (Confidentiality), 17 (Liabilities) and 21 (Consequences of Termination) shall survive termination or expiry of this Agreement.

21. PUBLICITY

21.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement.

22. EXCLUSION OF PARTNERSHIP OR AGENCY

22.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners, or render any Partner directly liable to any third party for the debts, liabilities or obligations of any Partner.

22.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

23. THIRD PARTY RIGHTS

23.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

24. NOTICES

24.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

24.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

25. ASSIGNMENT AND SUBCONTRACTING

25.1 This Agreement, and any right and conditions contained in it, may not be assigned or transferred by a Partner, without the prior written consent of the other Partners, except to any statutory successor to the relevant function.

26. SEVERABILITY

26.1 If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

27. WAIVER

27.1 No failure or delay by a Partner to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or

partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

28. STATUS

28.1 The Partners acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

29. ENTIRE AGREEMENT

29.1 This Agreement constitutes the entire agreement and understanding of the Partners and supersedes any previous agreement between the Partners relating to the subject matter of this Agreement.

30. GOVERNING LAW AND JURISDICTION

30.1 Subject to the provisions of Clause 18 (Dispute Resolution) and Clause 29 (Status), this Agreement shall be governed by and construed in accordance with English Law, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

31. FAIR DEALINGS

31.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that, if in the course of the performance of this Agreement, unfairness to either of them does or may result, then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

32. COMPLAINTS

32.1 Any complaints received by the Partners shall be dealt with in accordance with the statutory complaints procedure of the Partner to whose Commissioning Function(s) the complaint relates. For the avoidance of doubt, Partners shall manage all complaints in respect of the Service in Schedule 4.

33. COUNTERPARTS

33.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the date stated at the beginning of it.

SIGNED by ....

for and on behalf of **Integrated Care Board** of **NHS Derby and Derbyshire ("ICB"**); (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of **Integrated Care Board** of **NHS Leicester, Leicestershire and Rutland ("ICB"**); (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of **Integrated Care Board** of **NHS Lincolnshire** ("{●} **ICB"**). (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of **Integrated Care Board** of **NHS Northamptonshire** ("{●} **ICB"**). (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of **Integrated Care Board** of **NHS Nottingham and Nottinghamshire** ("{●} **ICB"**). (Signature)

.....

(Date)

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

DEFINITIONS AND INTERPRETATION

1. In this Agreement, unless the context otherwise requires, the following words and expressions shall have the following meanings:

“Agreement"	this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
“Area”	means the geographical area covered by the ICBs;
"Authorised Officer"	the individual(s) appointed as Authorised Officer in accordance with Schedule 3 (Terms of Reference);
"Change in Law"	a change in Law that is relevant to the arrangements made under this Agreement, which comes into force after the Commencement Date;
“Claim”	means for or in relation to the Joint Functions and Reserved Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
“Clinical Commissioning Policies”	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;
“Clinical Reference Groups”	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Services detailed in Schedule 4 should be provided;
“Collaborative Commissioning Agreement”	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Services detailed in Schedule 4;
"Commencement Date"	{means 1 April 2023};
"Commissioning Functions"	the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
"Confidential Information"	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or arrangements made pursuant to it and: (a) which comprises Personal Data or which relates to any patient or his treatment or medical history; (b) the release of which is likely to prejudice the commercial interests of a Partner; or

(c) which is a trade secret;

“Contracting Standard Operating Procedure”	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Services detailed in Schedule 4;
“Core Membership”	means the voting membership of the Joint Committee as set out in the Terms of Reference;
“Data Controller”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Processor”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health & Social Care, NHSE, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
“Data Protection Officer”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Security and Protection Incident Reporting tool”	the incident reporting tool for data security and protection incidents, which forms part of the Data Security and Protection Toolkit available at https://www.dsptoolkit.nhs.uk/;
"Dispute Resolution Procedure"	the procedure set out in Clause 18 (Dispute Resolution);
“Finance Guidance”	guidance, rules and operating procedures produced by ICBs that relate to these Joint Working Arrangements, including but not limited to the following: - Commissioning Change Management Business Rules; - Contracting Standard Operating Procedure; - Cashflow Standard Operating Procedure; - Finance and Accounting Standard Operating Procedure; - Service Level Framework Guidance;

"FOIA"	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
"ICB Functions"	the Commissioning Functions of the ICB;
"Information"	has the meaning given under section 84 of FOIA;
"Indemnity Arrangement"	mean either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Information Sharing Agreement"	any information sharing agreement entered into in accordance with Schedule 5 (Further Information Governance and Sharing Provisions);
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Initial Term"	the period of one year from 1 April 2023;
"Joint Committee"	means the joint committee of the ICBs, established under this Agreement on the terms set out in the Terms of Reference;
"Joint Working Arrangements"	means the arrangements for joint working as set out in Clause 3 (Scope of Joint Working Arrangements);
"Joint Functions"	as set out in Schedule 2, that shall be jointly exercised by the ICBs through the decisions of the Joint Committee in accordance with the Terms of Reference in Schedule 3;
"Law"	means: (a) any statute or proclamation or any delegated or subordinate legislation; (b) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and (c) any judgment of a relevant court of law which is a binding precedent in England;
"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Joint Functions and issued by NHSE from time to time as mandatory in respect of the Joint Working Arrangements. At the Commencement Date the Mandated Guidance in respect of the Joint Functions shall be as set out in Schedule 6;

"National Standards"	means the service standards for each Service, as set by NHSE and included in Clinical Commissioning Policies or National Specifications;
"National Specifications"	the service specifications published by NHSE in respect of Services detailed in Schedule 4 as applicable;
"Need to Know"	has the meaning set out in Schedule 5;
"NHS Act"	the National Health Service Act 2006;
"NHS England Functions"	NHSE's statutory functions exercisable under or by virtue of the NHS Act;
"Non-Personal Data"	means data which is not Personal Data;
"**Oversight Framework**"	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHSE;
"Partners"	the parties to this Agreement;
"Personal Data"	has the meaning set out in the Data Protection Legislation;
"Population"	means the population for which an ICB or all of the ICBs have the responsibility for commissioning health services;
"Regional Quality Group"	A group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) NICE; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;

“Relevant Information”	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, “confidential patient information” (as defined under section 251 of the NHS Act), and “patient confidential information” as defined in the 2013 Report, The Information Governance Review – “*To Share or Not to Share?”*);
"Request for Information"	has the meaning set out in the FOIA;
“Reserved Functions”	those aspects of the Specialised Commissioning Functions that are not Joint Functions, including but not limited to those set out in Schedule 6;
“**Relevant Clinical Networks”**	means those clinical networks identified by NHSE as required to support the commissioning of any Services detailed in Schedule 4 for the population;
“Shared Care Arrangements”	these arrangements support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification;
“Single Point of Contact”	the member of Staff appointed by each relevant Partner in accordance with the terms of reference in Schedule 3;
“Special Category Personal Data”	has the meaning set out in the Data Protection Legislation;
“Commissioning Budget”	means the budget identified by NHSE for the purpose of exercising the Joint Functions;
“Specified Purpose”	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Functions and Reserved Functions as specified in Schedule 5 *(Further Information Governance and Sharing Provisions)* to this Agreement;
“Services Staff”	means the Staff carrying out the Joint Services Functions immediately prior to the date of this Agreement;
“Staff”	means the Partners’ employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors’ and their sub-contractors’ personnel;
“System quality group”	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;
"Term"	the Initial Term, as may be varied by: (a) any extensions to this Agreement that are agreed under Clause 1.1 (Commencement and Duration); or (b) the earlier termination of this Agreement in accordance with its terms;
“Terms of Reference”	means the Terms of Reference for the Joint Committee agreed between the ICBs at the first meeting of the Joint Committee, a draft

	of which is included at Schedule 3 (Joint Committee – Terms of Reference);
“Triple Aim”	the duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to: (a) the health and well-being of the people of England; (b) the quality of services provided to individuals by the NHS; (c) efficiency and sustainability in relation to the use of resources by the NHS;
“UK GDPR”	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
"Working Day"	any day other than Saturday, Sunday, a public or bank holiday in England.

2. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

3. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are Clauses in this Agreement.

4. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.

5. References to a person or body shall not be restricted to natural persons and shall include a company, corporation or organisation.

6. Words importing the singular number only shall include the plural.

7. Use of the masculine includes the feminine and all other genders.

8. Where anything in this Agreement requires the mutual agreement of the Partners, then unless the context otherwise provides, such agreement must be in writing.

9. Any reference to the Partners shall include their respective statutory successors, employees and agents.

10. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

11. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

SCHEDULE 2: JOINT COMMITTEE OPERATING MODEL AND ITS SUB GROUPS

1.Introduction

1.1 The Joint Committee wil operate in 2 parts these being

- Part 1: Functions of NHSE that are not yet delegated to ICB's which are desingnated for formal joint working
- Part 2: Functions and services dlegated to it from the individual ICBs

1.2 The Terms of Reference for any sub groups operating on behalf of the joint committee must be formally approved by the Joint Committee

1.3 By entering into this JWA ICBs agree to work collaboratively with regard to the services for which they have commissioning responsibility and/ or delegated responsibility from NHSE as set out in schedule 4.

1.4 ICBs will also enter into a JWA agreement with NHSE for the purpose of specialised.

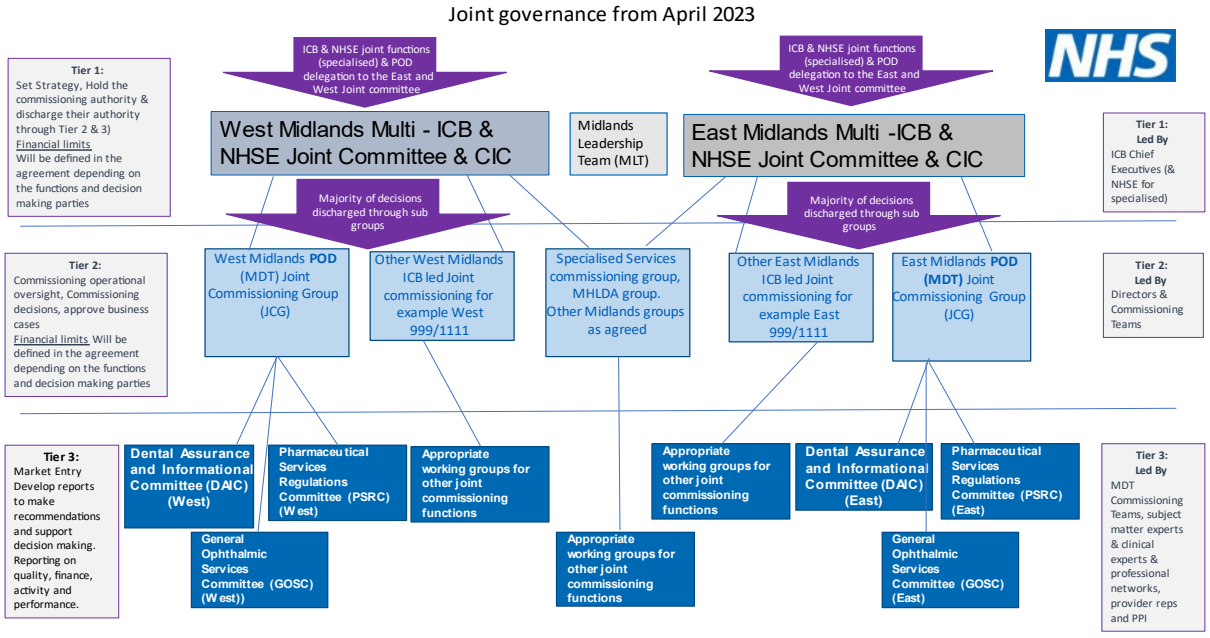
1.5 Both JWA align to the establishment of a single Joint Committee that will govern the discharging of the functions delegated to it.

1.6 The Joint Committee may at is determination establish a structure of commissioning groups/ subgroups through which the Joint Committee will discharge the functions delegated to it. An illustration of such a model ca be seen below.

1.7 This illustration (figure 1 below) should not be considered as the exhaustive or approved structure the Joint Committee will approve the Scheme of Reservation and Delegation and Scheme of Matters Delegated to Officers that sets out how the powers/ functions and duties delegated to it are to be discharges.

1.8 The joint committee will set the parameters of the commissioning committees and subgroups and will approve the Terms of Reference of any aligned commissioning committee or subgroup.

Figure 1



SCHEDULE 3: TIER 1 JOINT COMMITTEE – TERMS OF REFERENCE

Document name:		East Midlands ICB Joint Committee Terms of Reference	
Senior Responsible Owner (SRO):		[Insert]	
Lead:		[Insert]	
Version	[Insert]	**Date:**	[Publish Date]

Document management

Revision history

Version	Date	Summary of changes

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version

Related documents

Title	Owner	Location

Introduction and purpose	The Joint Committee has been established by the ICBs as listed: • **Integrated Care Board** of **NHS Derby and Derbyshire ("ICB"**); • **Integrated Care Board** of **NHS Leicester, Leicestershire and Rutland** ("{LLR} **ICB"**); • **Integrated Care Board** of **NHS Lincolnshire** ("{●} **ICB"**). • **Integrated Care Board** of **NHS Northamptonshire** ("{●} **ICB"**). • **Integrated Care Board** of **NHS Nottingham and Nottinghamshire** ("{●} **ICB"**). In order to jointly discharge commissioning responsibilities covering the East Midlands geographical footprint defined in Schedule 4 of the Joint Working Agreement between the parties. This includes:- • Responsibilities for which the ICBs are responsible for (including those delegated to them by NHSE England). [PART B of the meeting]. • The Joint Committee will collaboratively make decisions on the strategic planning and delivery, including resource allocation, oversight and assurance, to improve health and care outcomes and reduce health inequalities. • Subject to Clauses 6.1 and 6.2 of the Joint Working Agreement (Further Collaborative Working), the Partners may, to such extent that they consider it desirable, table an item at the Joint Committee relating to any other of their functions that is not a Joint Function to facilitate engagement, promote integration and collaborative working. The Partners may establish sub-groups or sub-committees of the Joint Committee, with such Terms of Reference as may be agreed between them. Any such arrangements that are in place at the commencement of the Joint Working Agreement may be documented in the Local Terms (Schedule 7).
The Terms of Reference	These Terms of Reference support effective collaboration between all Partners acting through this Joint Committee. They set out the role, responsibilities, membership, decision-making powers and reporting arrangements of the Joint Committee in accordance with the Joint Working Agreement between the ICBs, and ICBs & NHSE. The Joint Committee will operate as the decision-making forum for exercising the agreed Joint Functions in accordance with the Joint Working Agreement. By agreement, the Partners may use an alternative title for the Joint Committee that reflects local arrangements, for example, 'Commissioning Committee.'
Statutory Framework	The Partners have arranged to exercise the Relevant Functions jointly pursuant to section 65Z5 of the NHS Act 2006. The Joint Committee is established pursuant to section 65Z6 of the NHS Act 2006. Apart from as set out in the Agreement, the Joint Committee does not affect, and must act in accordance with, the statutory responsibilities and accountabilities of the Partners.

Role of the Joint Committee	The role of the Joint Committee for Part A and Part B is to provide strategic decision-making, leadership and oversight for the Joint Working and Joint Commissioning services and any associated activities. The Joint Committee and aligned subsidiary arrangements will safely, effectively, efficiently and economically discharge the Joint Functions and deliver these services through the following key responsibilities:- • Making relevant joint decisions in relation to the planning and commissioning of the services, and any associated commissioning or statutory functions, for the population, for example, through undertaking population needs assessments; • Making recommendations on population-based services financial allocation and financial plans; • Identifying and setting strategic priorities and undertaking ongoing assessment and review of services within the remit of the Joint Committee and aligned subsidiary arrangements, including tackling unequal outcomes and access; • Supporting the development of partnership and integration arrangements with other health and care bodies that facilitate population health management and providing a forum that enables collaboration to integrate service pathways, improve population health and services and reduce health inequalities. This includes establishing links and working effectively with Provider Collaboratives and cancer alliances, and working closely with other ICBs, Joint Committees and NHSE where there are cross-border patient flows to providers; • Will provide strategic quality leadership and oversight for services outlined in Schedule 4 • Determining the appropriate structure of subsidiary arrangements to enable:- • Oversight and assurance of the services in relation to quality, operational and financial performance, including co-ordinating risk / issue management or escalation; and developing the approach to intervention with Specialised Services Providers where there are quality or contractual issues; • Effective engagement with stakeholders, including patients and the public, and involving them in decision-making; • The input of appropriate clinical advice and leadership, including through Clinical Reference Groups and Relevant Clinical Networks; • Otherwise ensuring that the roles and responsibilities set out in the Agreement between the Partners are discharged in compliance with all statutory duties, guidance and good practice, including ensuring that the Joint Committee and aligned subsidiary arrangements have sufficient independent scrutiny of its decision-making and processes. The Joint Committee must adhere to these Terms of Reference and will operate the meeting in in two parts, these being PART A – NHSE & ICB NHS England will be a Partner for the commissioning of Specialised Services defined under a separate Joint Working Agreement. ICB and NHSE under that agreement will make joint decisions for the benefit of the population PART B – ICB Only ICBs defined in the Tier One Joint Committee of the East Midlands will make decisions regarding all services outlined in Schedule 4 and will act as a forum for discussion and make recommendations to ICBs on issues where further joint action or working between ICBs would be of benefit outside the arrangements delegated to it.

	• Joint Policy development • Links to other regional structures such as Academic Health Science Networks and Clinical networks.
Accountability and reporting	The Joint Committee will be formally accountable to the Boards of the ICBs for the functions delegated to the Joint Committee through the Schemes of Reservation and Delegation (SORDs). Where an ICB Board requests that the Joint Committee provides information or reports on its proceedings or decisions, the Partners must comply with that request within a reasonable timescale.
Membership	Core Membership The following individuals will be the core members of the Joint Committee:- • An Authorised Officer (the CEO) from each ICB • A Chair or a Non-Executive Member from each ICB Each of the Core Members may nominate a named substitute to attend meetings if they are unavailable or unable to attend or because they are conflicted. Each of the Partners must ensure that the members nominated on their behalf (and any named substitutes) are of a suitable level of seniority and duly authorised to act on its behalf and to agree to be bound by the final position or decision taken at any meeting of the Joint Committee. One of the authorised officers from a single ICB will act as the Executive Lead for the Joint Committee, it is expected therefore that the Chair of the Joint Committee be nominated from another ICB. Discretionary Membership Each of the Partners may be represented at meetings by representatives (who may be officers or, in the case of an ICB, Non-Executive Members / Directors of the ICB) who may observe proceedings and contribute to the deliberations as required, but these will not have the right to vote. The Partners may also identify individuals or representatives of other organisations that may be invited to observe proceedings and contribute to the Joint Committee's deliberations as required. These representatives will not have the right to vote. Term of Membership Members (and any substitutes appointed) will hold their appointment until the partner they represent nominates an alternative member or they cease to hold their substantive role with the relevant partner. Membership Lists The Chair (or in the absence of a Chair, the Partners themselves) shall ensure that there is prepared (and updated from time to time) a list of the members and that this list is made available to the Partners.
Chair	At the first meeting of the Joint Committee, the Core Membership shall select a Chair, or joint Chairs, from among the membership. The Chair(s) shall hold office for a period of two years and be eligible for re-appointment for one further term. At the first scheduled meeting after the expiry of the Chair's term of office, the Core Membership will select a Chair, or joint Chairs, who will assume office at that meeting and for the ensuing term. If the Chair(s) is / are not in attendance at a meeting, the Core Membership will select one of the members to take the chair for that meeting.

Meetings	The Joint Committee shall meet at least quarterly. At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Joint Committee shall prepare a schedule of meetings for the forthcoming year ("the Schedule"). The Chair(s), or in the absence of a Chair, the Partners themselves, shall see that the Schedule is notified to the members. Any of the Partners may call for a special meeting outside of the Schedule as they see fit, by giving notice of their request to the Chair. The Chair(s) may, following consultation with the Partners, confirm the date on which the special meeting is to be held and then issue a notice giving not less than four weeks' notice of the special meeting.
Quorum	A Joint Committee meeting is quorate if the following are in attendance: • at least one representative member (or substitute) from each ICB. • One NED member from any Partner ICB Attendance at meetings by telephone/video conferencing will count towards the quorum.
Decisions and veto.	The Committee must seek to make decisions relating to the exercise of the Joint Functions on a consensus basis. The Partners must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to Joint Committee meetings for discussions and negotiations between Partners to take place. Where it has not been possible, despite the best efforts of the Core Membership, to come to a consensus decision on any matter before the Joint Committee, Chair of Part B (s) may require the decision to be put to a vote in accordance with the following provisions:- • For decisions each ICB will have one vote with decisions being made by a simple majority of those voting. Any disputes will be resolved using the dispute resolution process outline in sections 17 of the joint working agreement.
Conduct and conflicts of interest	Members will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and relevant organisational policies. The NHS Standards of Business Conduct policy is available from: https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/ Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life): https://www.gov.uk/government/publications/the-7-principles-of-public-life Members should refer to and act consistently with the NHSE guidance: *Managing Conflicts of Interest in the NHS: Guidance for staff and organisations*. See: https://www.england.nhs.uk/ourwork/coi/ Where any member has an actual or potential conflict of interest in relation to any matter under consideration, the Chair (with appropriate advice) will determine the appropriate action to be taken in line with the principles of proportionality and preserving the spirit of collaborative decision making. Such action could include the member not participating in meetings (or parts of meetings) in which the relevant matter is discussed, or from the decision making and/or voting on the relevant item. A Partner whose Authorised Officer is conflicted in this way may secure . that their named substitute attends the meeting (or part of meeting) in the place of that member. A record of how the conflict has been managed will be recorded in the minutes.

Confidentiality of proceedings	The Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings is at the discretion of the Partners. All members in attendance are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners.
Publication of notices, minutes and papers	The Partners shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Committee. The Chair(s), or in the absence of a Chair, the Partners themselves, shall see that notices of meetings, together with an agenda listing the business to be conducted and supporting documentation, is issued to the Partners one working week (or, in the case of a special meeting, three calendar days prior to the date of the meeting). The proceedings and decisions taken shall be recorded in minutes, and those minutes circulated in draft form within one week of the date of the meeting. The Committee shall confirm those minutes at its next meeting.
Review of the Terms of Reference	These terms of reference will be reviewed within twelve months of the committee's establishment and then at least annually thereafter. Any changes to the committee's decision-making membership or core functions must be approved by the partners. Other changes to the terms of reference may be agreed by the committee and reported to the Partners for assurance.
Date of Approval of Terms of Reference	TBC

SCHEDULE 4: SCHEDULE OF SERVICES

4A Dental Services

The Joint functions in respect of Dental Care services are those delegated to the ICBs by NHSE which are, in summary:-

- Decisions in relation to the commissioning and management of Primary Prescribed Community Dental Services;
- Planning Primary Dental Services in the Area, in compliance with Mandated Guidance issued by NHS England, including carrying out needs assessments;
- Undertaking reviews of Primary Dental Services in the Area;
- Management of Dental Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by:-
    - Reviewing and monitoring spending on services provided pursuant to Dental Services Contracts in the Area;
    - Reviewing and monitoring spending on Primary Dental Services commissioned in the Area;
    - Assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);
    - Managing variations to the relevant Dental Services Contract or services in accordance with national policy, service user needs and clinical developments;
    - Agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);
    - Undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;
    - Conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;
    - Allocating sufficient resources for undertaking contract mediation; and
    - Complying with and implementing any relevant Mandated Guidance issued from time to time.
    - Taking timely action to enforce contractual breaches, serve notices or provide discretionary support ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Dental Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local oral health needs;
- Planning of the Provider landscape for Dental services, including considering and taking decisions in relation to:-
    - Establishing new Dental Services Providers in the Area;
    - managing Dental Services Providers providing inadequate standards of patient care;
    - the procurement or award of new Dental Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and
    - closure of practices.
- Management of the Delegated Funds for Primary Dental Services in the Area;
- Co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate including working with NHS England to coordinate the exercise of their respective performance management functions and with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level; and
- Such other ancillary activities that are necessary in order to exercise the Delegated Functions.

4B Pharmacy Services

The Joint functions in respect of Pharmaceutical services are those delegated to the ICBs by NHSE which are, in summary:-

- Decisions in relation to the commissioning and management of Primary Prescribed Community Pharmaceutical Services;
- Planning Primary Pharmaceutical Services in the Area, in compliance with Mandated Guidance issued by NHS England, including carrying out needs assessments;
- Undertaking reviews of Primary Pharmaceutical Services in the Area;

- Maintaining and submitting Practitioners list of persons who have undertaken to provide pharmaceutical services from premises situated within the Area, including the provision of drugs, appliances, Electronic Prescription Service (Known as the "Pharmaceutical Lists)
- Managing and determining applications for inclusion in a Pharmaceutical List
- Overseeing the compliance of those included in the Pharmaceutical Lists exercising powers in respect of Performance Related Sanctions and Market Exit
- Management of Pharmaceutical Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by:-
    - Reviewing and monitoring spending on services provided pursuant to Pharmaceutical Services Contracts in the Area;
    - Reviewing and monitoring spending on Primary Pharmaceutical Services commissioned in the Area;
    - Assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);
    - Managing variations to the relevant Pharmaceutical Services Contract or services in accordance with national policy, service user needs and clinical developments;
    - Agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);
    - Undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;
    - Conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;
    - Allocating sufficient resources for undertaking contract mediation; and
    - Complying with and implementing any relevant Mandated Guidance issued from time to time.
    - Taking timely action to enforce contractual breaches, serve notices or provide discretionary support ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Pharmaceutical Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local pharmaceutical health needs;
- Planning of the Provider landscape for Pharmaceutical Services, including considering and taking decisions in relation to:-
    - Establishing new Pharmaceutical Services Providers in the Area;
    - managing Pharmaceutical Services Providers providing inadequate standards of patient care;
    - the procurement or award of new Pharmaceutical Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and
    - closure of practices.
- Management of the Delegated Funds for Primary Pharmaceutical Services in the Area;
- Co-ordinating a common approach to the commissioning and delivery of Primary Pharmaceutical Services with other health and social care bodies in respect of the Area where appropriate including working with NHS England to coordinate the exercise of their respective performance management functions and with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level; and
- Such other ancillary activities that are necessary in order to exercise the Delegated Functions.

4C Primary Ophthalmic Services

The Joint functions in respect of Primary Ophthalmic Services are those delegated to the ICBs by NHSE which are, in summary:-

- Decisions in relation to the commissioning and management of Primary Ophthalmic Services;
- Planning Primary Ophthalmic Services in the Area, in compliance with Mandated Guidance issued by NHS England, including carrying out needs assessments;
- Undertaking reviews of Primary Ophthalmic Services in the Area;
- Management of Primary Ophthalmic Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by:-

    - Reviewing and monitoring spending on services provided pursuant to Primary Ophthalmic Services Contracts in the Area;
    - Reviewing and monitoring spending on Primary Ophthalmic Services commissioned in the Area;
    - Assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);
    - Managing variations to the relevant Primary Ophthalmic Services Contract or services in accordance with national policy, service user needs and clinical developments;
    - Agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);
    - Undertaking annual contract activity negotiations, including agreeing local prices, managing agreements or proposals for local variations and local modifications;
    - Conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes;
    - Allocating sufficient resources for undertaking contract mediation; and
    - Complying with and implementing any relevant Mandated Guidance issued from time to time.
    - Taking timely action to enforce contractual breaches, serve notices or provide discretionary support ensure that it obtains value for money on behalf of NHS England, including by avoiding making any double payments under any Primary Ophthalmic Services Contracts and reducing the number of contracts which are under-delivering so that funds can be reallocated to meet local eye health needs;
- Planning of the Provider landscape for Primary Ophthalmic Services, including considering and taking decisions in relation to:-
    - Establishing new Primary Ophthalmic Services Providers in the Area;
    - managing Primary Ophthalmic Services Providers providing inadequate standards of patient care;
    - the procurement or award of new Primary Ophthalmic Services Contracts (in accordance with any procurement protocol or Guidance issued by NHS England from time to time); and
    - closure of practices.
- Management of the Delegated Funds for Primary Ophthalmic Services in the Area;
- Co-ordinating a common approach to the commissioning and delivery of Primary Ophthalmic Services with other health and social care bodies in respect of the Area where appropriate including working with NHS England to coordinate the exercise of their respective performance management functions and with a view to achieving greater integration of dentists into the Integrated Care System at the Primary Care Network level; and
- Such other ancillary activities that are necessary in order to exercise the Delegated Functions.

SCHEDULE 5: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

1. Introduction

1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Partners on a Need To Know basis, in order to enable the Partners to exercise their functions in pursuance of this Agreement.

1.2. References in this Schedule *(Further Information Governance and Sharing Provisions)* to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3. This Schedule and Data Sharing Agreements entered into under it are designed to:

1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Partners;

1.3.2. describe the purposes for which the Partners have agreed to share Relevant Information;

1.3.3. set out the lawful basis for the sharing of information between the Partners, and the principles that underpin the exchange of Relevant Information;

1.3.4. describe roles and structures to support the exchange of Relevant Information between the Partners;

1.3.5. apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff;

1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8. apply to the activities of the Partners' Staff; and

1.3.9. describe how complaints relating to Personal Data sharing between the Partners will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Functions and NHSE's Reserved Functions.

2.2. Each Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant Legislation and Guidance.

3. Benefits of information sharing

3.1. The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Joint Specialised Services.

4. Lawful basis for sharing

4.1. The Partners shall comply with all relevant Data Protection Legislation requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Partners shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.

4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5. Restrictions on use of the Shared Information

5.1. Each Partner shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

5.2. Access to, and processing of, the Relevant Information provided by a Partner must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Partners' Staff should only have access to Personal Data on a justifiable Need to Know basis.

5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Partners.

5.4. Neither Partner shall subcontract any processing of the Relevant Information without the prior consent of the other Partner. Where a Partner subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

5.5. The Partners shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

5.6. Any particular restrictions on use of certain Relevant Information should be included in a Personal Data Agreement.

6. Ensuring fairness to the Data Subject

6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Partners will take the following measures as reasonably required:

6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and

6.1.4. giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

6.2. Each Partner shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.

6.3. The Partners shall reasonably cooperate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

6.4. Further provision in relation to specific data flows may be included in a Personal Data Agreement between the Partners.

7. Governance: Staff

7.1. The Partners must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.

7.2. The Partners agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Partners' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing Partners must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

7.3. The Partners shall ensure that all Staff required to access Personal Data (including Special Category Personal Data are informed of the confidential nature of the Personal Data. The Partners shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

Each Party shall provide evidence (further to any reasonable request) that all personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

7.4. The Partners shall ensure that:

7.4.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information; and

7.4.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and

7.4.3. specific limitations on the Staff who may have access to the Information are set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8. Governance: Protection of Personal Data

8.1. At all times, the Partners shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.

8.2. Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Partners. The Partners shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.

8.4. If any Partner

8.4.1. becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

8.4.2. becomes aware of any security vulnerability or breach in respect of the Relevant Information,

it shall promptly, within 48 hours, notify the other Partners. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

8.5. In processing any Relevant Information further to this Agreement, the Partners shall process the Personal Data and Special Category Personal Data only:

8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.

8.6. The Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protected the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

8.6.1. take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and

8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

8.7. In particular, teach Partner shall:

8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;

8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

8.7.3. obtain prior written consent from the originating Partner in order to transfer the Relevant Information to any third party;

8.7.4. permit any other Partner or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Partner to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

The Partners shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8.8. The Partners shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.9. The Partners' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third party security measures.

9. Governance: Transmission of Information between the Partners

9.1. This paragraph supplements paragraph 8 of this Schedule.

9.2. Transfer of Personal Data between the Partners shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record / data is identified.

9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered into in accordance with this Schedule.

9.5. Each Partner shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

9.6. The Partners' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Partners.

10. Governance: Quality of Information

10.1. The Partners will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11. Governance: Retention and Disposal of Shared Information

11.1. A non-originating Partner shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Partner they came from.

11.2. Each Partner shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3. If a Partner is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Partners in writing of that retention, giving details of the documents or materials that it must retain.

11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

11.5. The Partners shall set out any special retention periods in a Data Sharing Agreement where appropriate.

11.6. The Partners shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

11.7. Each Partner shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

11.8. Electronic records will be considered for deletion once the relevant retention period has ended.

11.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Partner shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

12.1. The Partners shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("**Subject Access Requests**"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2. Complaints about information sharing shall be reported to the Single Points of Contact and the Joint Committee. Complaints about information sharing shall be routed through each Partners' own complaints procedure unless otherwise provided for in the Joint Working Arrangements or determined by the Joint Committee.

12.3. The Partners shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4. Basic details of the Agreement shall be included in the appropriate log under each Partner's Publication Scheme.

13. Governance: Single Points of Contact

13.1. The Partners each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

14.1. The Partners shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 6: MANDATED GUIDANCE

Generally applicable Mandated Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- IG Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable guidance relating to the use of data and data sets for reporting.

Workforce

- Guidance on the Employment Commitment.

Finance

- Guidance on NHS System Capital Envelopes.
- Managing Public Money (HM Treasury).

Specialised Services Mandated Guidance

- Commissioning Change Management Business Rules.
- Cashflow Standard Operating Procedure.
- Finance and Accounting Standard Operating Procedure.
- Provider Collaborative Guidance.
- Clinical Commissioning Policies.
- National Specifications.
- National Standards.
- The ‘Manual’ for Specialised Commissioning.

SCHEDULE 7: LOCAL TERMS

Guidance notes are provided in red text and can be deleted prior to completing the agreement.

This Schedule should be used by the Partners to agree local terms to the Agreement. Headings and guidance have been provided for areas that may need local agreement. Additional headings can be added as required to support local arrangements.

Sufficient detail should be provided to describe what ICBs have agreed to do, including any role of the relevant Joint Committee, where required.

General

Where there is a dispute as to the content of this Schedule, the Partners should follow the Disputes Resolution procedure set out at Clause 18.

Following signature of the Agreement, this Schedule can be amended by the Partners using the Variations procedure at Clause 10.

Part 1 – Further Governance Arrangements

The Partners can use this Part for any governance arrangements not covered by the main agreement or the existing Schedules.

It is advised that sub-committees (those forums with decision-making power) and sub-groups (those forums without decision-making power, but are advisory in nature) are set out in this part. It is advised that the role, purpose and membership of the sub-committees or sub-groups are set out in this part.

Part 2 – Workforce Arrangements

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[*EAST*] / [*WEST*] Midlands Integrated Care Boards[1]
POD JOINT COMMISSIONING GROUP
Terms of Reference

Effective from 1st April 2023

(1) Introduction and Statutory Framework

1.1 In accordance with its statutory powers under section 13YB of the National Health Service Act 2022, NHS England (NHSE) has delegated the exercise of the functions specified in these Terms of Reference (TOR) to NHS Integrated Care Boards ("the ICBs"). The delegation and list of participant ICBs is set out in Schedule One.

1.2 In accordance with the delegation and section 65Z5 of the NHS Act 2022, the ICBs have together established the Pharmacy-Ophthalmic-Dentistry ("POD") Joint Commissioning Group ("the Group"). It will function as a joint entity, to act as the collaborative ICB decision-making body for the joint management and exercise of the powers delegated to each ICB by NHSE.

1.3 Arrangements made under section 13YB do not affect the liability of NHSE for the exercise of any of its functions. However, the ICB(s) together acknowledge that in exercising its / their functions, it / they must comply with the statutory duties set out in the 2022 Act and including:

(a) Management of conflicts of interest (section 14Z30);
(b) Duty to promote the NHS Constitution (section 14Z32);
(c) Duty to exercise its functions effectively, efficiently and economically (section 14Z333);
(d) Duty as to improvement in quality of services (section 14Z34);
(e) Duty as to reducing inequalities (section 14Z35);
(f) Duty to promote the involvement of each patient (section 14Z36);
(g) Duty as to patient choice (section 14Z37);
(h) Duty as to promoting integration (section 14Z42);
(i) Public involvement and consultation (section 14Z45);
(j) Duty to have regard to impact on services in certain areas (section 14Z43).

1.4 The ICB members together acknowledge that the Group is subject to any directions made by NHSE or by the Secretary of State.

(2) Constitution

2.1 The Group is established in accordance with Section 65Z5 of the NHS Act 2006 (as amended) and within each ICB's Constitution; as a group of the ICB. These TOR set out the membership, remit, responsibilities and reporting arrangements and shall have effect as if incorporated into the ICBs' Constitutions.

(3) Role of the Group

3.1 The Group has been established in accordance with the above statutory provisions to enable the members to make collective, joint decisions on the review, planning and procurement of Primary Care POD services in the *[East] and [West]* Midlands.

[1] One Joint Group shall be formed for each of the East and West Midlands sub-regional footprints.

3.2 In performing its role, the Group will jointly exercise the management of individually-delegated functions in accordance with the agreements entered into between each ICB individually. Which will sit alongside these TOR.

3.3 Its functions are to be undertaken jointly in the context of a desire to promote increased collaborative commissioning and at-scale decision-making on quality, efficiency, productivity and value for money and to remove administrative barriers.

3.4 The Group shall carry out the broad functions relating to the commissioning of Primary Care POD services under section 83 of the NHS Act. This includes, but is not exclusive to, the areas outlined below and more fully in Schedule Two (the full functions / decisions of the Group and its subsidiaries):

- Carrying out of those Delegated Functions relating to Primary Care POD and Secondary Care Dental Services outlined in each NHSE-to-ICB Delegation Agreement[2] including;
- Receive and approve newly-designed pan-ICBs Enhanced Services funded entirely from the delegated Primary Care POD budget[3];
- Note the introduction of new "Directed Enhanced Services" and the financial impact on the Primary Care POD budget;
- Decision-making on whether to establish new POD Contractors in the combined area or as unique to their own ICB area;
- Approving POD Contractor mergers; and
- Making decisions on 'discretionary' payment schemes.
- Decision-making on POD services closure proposals;
- Planning Primary Care POD services, including carrying out needs assessments with Local Authorities aligned to ICS Integrated Care Strategies;
- To undertake reviews of Primary Care POD services;
- To co-ordinate a common approach to commissioning Primary Care POD services;
- To manage the budget for commissioning of Primary Care POD services across the [*East*] *and* [*West*] Midlands footprint;
- Procurement of Agreed Services – the ICBs will make collaborative procurement decisions relevant to the exercise of Delegated Functions in accordance with the detailed arrangements regarding procurement set out in the protocols issued and updated by NHSE from time to time.

3.5 The majority of operational, day-to-day decisions will be taken by the three "Pillar Groups" (operational groups at tier three, set out in Schedule Two) that sit underneath this Group. With each providing upwards assurance to the Group on their own pillar, including related quality and finance decisions. This will also act as the formal route of escalation from Pillar Groups. As set out within Joint Working Agreement escalation / mediation / dispute resolution procedures.

[2] Being in summary: decisions in relation to the planning. commissioning & management of Primary Dental Services in the Area, including carrying out needs assessments; undertaking reviews of Primary Dental / Ophthalmic Services in the Area; management of the Delegated Funds in the Area; co-ordinating a common approach to the commissioning & delivery of Primary Dental / Ophthalmic Services with other commissioners where appropriate; and in such other ancillary activities that are necessary in order to exercise the Delegated Functions. *[A complete list will be presented as a full Schedule in the Joint Working Agreement each ICB will be requested to sign].*

[3] Where LES arrangements are locally developed (e.g. from multiple funding sources or are bespoke, single-ICB facing in nature), to inform partners of the relevant local funding and design / co-ordination contributions towards those from single-ICB budgets or resources.

3.6 In discharging its / their responsibilities in the performance and joint exercise of the Delegated Functions (set out by the Delegation Agreement), each ICB must comply at all times with procurement law and other statutory guidance.

3.7 Where an ICB wishes to develop and offer a locally-designed contract, it should engage their Local Pharmacy - Ophthalmic - Dental Committee in relation to the proposal and demonstrate whether / how the scheme will improve outcomes, reduce inequalities and provide value for money.

(4) Membership and Attendees

4.1 The ICBs will work collaboratively to ensure that the membership of the committee includes sufficient expertise to enable it to discharge its functions effectively.

4.2 The Group will operate a 'Distributed Leadership' model to enable safe decision-making is embedded into its processes; and shall consist of the following members:

- The 'Authorised Officer' of each ICB (usually the Executive Director responsible for Primary Care), who shall have voting rights;
- One other Executive Director from each of the following ICB functions, providing specific advice and expertise from those functions to the whole Group, on a multi-ICB, representational basis. Who shall not have voting rights or count towards quoracy Their purpose is to provide the Group with relevant advice / expertise to ensure robust, transparent decision-making under the Distributed Leadership model:
  - Finance
  - Quality & Patient Safety / Clinical
  - People
  - Digital
  - Governance

4.4 A suitably empowered individual acting as deputy may be agreed, in advance, with the Chair, where a member or attendee is unable to attend a meeting. Where members are unable to attend, they should ensure that any named and fully-briefed deputy in attendance is able to participate (and vote, if so empowered) on their behalf.

4.5 The following will be invited to routinely attend meetings of the Group. For the avoidance of doubt, these will hold the same "Participant Member" (in-attendance, representational) status as may be set out within ICB Constitutions for certain posts. As such, they will not be entitled to vote on matters:

- Hosted POD Team Functional Leads
- Hosted POD Team reps from each Tier 3 'Pillar Group' (DAIG – PSRG – GOSG)

4.6 One of the Authorised Officers shall be appointed / nominated from those who express an interest by the members as Chair of the Group. Another one of whom shall similarly be appointed as Vice-Chair[4].

4.7 The Group may call additional experts to attend meetings on an ad hoc basis to inform their joint discussions.

[4] Ideally both should not be selected from the same ICB within the sub-regional footprint.

(5) Meetings, Quoracy and Voting Rights

5.1 The Group can by agreement meet 'in common' with the corresponding meeting in the other sub-regional footprint, if both East & West Midlands agendas have joint, common areas that would benefit from a broader, whole-Midlands regional discussion.

5.2 Members will operate in accordance with each individual representative ICB's own Standing Orders. The Secretariat will be appointed from within the same ICBs who comprise the from-ICBs elected Chair and Vice-Chair roles. *(for further definition)*

5.3 The Secretariat will be responsible for giving notice of meetings. When the Chair deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as they specify. Where all efforts will be made in advance of such exceptional-needs circumstances to mirror any variable arrangements as may be established differently by each ICB's own Standing Orders.

5.4 The standard decision-making basis will be to achieve a consensus, wherever possible. However, where this is not possible, each ICB shall have one vote each. The Group shall reach decisions by a simple majority. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result (of an exceptional vote) will be recorded in the minutes: to note those for, or against a motion, or if any member abstained).

5.5 To be quorate, the Chair or Vice-Chair and **a minimum of one member from each of the participant ICBs** must be present to enable joint working to take place. An ICB's Authorised Officer (or nominated deputy) shall ordinarily be this member.

5.6 This is required to reflect the consensus, joint working nature of Group decision-making. And in order to avoid all bar the most exceptional decisions being challenged under ICB Joint Working Agreement escalation and/or dispute resolution procedures.

5.7 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic media. Any decision will be reported in the minutes of the subsequent meeting.

(6) Frequency and Operation of Meetings

6.1 Meetings will be held monthly as a minimum; and shall be held in private.

6.2 Members have collective responsibility for the joint operation and focus of all meetings. They will participate in joint discussions, jointly review evidence and jointly provide objective expert input to the best of their knowledge, ability and endeavours to reach a collective, pan-ICB consensus view.

6.3 The Group may devolve decision-making tasks to such individuals, to sub-groups or to individual members as it sees fit, provided that these are recorded in ICB Schemes of Reservation & Delegation (SoRDs), are governed by these Terms of Reference or Collaborative Working Agreements as appropriate and reflect each ICB's arrangements for the management of conflicts of interest.

6.4 All members shall respect confidentiality requirements set out in ICB Constitutions.

6.5 The Committee shall be supported with a Secretariat function who will ensure that the agenda and papers are prepared / distributed a minimum of five (5) calendar days before the meeting.

(7) Accountability of the Group

7.1 The Group is established as a Joint Commissioning Group. It will be accountable to the Unitary Board of each member ICB through the Tier One Joint Committee.

7.2 Responsibility of this Group is outlined within each ICB's 'Governance Handbook' and within each ICB's SoRD. Where each ICB's Delegated Financial Limits (a.k.a 'Scheme of Financial Delegation': SoFD) will also outline any local budgetary delegation / approval arrangements applicable to their members in attendance[5].

7.4 Minutes of the meetings (including any sub-groups will be made available to each ICB's Unitary Board.

7.5 The Group is responsible for both overseeing the management of Primary Care POD delegated and aligned budgets; and for ensuring that joint decisions made do not exceed these. In addition to the management of those budgets delegated by NHSE, an ICB's Unitary Board may delegate the management of additional budgets as deemed appropriate by it.

7.6 The Group will ensure that patient and public engagement / consultation is considered, and undertaken as appropriate or required, as part of its remit. Members must also demonstrably consider the Equality and Diversity implications of decisions they make.

(8) Conflicts of interest

8.1 Members should comply with their ICB's Standards of Business Conduct and/or Declarations of Interest policy and complete declarations as required. If a member feels compromised by any agenda item they should declare a conflict of interest as soon as they are aware of it, ideally before the meeting.

8.2 The conflict will be considered by the Chair, either prior to the meeting or at it; who will then determine the appropriate course(s) of action available from the generally-accepted standard policy options pertinent to ICBs.

8.3 A detailed record of declarations made in relation to agenda items and their agreed actions will be recorded in the minutes of the meeting.

8.4 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the ICB's policy for managing Conflicts of Interest, and may result in suspension from the Group.

(9) Decisions

9.1 The Group will only make decisions within the bounds of its remit; and ultimately responsible for the delivery of Primary Care POD services.

[5] If an ICB is delegating to the Group via their SoRD, rather than to individual members via their SoFD, the delegation here will be to the joint body and not individual ICB staff. Each ICB will therefore need to determine accordingly whether it is delegating financial decisions to a joint body or a person, or both, in their own local delegation governance arrangements, set out as best suits local circumstances.

9.2 The Group will produce an executive summary report on decisions made (frequency to be agreed), which will be presented to the next-available ICB Unitary Board meeting.

9.3 Each ICB may establish a local arrangement that incorporates POD oversight of ICB-specific, sovereign decisions (or indeed to prepare for decisions to be reached at this joint meeting); which may run alongside or separate to local arrangements similarly made for Primary Medical Services.

9.4 The members note that many decisions on contract management and/or service delivery are made following national processes and contract procedures through mandated committees.

9.5 ICBs will each receive regular performance, activity, finance and quality reports. Where local decisions are made by an ICB's own individual decision-making arrangements, it will be responsible under its own SoRD to arrange for how those best fit with the decisions made by this Group. For example, how ICB-specific concerns and/or reports will come to the appropriate ICB body for local decision in response to the wider delegated from ICB to ICBs decisions reached at this Group.

Effective From: 1st April 2023

Review Date: Annual, unless specific circumstances require more-frequent review (especially in the first year of operations while new arrangements bed in). A review log for the TOR may also be kept within each ICB's 'Governance Handbook', if so required locally.

Schedule One: Primary Care POD Delegation

This will be set out as a Schedule of the Tier One (Joint Committee) Joint Working Agreement, setting out Delegated Functions in line with Delegation Agreement.

Schedule Two: ICB Delegated Decisions and role / duties of the Group

(a) CORE COMMISSIONING FUNCTIONS: joint POD decision-making by ICBs as a Tier Two Joint Commissioning Group

- The delivery of POD commissioning as a whole - oversight, assurance, risk management (inc. audit, counter fraud) and high-level decision-making of the POD function and Secondary Care Dental services, including reviewing the performance of the relevant contract in respect of quality standards, incentives, observance of service specifications, monitoring of activity and finance, assessing quality and outcomes (including clinical effectiveness, patient experience, patient safety and addressing inequalities);
- The delivery of POD commissioning pertinent to Sections 3.4 / 3.5 of these TOR inc. POD LES commissioning (barring individual ICB-bespoke arrangements for its own patch only);

(b) CORE COMMISSIONING FUNCTIONS: joint POD decision-making by ICBs at Tier Three "Pillar Groups"

- Pharmaceutical Services Regulations Group (PSRG):
  - The majority of decisions must be made following nationally-governed rules through this mandated group;

- For all other operational decisions / service development / strategic input, the meeting will need to split into a Part A: PSRC; Part B: Pharmacy Governance Group, which will require ICB SORD resolution inc. for procurement decisions;
- This will report into the ICB POD Joint Group: it is not envisaged that each ICB will need to send representatives, though it may choose to;

- Dental Assurance & Improvement Group (DAIG):
  - This will be responsible for the majority of decisions, development of strategy and operational delivery, which will require ICB SORD resolution inc. for procurement decisions;
  - E.g. Dental Activity Redistribution Activity: work undertaken by the hosted POD team and presented to DAIG for sign off unless the figure hit the threshold for escalation to the ICB POD Joint Group
  - Exceptions to this principle and therefore necessary to escalate to ICB POD Joint Group are non-recurrent additional funding for winter pressures and funding for urgent access on a short term basis to meet a gap in service provision
  - This will report into the ICB POD Joint Group: as there are more decisions here that can be influenced by ICBs, it is suggested there are ICB reps at this group;
- General Ophthalmic Services Group (GOSG):
  - This committee will be responsible for the majority of decisions, development of strategy and operational delivery, which will require ICB SORD resolution inc. for procurement decisions;
  - This group will report into the ICB POD Joint Group: it is not envisaged that each ICB will need to send representatives, though it may choose to.

Proposed Financial Transitional Risk Framework – Pharmacy, Optometry, and Dentistry (PODs)

1. Changes to Delegation

This document has been written in response to the upcoming delegation of Pharmacy, Optometry, and Dentistry (PODs) commissioning to Integrated Care Boards (ICBs)(1). In November 2022 its expected that Midlands region ICBs the Midlands region will apply for delegation of these services to commence from April 2023.

(1) This document has been written prior to statutory changes relating to Clinical Commissioning Groups (CCGs) and Integrated Care systems (ICS). On the 1st July 2022 ICBs will become a statutory body.

2. What is a financial risk framework?

The financial risk framework is a set of rules and behaviours (as set out in section 5) which govern the way we manage the risk that may arise from variation in POD budgets between delegated ICBs of the Midlands Region. This will be to mitigate the potential risks to systems from allocation methodology change, as well as in year budget variation in year by ICB due to unknown factors. This will not include risk sharing as a result of individual commissioning decisions made by ICBs. The focus of this risk share being a pooling of resources enabling risks to be understood, as well as the impact of overspend risk.

It should be noted that the risk framework is intended to support the transition, and therefore will require review to determine its continuation or cessation.

The document aims to describe;

- How over, and underspends are managed within the regional hosted service,
- How the changes to services are managed between organisations and services,
- The risk mechanism that is in place,
- The process for changes to the risk mechanism.

3. Who/What does this document concern?

This document is intended for all ICBs within the Midlands Region that will be in receipt of delegated budgets at the 1st April 2023.

Initial entry into the risk share is for all ICBs in the region but to protect the risk share ICBs can only leave at the point of review (refer to section 8).

This agreement relates to the Pharmacy, Optometry and Dental budgets delegated at April 2023.

The document has been written with a ‘commissioner lens’. As a result this excludes the financial impact of under/overperformance within providers accounts as part of the risk share.

This risk share excludes previously delegated primary care budgets, on only those that transfer under the current delegation process.

This document may touch on expected financial reporting routes as part of the risk management, but reporting is subject to the development of a reporting framework. The two documents must be written and read in consideration of each other.

4. Why do we need a financial risk framework?

- ICBs are new organisations, and not all ICBs have experience managing these specific commissioning budgets. Until that knowledge is built up, this may mean additional caution in applying budgets in year, or additional exposure to risk. A risk share allows a mitigation to this while there is a common route to delivery.
- POD budgets are currently managed across the Midlands which provides a large budget in which to manage variability in activity across contracts and movements in patient charge revenue. After delegation budgets and areas covered will be smaller meaning risk management agreements will be needed to manage variability between ICBs.
- Allocations have been established using 2019/20 activity and spend levels. However, two years of alternative financial processes may impact on the accuracy of allocations at an ICS level. In addition, there are changes to the Dental contract expected in the second half of 2022/23 all of which creates additional uncertainty on ICB allocations
- As part of the move to delegated budgets, allocations may change as they are transferred to ICB level. There is an expectation of a move to a more capitated share of budgets after 2024. This raises the risk of variation to in year budgets which may not be fully known when budgets are first delegated, therefore future risk sharing needs to mitigate this risk.
- A number of 'wicked' problems as examples have been listed below to prompt the draft framework proposed in this slide/document.
    - How does the system minimise variation to plan?
    - An ICB may wish to make a change to service that is within the risk share, this could include additional investment, change in policy, or pathway. How will this be managed within the risk share?
    - An ICB may wish to withdraw a service from the risk share, how will this be managed?
    - An ICB may work unilaterally on service changes or savings which then impacts on the overall risk share. How is this managed?
    - Should risk sharing be the answer to an overspend?
    - If ICBs disagree on how a risk should be handled, how is this resolved?
    - If there are differential impacts against system allocations due to new allocation methodologies, how are these risks managed?

5. Behaviours and Standards

This document has been written with an expectation of openness, transparency, and trust in mind between ICBs. These risk principles should be considered in the application of the document. This also means that while we use this document there will be elements of clarity and refinement required. It's expected that in these cases partners use judgement for the spirit of document in its application; however, this should **not** be used to challenge each aspect of the framework.

Any ambiguity that cannot be resolved between partners, through use of the Finance and Contracting Sub-Group should then follow the escalation process (section 11); however, this should be avoided wherever possible.

6. In Year Financial Management

- Risk sharing should not be the primary source of net cost avoidance and should only be applied once the Finance and Contracting Sub-Group (FCAG) has assured itself that appropriate mitigations have been put in place.
- Virement should not be enacted between services or ICBs without express agreement by FCAG on POD budgets, to allow maximum knowledge gained in this first year by ICBs. Unlike specialised commissioning budgets, POD budgets should be risk shared on the total financial position for POD within ICBs.
- Should appropriate mitigation and virement proposals not bring the budget back to plan then risk sharing should be considered. Enacting the risk sharing should be a recommendation of the FCG to the East and West Boards.

7. Financial risk sharing

- The principles of any financial risk (and reward) sharing agreement are based on agreeing fair and equitable funding to control expenditure whilst optimising outcomes.
- Financial risk sharing agreements should be the final option after all efforts have been made to manage the risk in-year.
- It's expected these risk shares will work the risk share allows the movement of budget in year between systems within the hosting organisation in a balanced economy to resolve allocation methodology issues to system allocations mismatching to historical spend.
- The first route recognises individual ICB shortfalls in total POD budgets. Therefore allowing an adjustment to vire budgets between ICBs below the bottom line position to bring in line with plan. This excludes individual commissioning decisions made by ICBs, eg a variance to budget spend caused by investment. As a result variances to budget should be explained before virement or risk share is made to ensure it is due to unexpected causes.
- If the above is not possible due to an overall shortfall, the position will be shared based on proportionately based on plan budget values by ICB delegated budgets agreed at plan. This is with the exception of decisions made by individual ICBs e.g., ICB

investment/disinvestment above initial financial plan levels decisions are excluded from the risk share unless with the explicit agreement of all ICBs.

- System allocation mismatch assumes an overall balanced economy. As the reporting develops, reporting will also be produced at a system level (by Q2 of 2023), and a balancing adjustment between systems will be proposed by the hosted team to bring systems in line with budgets. Any overall shortfall from budget will be dealt with as highlighted in the previous paragraph. The balancing adjustment should be shown within the reporting to support transparency and understanding.
- Quarterly position statements of agreed risk sharing should be produced including a forecast at each quarter. These will form the basis of recommended adjustments, and at Q3 a forecast and recommendation will be made for the year end to support delivery of year end positions. This may be supplemented by a Month 11 update and recommendation.
- Reporting will be in place monthly to support budget monitoring. Application of risk arrangements will commence by Q2 of 2023 to allow sufficient actual activity to be available. Reporting will be at a level that allows the drilling down into PODs to understand the cause of variances. (This will be developed by a separate sub-group)
- Enacting the risk share will be a recommendation of the FCG to the East and West Boards.
- The risk share will be region wide, i.e., East and West Midlands. This should be part of a review after year 1 and a better understanding of budget variations.
- All services that are part of the delegation will be included in the risk share. Currently there are not specific risk shares for each speciality.

8. The future of risk sharing for Pharmacy, Optometry, and Dentistry (PODs)

- This risk share is intended to be in place to allow a greater degree of understanding by ICBs of the risks inherited from delegating budgets either from changes in allocation methodology, or in year changes in spend.
- Whilst the risk share continues to be in place it will be subject to annual review and amendment by consensus agreement
- The risk share is seen as transitional, however the risk share will continue by default in the absence of any agreed changes that would be recommended by the FCAG, and approved by the East/West Board.
- The review should consider the geographical coverage, as well as service coverage.
- Removal and addition of services from the risk share should be by agreement of all members of the risk share group, including resource flow. This means an ICB cannot unilaterally leave the risk share. This should form a review at the end of the first year. Changes should not remove the viability of a risk share.

9. Use of contingency/ unallocated funds

- Best practice looks to avoid holding back significant sums from the planning process, in terms of a central contingency. This is in part because of the requirement on the public sector to use the funds allocated for the purposes intended and in part to discourage organisations relying on such funds to 'bail them out' or ending with last minute year-end expenditure resulting in a sub-optimal use of resources. However, there are often unforeseen costs and a small level of contingency set aside to support may be required.

- To meet unforeseen costs a planned contingency of 1% should be aspired to from within the delegated budgets, and form a part of the mitigation process, however this should be reviewed each time plans are agreed to ensure affordability of contingency creation is possible, and if not possible, a recommended level put forward to the Finance and Contracting Sub-group.

10. Assurance

- Following delegation there will be joint commissioning boards for East Midlands and West Midlands with a specific finance sub-committee. Through delegation from the ICBs this sub-committee will have responsibility for oversight and delivery of the risk management framework. Regular financial performance reporting will facilitate monitoring and management of financial risk and application of the terms of the framework will be the responsibility of the finance sub-committee.

11. Appeals and escalation

- While there may be a financial risk sharing agreement, there will need to be a process for dispute resolution where consensus cannot be agreed.

- Primarily risk sharing disagreements will be managed by the chair of the FCAG, unless conflicted. In the case of conflict, an agreed independent party will provide arbitration.

- Escalation to the East and West Boards is required upon recommendation of the FCAG chair should a disagreement not be settled.

- Should this not be resolved, NHS E will be requested to provide arbitration, however this should be avoided where possible and alternative routes identified.

Joint Governance from April 2023

Tier 1:
Set Strategy, Hold the commissioning authority & discharge their authority through Tier 2 & 3)
Financial limits
Will be defined in the agreement depending on the functions and decision making parties

ICB & NHSE joint functions (specialised) & POD delegation to the East and West Joint committee

Midlands Leadership Team (MLT)

East Midlands Multi-ICB & NHSE Joint Committee

Majority of decisions discharged through sub groups

Tier 1:
Led By
ICB Chief Executives (& NHSE for specialised)

Tier 2:
Commissioning operational oversight, Commissioning decisions, approve business cases
Financial limits Will be defined in the agreement depending on the functions and decision making parties

Specialised Services commissioning group, MHLDA group. Other Midlands groups as agreed

Other East Midlands ICB led Joint commissioning for example East 999/1111

East Midlands **POD (MDT)** Joint Commissioning Group (JCG)

Tier 2:
Led By
Directors & Commissioning Teams

Tier 3:
Market Entry
Develop reports to make recommendations and support decision making.
Reporting on quality, finance, activity and performance.

Appropriate working groups for other joint commissioning functions

Appropriate working groups for other joint commissioning functions

Dental Assurance and Informational Group (DAIG) (East)

Pharmaceutical Services Regulations Group (PSRG) (East)

General Ophthalmic Services Group (GOSG) (East)

Tier 3:
Led By
MDT Commissioning Teams, subject matter experts & clinical experts & professional networks, provider reps and PPI

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 094

Report Title	Integrated Place Executive Chair and GP Lead roles							
Author	Kate Brown, Director of Joint Commissioning & Community Development							
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer							
Presenter	Dr Chris Clayton, Chief Executive Officer							
Paper purpose	Decision	☒	Discussion	☒	Assurance	☐	Information	☐
Appendices	None							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Integrated Place Executive							

Recommendations
The ICB Board are recommended to: • **APPROVE** the recurrent role of Integrated Place Executive Chair at 4 sessions per week with a fixed term office holder for a 3-year term; • **APPROVE** recurrent General Practice Place Lead roles at 2 sessions per week with fixed term office holders for a 3-year term; and • **APPROVE** the proposed recruitment process.
Purpose
The purpose of this paper is to seek approval for key leadership roles to ensure delivery of Place based integration and improvement as outlined elsewhere on today's ICB agenda.
Background
The work elsewhere on the agenda of the Board today shows the significant role of Place within the system and the need for leadership with the capacity to deliver at all levels of the structure. The IPE Chair role (formally Derbyshire Place Board Chair) was implemented in April 2019 as part of the Derby and Derbyshire CCG role of Governing Body GP. In July 2022 the ICB Executive Team supported a proposal to increase the number of sessions for the IPE Chair following establishment of the new Integrated Care Board on 1 July 2022 and the increasing role of Place Partnership structures within the new Integrated Care System. This took the role to 4 sessions ie 2 days per week, and it was also decided to extend the post until July 2023 to enable the new structures to be developed.

It is now proposed to make the post recurrent with appointment of a fixed term office holder for a 3 year term.

General Practice is at the heart of our model in local places place due the 'registered' list and the unique knowledge that GPs have about the residents and families in their respective communities. From the outset we have had clinical leads for each local Place. The roles have been remunerated at one session per week (ie half a day) but it has not been possible for colleagues to fulfil the demands of the role in that time and expectations upon the roles are now increasing.

Report Summary

Integrated Place Executive Chair

The IPE works on behalf of the 2 Place Partnerships to drive integration between health and care services, taking a 'plan/design once' and 'implement locally' approach that makes best use of evidence and transformation capacity across the system. The chair of the Integrated Place Executive is a key clinical leadership role that the system formally recognises. The clinical chair contributes beyond chairing the IPE board, with the role being recognised and included as a member of broader ICS forums including Clinical and Professional Leadership Group (CPLG) and the GP Provider Board (GPPB).

The overarching purpose of this key role is to ensure that distributed leadership within and between organisations occurs to effect true integration in the design of new services for the people of Derby and Derbyshire and in the other forums to which they lead or contribute. The Chair will embody and champion distributed leadership attributes and will support and challenge others to do so in the co-production of these services with the people that we serve, living and working in a geography. And with a personal and professional drive to improve the health and wellbeing outcomes of our population.

The chair will also ensure that the Integrated Care Strategy is developed and ultimately delivered.

Working with the other system Place leads and IPE members the Chair will ensure the following:

Strategy: that integrated care strategy happens, including identifying Place priorities from system strategic plans; the Chair will oversee local delivery at Place Alliances of performance against national targets and ensure that work done will address health inequalities at the forefront of planning. They will work with partners to develop the Derby and Derbyshire Place Partnership Boards and ensure that the IPE is working on behalf of the Places to coordinate and streamline transformation and integration where this is agreed as appropriate.

Workforce: that an integrated place-based workforce plan is developed within the ICS to support the delivery of the Place Partnership's objectives.

Working with Communities: stakeholder engagement is assured including with VCSE partners, embedding co-production with people who use our local services and amplifying the voice of the least heard.

Data and Digital: Ensure that the JUCD Digital and Data strategy and function effectively supports and delivers a population health management system to ensure care coordination and integration is informed by population health data and analytics.

Transformation: Managing relevant whole system transformation programmes. Interface with provider collaborative and delivery boards to determine the implications for local provision. Identifying and addressing system / inter-agency barriers to integrated care.

Governance: Oversee the use of resources within any delegated financial allocations and promote financial sustainability. Make recommendations to the ICB for appropriate integrated / community services and joint commissioning budgets. Establishing governance mechanisms to support Place.

Clinical and Professional Leadership: Engaging and developing full range of professional leadership and driving change at all place level. In particular, providing a support and challenge function with our clinical Local Place Alliance leads to both hold to account and to develop leadership capability, courage, capacity and confidence. This is key in ensuring insight and input for the ICS as PCNs and LPAs mature and transition over time.

In order to maintain momentum and continuity of the developments as the Derbyshire ICS evolves, we suggest that this post description is subject to ongoing review so that the role continues to be well governed and align with strategic intent.

The Chair will need to ensure strong engagement and liaison with the various ICS developments as they evolve and will perform various representation and leadership positions on other ICS committees including a key role on the Clinical and Professional Leadership Group reflecting the CPLG remit working across three areas including the Place Partnerships.

General Practice Place Leads
Place General Practice Leads will have responsibility for the development of partnership working and integrated care in their respective localities including fostering member and patient engagement. There are seven Local Place Alliances within the Derbyshire Place Partnership Board and two GP leads roles within the Derby Place Partnership.

They will work collaboratively with local partners representatives (statutory and non-statutory) to understand the needs of their populations and give a clear steer on integrating care and addressing the key themes in health and social care including health inequalities in their Place.

They will engage with Providers and particularly the Primary Care Networks and their nominated Clinical Directors to ensure aligned objectives and collaborative responses to population needs.

The lead role will include the following responsibilities:

- Create goal congruence/ shared vision amongst local partners
- Create and maintain a partnership working environment to enable organisations to coordinate and integrate services and support for the benefit of the population
- Ensure there is a suitable structure within the Place to identify needs and/or receive asks from the system (such as transformation delivery), to plan, coordinate and monitor delivery of a range of responses to the asks and to feedback / escalate as appropriate.
- Creating environment and expectation that each member of the strategic core group of a LPA is equally able to contribute to agenda items and is bringing items best worked on in partnership to the group and to encourage this.

They will also bring the following leadership qualities:

- **creating the vision** –creating a compelling vision for the future and communicating this within and across organisations;
- **working with others** – working with others in teams and networks to commission continually improving services;
- **being close to patients** –truly engaging and involving patients and communities; a good understanding of the medical, but increasingly more mental health, domestic and social problems that are presented to a GP practice, so gaining a wide perspective on the nature of a community's opportunities and challenges;

- **intellectual capacity and application** – able to think conceptually in order to plan flexibly for the longer term and being continually alert to finding ways to improve within a complex environment;
- **demonstrating personal qualities** –draw upon their values, strengths and abilities to commission high standards of service;
- **leadership essence** –demonstrate presence and engages people by the way they communicate, behave and interact with each other; and
- supporting the connections between general practice (PCNs) and Place and helping to create the conditions for **integrated working of general practice within their Places** to best effect positive health and wellbeing outcomes for the populations that they serve.

Recruitment
It is recommended that (in line with the approach taken recently for the CPLG Chair) the appointment process for all roles is undertaken by seeking expressions of interest from members of the relevant forum. That means IPE members for the Chair role, the Local Place Alliance members for the 7 LPA roles and the City Partnership Board for the 2 GP leads roles supporting the Partnership.

The rationale for this approach is based on the need to:
- maintain continuity and momentum through colleagues that have been part of the development journey and therefore have a better understanding of the current the state of play rather than needing to familiarise themselves with where we have got to, why and how etc.;
- allow us to build on established relationships;
- build on and maximise the leadership skills already in place within Place which are inclusive of all system partners; and
- keep the approach within Derbyshire and recognise the strong leadership in our system; it is strongly felt that it would send the wrong message if we were to go out to wider recruitment.

Identification of Key Risks
There is a risk to the delivery of Place based integration and improvement.

Has this report considered the financial impact on the ICB or wider Integrated Care System?		
Yes ☐	No☐	N/A☒
Details/Findings Remuneration is commensurate with the profession of the person recruited into the role.		**Has this been signed off by a finance team member?** Not applicable

Have any conflicts of interest been identified throughout the decision making process?
Not applicable to this report.
Project Dependencies
Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
	Yes ☐	No☐	N/A☒	**Details/Findings**

Equality Impact Assessment				

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable to this report.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings Not applicable to this report.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item:095

Report Title	General Practice Provider Board							
Author	Ian Potter, Programme Director – General Practice Provider Board							
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer							
Presenter	Dr Andrew Mott, ICB Board GP Partner Member and Medical Director General Practice Provider Board							
Paper purpose	Decision	☒	Discussion	☒	Assurance	☐	Information	☐
Appendices	Appendix 1 – GPPB Governance and Organisational Structure Appendix 2 – Priorities and Work Programme							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	ICB Executive							

Recommendations
The ICB Board are recommended to: • **NOTE** the background section; • **SUPPORT** the General Practice Provider Board's role in our system; and • **APPROVE** recurrent funding for 3 years for our core team. We would also recommend a more detailed discussion about the roles and opportunities for General Practices and Primary Care Networks at a future ICB Board meeting.
Purpose
The purpose of the paper is to provide the ICB Board with an update on the work of the Derbyshire General Practice Provider Board (GPPB) in the context of the challenges faced by general practice, and seek approval for our role in the system and approve recurrent funding to deliver our work programme.
Background
General Practice is widely acknowledged to be the foundation of the NHS, providing 367 million patient consultations in England in 2021. It is the first point of contact for the diagnosis and treatment of illness and poor health providing a continuous, person centred, relationship-based care that considers the needs and preferences of individuals, families, and communities. The essential attributes of a GP service are: • first point of contact for majority of health concerns; • continuous person and family-focused care;

- care for all common health needs;
- management of long-term conditions;
- referral and co-ordination of specialist care;
- care of the health of the population, as well as the individual;
- delivery of a range of preventative and screening activity; and
- based in the heart of communities.

National Context

The General Practice Forward View (GPFV)[1], published in 2016, recognised the importance of the GP service, noting the reliance of the public on general practice services for the health and wellbeing of individuals and families. Identifying it as one of the great strengths of the NHS, the report set out the many challenges faced at that time including an increase in patient expectations and a growing requirement for GPs to accommodate work previously undertaken in hospitals. Acknowledging the challenges faced by general practice including historic underfunding, the GPFV provided investment and initiatives to tackle the greatest challenges including workload, workforce, and infrastructure.

In 2019, The NHS Long Term Plan[2] was published, setting out further developments for general practice and primary care, building on the ambitions in the General Practice Forward View. Whilst the implementation of the GPFV and the Long Term Plan included the establishment of Primary Care Networks (PCNs) and the welcome introduction of a range of new professions to general practice, there is increasing evidence that these are not making a meaningful impact on the future sustainability of general practice.

In May 2022, the Next Steps for Integrating Primary Care: Fuller Stocktake Report[3] was published. This was commissioned by Amanda Pritchard (NHS England CEO) and outlines a new vision for primary care that reorientates the health and care system to a local population health approach through building integrated neighbourhood teams, streamlining access and helping people to stay healthy.

This key report provides practical steps that integrated care systems (ICS) and national leaders need to take to create this shift through locally driven change. The report was published prior to formation of ICSs and provides specific and practical advice on how they should accelerate the implementation of integrated primary care. All ICS Chief Executives were signatories to this report.

In October 2022, The Health and Social Care Select Committee published a report exploring the future of NHS general practice[4]. The inquiry examined the future challenges facing general practice in the next five years as well as the current and ongoing barriers to access. The report outlines a challenging picture of general practice in crisis, with the government and NHS England neither acknowledging nor remedying the situation. The crisis is caused by a depleting GP workforce and ever-increasing demands on services from an ageing, more clinically complex population, resulting in the increased use of expensive locum doctors. The report includes a number of recommendations focused in four areas: access to general practice; continuity of care; general practice and new NHS organisations; and the GP partnership model.

Given the fundamental importance of general practice in realising the ambitions of Integrated Care Systems, many health and care systems are exploring the development of formal structures to ensure general practice has a voice at system level. Whilst this is inherently complex and

[1] https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf
[2] https://www.longtermplan.nhs.uk/
[3] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/
[4] https://committees.parliament.uk/publications/30383/documents/176291/default/

challenging given the number of practices and our independent contractor status it is seen as a priority in many systems.

General Practice in Derbyshire
Within Derby and Derbyshire there are 114 general practices and 17 PCNs providing services to over 1.1 million patients. The last three years have seen unprecedented demand on health and social care services. General Practices have had to make significant changes to the way they deliver services to adapt and respond to the COVID-19 pandemic. Our PCNs delivered the majority of the covid vaccination programme in Derbyshire, responding very rapidly to set up and administer vaccines within our communities.

As we moved out of the pandemic response, we are now faced with a number of challenges including a significant increase in the demand for General Practice. In 2022 we provided over 6.5 million appointments to our population. In January 2021 general practices provided 468,632 appointments increasing to 583,123 in January 2023, an increase of 24.4%. This increase in activity was delivered with a diminishing workforce and during one of the most challenging periods in the NHS.

Derbyshire GP Provider Board
During this period, GPPB has been developed by our GP leaders to represent practices and PCNs and look forward with ICS partners to contribute to future plans and system redesign. Operating at System and Place, we are confident that GPPB has a lot to offer and needs to be seen as an integral part of the Provider landscape in Derbyshire. We have shown that by working in a collaborative and integrated way with colleagues in other parts of the system, that we add value and ensure efficient use of resources. Building on this integrated way of working not only demonstrates the culture change within our ICS but will realise significant benefits in the integration of care envisioned by the ICB.

GPPB is the culmination of work initiated by the Derbyshire GP Alliance, to create a single, unified, appropriate, representative and learned Derbyshire General Practice voice into the Integrated Care System (ICS). DDICB (and DDCCG beforehand) had the foresight to support GP leaders as we have come together through the GP Alliance and its evolution into the formal establishment of GPPB.

GPPB brings together Primary Care Networks (via their Clinical Directors) and General Practices and GPs (via the Local Medical Committee). PCN CDs and LMC committee members are elected by our practices and hence practices have given a mandate to these individuals to represent general practice and PCNs in our ICS. The GPPB governance and organisational structure is provided in appendix 1.

General Practice does not have the same infrastructure as the other main providers in our ICS due to our status as independent contractors to the NHS. Instead, the infrastructure has been provided by Primary Care Organisations from PCGs/PCTs to CCGs as membership organisations. This responsibility has now transitioned into ICBs, though they are not GP membership organisations in the same way. Over time and working with the ICB, we see value in much of the infrastructure and enabler function responsibilities transitioning over to general practice/GPPB.

The creation of ICSs and the key position of general practice in our healthcare system gives us the opportunity and imperative to build on our progress to date to drive future integration of care in communities and help achieve the aims of the ICS.

Mission, Vision, Values
GPPB's mission, vision, values, and governance structure are the result of extensive engagement and clinical leadership over a 2–3 year period.

- Mission = To provide a collaborative voice for developing the future of general practice provision within the Derbyshire health and care system.
- Vision = Maximise the opportunities to lead General Practice to improve patient outcomes and reduce health inequalities.
- Values = Progressive, collaborative, supportive and transformative.
-

Key elements as detailed in the terms of reference are set out below:

- Be the focal point for the strategic and high-level operational interaction of Derby & Derbyshire General Practice (DDGP) with the ICS, wider system and other third parties.
- Provide a unified DDGP voice that is at all times representative of the current DDGP view on strategic and operational issues.
- Ensure (so far as is possible) security, sustainability, and a better work/life balance for DDGP practice staffing.
- Collaborate with partners as and when required to seek the best outcomes possible.

GPPB Board Members are committed to ensuring our mission, vision and values inform how we work and ensure consistent understanding and alignment to the key aims of the ICS. There is significant evidence that change in general practice is best led by those working in general practice. This is backed by research by the Kings Fund, Levers for Change in Primary Care[5] which highlights the importance of avoiding 'top down' approaches to change management and the importance of leadership, culture, and access to appropriate training.

The triumvirate of GPPB, DDLMC, and GP Task Force (GPTF, incorporating Health Education Derbyshire) in Derbyshire adds further strength to the leadership and development of general practice in Derbyshire. Each organisation provides key functions for leading and supporting general practice which maximises the opportunity for innovation and leadership across the spectrum of general practice. GPTF supports individuals within practices with education, skills, and resilience as well as wider workforce issues. DDLMC has a statutory function in relation to the contracts held by GPs and practices and provides a lot of support to practices. GPPB provides the strategic voice of the whole of general practice provision, as well as our Primary Care Networks that are a key building block of integrated community care. We see a lot of potential to build on the triumvirate of general practice organisations to enhance both the support and development of clinicians and practices, as well as our collective constructive impact in the system.

GPPB Progress to date

As a relatively new organisation, GPPB has made significant progress over the last 12 months with the recruitment of an executive leadership team to drive forward key priorities. The recently appointed Medical Director (0.5 WTE) will work alongside a Programme Director (full time) and a Head of Operations (0.8 WTE) both of which joined GPPB in Summer 2022 on short term arrangements. Subject to continued funding, this team will lead the further development of the GPPB, reporting to our Board and providing leadership and capacity to take forward an exciting and challenging work programme.

Despite the relatively recent appointment of an exec team, GPPB has been proactive in taking forward a range of initiatives with work grouped into the following areas:

<u>Engagement</u>

- Clinical and senior managerial representation at System meetings including the ICP, Integrated Place Executive, Provider Collaborative Leadership Board, SEC, SORG and many others.

[5] https://www.kingsfund.org.uk/sites/default/files/2022-05/Levers-change-primary-care-literature-review.pdf

- Engagement with General Practice re Fuller Stocktake Report
- Development and dissemination of a presentation detailing the structure, role and current challenges faced by general practice in Derbyshire to raise awareness and support integrated working.
- Ongoing support for our PCN Area Boards.
- Discussion and shared learning with other similar General Practice structures in other systems.

Governance
- Externally facilitated Board Membership Development Training.
- Revision of GPPB Terms of Reference, mission, vision, and values.
- Options appraisal and instruction of external support to assist in planned establishment of GPPB as a legal entity.
- Appointment of Programme Director, Chief Operating Officer, and Medical Director.
- Annual programme of Board and informal Board meetings including, finance, risk register and work programme.

Planning
- Co-ordination of general practice informed response to national planning guidance.
- Representation and contribution to operational and transformation planning at a System level.
- Initiating and lead initial response to the Fuller Report
- Development of high-quality data & analysis to inform planning.

Delivery
- Co-lead in the design and implementation of the Primary Care Winter Resilience plan.
- Establishment and implementation of OPEL reporting for general practice.
- Co-lead on the practice sustainability and resilience visits as integral part of the winter plan.
- Active members of System escalation structures including SORG and SEC.

GPPB Future Work Programme
Whilst the challenges faced by the NHS are complex and multifaceted, the opportunities offered by the development and subsequent implementation of the Integrated Care Strategy are clearly evident.

GPPB firmly believes that the aspirations of the ICB set out in the draft Integrated Care Strategy must include and can only be enhanced a strong general practice voice at a System level. Building on the commitment made and progress to date, the ICB is at the forefront of developing a robust mechanism to ensure the voice of general practice is understood and supports the aspirations of the ICB.

GPPB works in an agile and collaborative way adding value to and leading on key areas of work that support general practice, general practice working in neighbourhoods and Local Place Alliances, and general practice as a powerful partner in System working. Working closely with the ICB Exec Team, GPPB has developed a detailed work programme for 2023/24 and a high-level road map setting out priorities for 2024/25 and 2025/26. The work programme covers 2 main areas, strengthening mechanisms for engaging with general practice and the delivery of key priorities in line with national and local planning guidance. For more detail, please see appendix 2.

Funding
The support of the ICB and work of the GPPB Board and Exec Team have established GPPB as a functioning and credible organisation contributing to the realisation of the ICS priorities. To

continue and then expand the work, recurrent funding is required to secure the development of GPPB and its role supporting the ICS and bringing a general practice voice into System discussions.

The Board members' attendance at our Board meetings is funded from general practice directly, via DDLMC or the PCN development fund. We are seeking recurrent funding for 3 years for our core team and clinical leadership, who will continue to ensure value for money and work innovatively with all colleagues in our ICS. GPPB is committed to remaining a lean and agile organisation that seeks economies of scale by working collaboratively. As examples, fixed costs will be minimised by sharing office space with DDLMC and GPTF, and we endeavour to build on using GP Fellowship funding to help with GP input into pathway work areas.
We require a core team to hold our work plan together and ensure that general practice can lead effectively on the key areas of work outlined.

Annual Costs	£
Exec Team	£349k
Support Team	£117K
Clinical Leadership at System meetings	£83K
Fixed Costs	£42K
Total	£591K

We are happy to discuss the mechanism for any agreed funding with ICB colleagues, being conscious of any VAT implications and efficient use of time.

Looking further ahead GPPB is keen to look at becoming more self-sufficient as the ICS matures, though this will in part depend on how general practice and PCNs are commissioned as part of an integrated system.

Report Summary

General practice in Derbyshire is a key component of our health and care system, delivering large numbers of appointments in response to record demand despite some significant challenges. GP Provider Board has been developed by GP leaders with CCG/ICB support, in order to ensure general practice is collectively represented in the ICS and to play a full role in system integration.

GPPB has wide support from system colleagues as well as from PCNs and practices, and now seeks recurrent funding for our core team in order to fulfil our roles. We are keen to continue to work with all parts of the ICS, and especially with ICB colleagues to adopt more responsibility and accountability for general practice support and infrastructure as we look to become more self-sufficient in the years ahead.

Most other integrate care systems have vehicles to provide a strategic general practice voice in their work, though structures differ from area to area. We believe that Derbyshire is in a good position with our cohesive arrangements with the LMC, GP Task Force, and GPPB.

Identification of Key Risks

The report supports assurance against a number of the risks identified in the Board Assurance Framework and is referenced as a System control in SR7.

Has this report considered the financial impact on the ICB or wider Integrated Care System?		
Yes ☒	No☐	N/A☐
Details/Findings Meeting and discussion with Keith Griffiths, Executive Director of Finance.		**Has this been signed off by a finance team member?** Yes – Keith Griffiths, Executive Director of Finance.

Have any conflicts of interest been identified throughout the decision making process?
No conflicts of interest have been identified.
Project Dependencies
Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

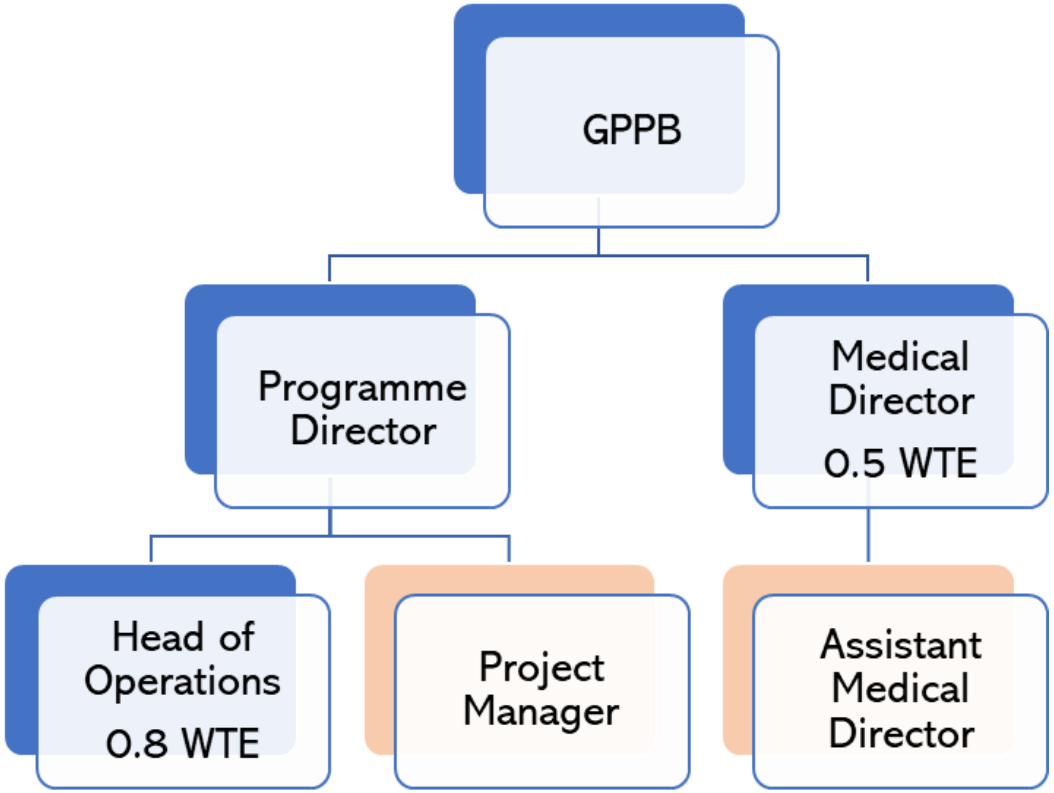
Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☐

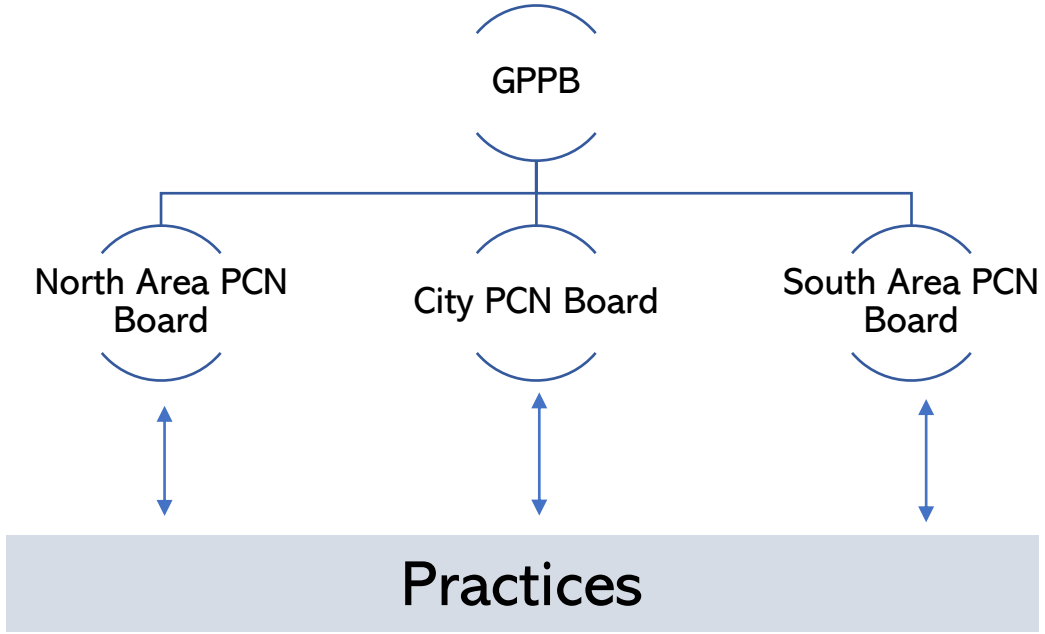
Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
None identified.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings None identified.					

Structure and Governance

Derbyshire GP Provider Board





- GPPB Board
- Area Representatives x 6 (1 PCN Clinical Director and 1 LMC committee representative each for North, South & City Areas)
- Standing Invitees LMC MD & GPTF MD
- Advisors x2

Derbyshire GP Provider Board

Place

PCN & Area Board development
TeamUp/INTs
Health Inequalities/PHM

Urgent Care

Core general practice offer
SDEC at scale
(UTC)

Core

Workforce
Data & Digital
Communications
Estates
Clinical Leadership
Quality Improvement

Elective Care

Core LTC care in practice/PCN
System pathway redesign
Left shift

Access & Continuity

Safe working level
Quality of care
Consistency

Outcome 1: Move to a high trust relationship where general practice is seen as a key and equal partner in the ICS

Derbyshire GP Provider Board

- Clinical and managerial leadership providing an informed and representative general practice provider voice at key System meetings including: NHS Exec, PCLB, Delivery Boards, SQG, ICP, other (see appendix)
  - Strategic planning, (accessing needs, reviewing service provision, deciding priorities,) Designing services, transformational/ pathway, delivery
  - General practice perspective & early identification of opportunities, barriers.
  - Identification of areas needing further engagement.

- Develop, Lead and co-ordinate communication and engagement with general practice to include:
  - Establishment of quarterly General Practice Forum – joint ownership of the outcomes to inform work of the ICB.
  - Build on and strengthen the role of PCN Area Boards, PCLG, PCOG, PCN Manager Forum
  - Development of a Derbyshire general practice nursing forum
  - Mechanisms to provide quick and efficient sounding board to assist at relevant stages of integration and transformation.

- Own clear process to identify and support general practice clinical representation into key ICS transformation workstreams, along with existing ICB clinical lead capacity.

- Facilitate and lead engagement of specific issues as part of pathway redesign.

- Mechanism to develop solutions to local problems.
  - Early mediation and support to local problems e.g. PCN level.
  - GP input to identifying and solving local issues.

- Proactive engagement with key System stakeholders to aid understanding of the role and contribution of general practice to support the delivery of integrated care

- Work with LMC and GPTF to ensure efficient processes between our organisations, and realise best value in the integrated system.

Outcome 2: Delivery of Key Priorities to support the sustainability and transformation of General Practice

Derbyshire GP Provider Board

- Informed and visible General Practice leadership contribution into system transformation, strategy and planning processes.

- 2023/24 Strategic Priorities
  - Jointly lead (with PCCDB/ICB) the system response to Fuller, and the programmes of work that will emerge.
  - Lead on the development of a primary care plan focusing on model, access, quality (strategic)
  - Maximise the use of primary care data to inform planning, delivery and research.

- 2023/24 Operational Priorities
  - Joint lead on review of 2022/23 Primary Care Winter Plan and design of 2023/24 plan.
  - Joint leads (with ICB) on the implementation of general practice facing elements of Operational Plan priorities including Primary Care Access Recovery Plan.
  - Lead on development and delivery of General Practice Sustainability & Resilience Plan (winter classed as phase 1) phase 2 to how we support on an ongoing basis sustainability and resilience of general practice.
  - Establish a programme for Quality Improvement activity in General Practice
  - Drive progress with system partners for the key enablers in general practice transformation including workforce, data, digital and engagement
  - Consolidate and realise PCN Area Boards as a key substructure that can focus on delivery of key areas of work, with system partners (such as Urgent care, Mental health, health inequalities)
  - Review PCN development, function, and priorities in our future ICS.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 096

Report Title	System Development							
Author	Kate Brown, Director of Community Development Tamsin Hooton, Programme Director JUCD Provider Collaborative Zara Jones, Executive Director, Strategy & Planning Chris Weiner, Executive Medical Director Julian Corner, Non-Executive Member (Population Health & Strategic Commissioning and Public Partnerships) Sue Sunderland, Non-Executive Member (Audit & Governance)							
Sponsor (Executive Director)	Chris Clayton, Chief Executive Officer							
Presenters	Integrated Care – Penny Blackwell and Stephen Posey Integrated Commissioning – Julian Corner Integrated Assurance – Sue Sunderland							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☒
Appendices	Appendix 1 – PCLB work programme priorities and milestones to 2027 Appendix 2 – IPE work programme priorities and milestones to 2027 Appendix 3 – Letter from John MacDonald							
Assurance Report Signed off by Chair	N/A							
Which committee has the subject matter been through?	Integrated Place Executive Provider Collaborative Leadership Board Population Health and Strategic Commissioning Committee							

Recommendations

The ICB Board are recommended to **NOTE** and **DISCUSS** the System Development presentation in regard to:

- Integrated Care
- Integrated Commissioning
- Integrated Assurance

Purpose

The attached slide pack sets out the vision, purpose and strategic objectives of the Joined Up Care Derbyshire (JUCD) Place and Provider Collaborative and describes the role that collaboration at place and scale play within the Integrated Care System in Derby and Derbyshire.

Following previous discussions as a Board, lead officers for the Population Health & Strategic Commissioning Committee were asked to develop the next steps in our Integrated Commissioning approach. A Population Health & Strategic Commissioning Committee development session took place in February 2023 to start this work and the outputs are enclosed.

Background

The ICB Chair John MacDonald wrote to the Chairs of the Integrated Place Executive and Provider Collaborative Leadership Board in November 2022, asking them to set out their plans to develop the integrated care model for the ICS.

The Place and Provider collaborative groups have worked together to articulate a joint response which sets out the approach to developing integrated care and how the two structures will work together, and with wider partners to achieve this.

This work is still under development and we are sharing some of the headlines from our discussions to date. Further updates will be provided as the work progresses and it is proposed that this is aligned to the development of our Joint Forward Plan through Quarter 1 of 2023/24.

Report Summary

Integrated Care

The enclosed slide pack responds to the key questions posed by the ICB, which were:

The key purpose/s of the Integrated Care approach

The key Strategic Objectives of the Integrated Care approach were the:

- key priority areas in the Short (6 Month - March 2023), Medium (2 Year - March 2024/25) & Longer (five-year) terms for the *Integrated Care* approach;
- key "Milestones" and "Measures of Success" against the priority areas in the Short (6 Month - March 2023), Medium (2 Year - March 2024/25) & Longer (five-year) terms for the *Integrated Care* approach;
- model of Leadership, Accountability, Delegations and Responsibility for the two principal areas of *Integrated Care* development and what are the interdependencies and governance relationships between the two;
- areas of delegated authority and responsibility from the NHS (ICB and Provider Boards) that would further support the development of *Provider Collaboration at Scale and Place;*
- approach to risk identification and mitigation; what are the key risks as currently viewed and how they will be mitigated; and
- key partners and how relationships will continue to be built?

The slides describe the emerging operating model for integrated care in Derby and Derbyshire, structured as Place, Provider and Programme working together. They conclude by setting out the ask of the ICB to help deliver the future vision and seeking confirmation that the strategy and direction of travel are the right ones and will be supported by partners as we progress to next steps to make the vision a reality.

The slide pack also includes detailed milestones against each priority as Appendices 1 and 2 to the main body of the presentation. These form the basis of more detailed 5-year work programmes of the integrated care approach which will complement the work of existing system Delivery boards and programme groups.

Integrated Commissioning

Key priority areas looked at during the PHSCC Development session were:

- strategic commissioning priorities and interventions which reduce our “front door” pressure and release resources to deliver prevention, reduce health inequalities and improve quality;
- specific integration examples that we work up and test new approaches against;
- supporting the mobilisation / delivery of the 3 key areas of our integrated care strategy – be clear what we are enabling through integrated commissioning;

- progressing our engagement and partnership with VCSE sector – targeted work on procurement and contracting approaches starting;
- linking this to the Population Health Management approach;
- establishing our approach to prioritisation that can deliver measurable improvement;
- working out our delegation approach for commissioning to better define the strategic commissioning role of the ICB.

Integrated Assurance

Discussions with Audit Chairs, and Trust Chairs and Secretaries have explored a number of strategic themes, areas of focus, duties and aspirations of the ICB and ICS in the short, medium and long term. The emerging themes have been identified within the slide pack and next steps have been agreed.

Identification of Key Risks

The place and provider collaboration proposals support mitigation of the following ICB risk:

SR7 There is a risk that decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.

Has this report considered the financial impact on the ICB or wider Integrated Care System?

Yes ☐	No☐	N/A☒

Details/Findings	**Has this been signed off by a finance team member?**
The work is still progressing and too early to fully assess impacts.	Not applicable.

Have any conflicts of interest been identified throughout the decision making process?

None identified.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:** Not at this stage

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Summary:** Not at this stage

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
None identified at this stage.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable at this stage.

Joined Up Care Derbyshire

Integrated Care: Place and Provider Collaborative Development: 5 year roadmap and next steps

Penny Blackwell and Stephen Posey

16th March 2023

Contents:

Joined Up Care Derbyshire

Place Vision and Purpose

Our Vision

Empowering people to live a healthy life for as long as possible through joining up health, care and community support for citizens and individual communities.

Our Purpose and function

- **Co-ordinate and integrate local services** built on a mutual understanding of the population and a shared vision;
- Take accountability for the delivery of coordinated, **high quality care and improved outcomes for the population;**
- Take on the **planning, management of resources, delivery, and performance** of a range of community-based health and care services, in line with the strategic requirements of the ICB and ICP.
- Deliver through **a social model that is outcome driven and strength based**; focussing on the assets of individuals and communities and developed with them through local leadership
- Progress towards our ambition for delegated responsibility and accountability to enable maximum impact from existing and enhanced structures
- **Co-ordinate and support delivery of the Integrated Care Strategy.**

Provider Collaborative Vision and Purpose

Our Vision

Working together as providers to achieve tangible improvements to the way care is delivered, supporting the Joined Up Care Derbyshire quadruple aim

Our Purpose and function

To **add value** to the ICS and beyond by:

- developing and **delivering collaborative approaches to specific challenges** within providers' gift to resolve
- addressing **efficiency, productivity and sustainability** through collaborative working, integration or the consolidation of service delivery or corporate functions
- developing **partnership relationships**, strengthening communication between providers, sharing approaches to challenges and opportunities
- **reducing inequalities of access and unwarranted variation**, where provider collaboration can best achieve this
- taking on some **commissioning responsibilities** within the ICS where this will align better with operational delivery and transformation**, improve decision making and accelerate change**

Strategic Priorities/Areas of Focus

	Provider Collaborative	Place
Organisational development, governance, leadership	Growth and evolution of the provider collaborative	Developing Place Operating model
Integrated, sustainable model of care, Improved outcomes	Clinical pathway improvement	Integrating and transforming services
Workforce, digital, estates	Clinical Pathway Enablers	Enablers of integrated care
Improving outcomes and value	Corporate efficiencies	Improving Population Outcomes
Delegated functions within the ICS	Oversight of delivery and transformation programmes	Co-ordinating delivery of the integrated care strategy

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What has been achieved so far

Provider collaborative achievement so far

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Progress in establishing PCLB, relationships and ways of working

5 Strategic Areas of focus agreed by the Provider Collaborative

Stocktake was undertaken in **Sept 22**

Clinical Enablers structures, priorities and leadership in place

Clinical priorities: Phase 1 – MSK & orthopaedics referrals, and speech and language therapy. Phase 2 - fragile services and delivering the integrated care strategy

Collaborative has taken responsibility for delivery and transformation activities across the system

Collaborative areas of focus – progress and maturity

Area of Focus	Evolution and development of JUCD provider collaborative	Clinical pathway design	Clinical pathway enablers	Monitoring system performance, overseeing performance delivery and transformation	Corporate efficiencies
Confirmed Lead	Stephen Posey/Tamsin Hooton		Jim Austin/Amanda Rawlings	Tamsin Hooton	Simon Crowther
Governance/ Delivery groups					
Agreed Priorities			Digital People Services Estates/Other		
Plans in place			D3B and PS		
Maturity Level	Developing	Emerging	Developing	Developing	Emerging
Next steps	Confirm accountability arrangements with ICS, develop programme work. OD plan	Complete prioritisation process and confirm clinical priorities	Agree options for People services collab.	Finalise Transformation and Delivery governance, decision making and escalation. Embed e-PMO	Identify opportunities and priorities.
Overall Status					

What has been achieved so far? Place

Local Place Level

The top delivery priorities for Local Place Alliances include ensuring a range of services within the Team Up approach plus partnership development and addressing local needs, for example;

1. Set-up of acute home visiting services at scale by supporting PCNs through the planning, governance, implementation and delivery process.
2. Support implementation of a phased delivery programme of an integrated local access point for urgent community response involving DCHS, Social Care, home visiting and falls recovery services.
3. Continue to develop mental health working groups to support local mental health priorities and support the delivery of the Community Mental Health Framework and the development of Living Well Teams locally.
4. Continue to maintain, support and develop multi disciplinary team working at scale to support care homes.
5. Continue to maintain, support and develop connections across the wider Place between all partnerships
6. Continue current work on priorities based on local need as identified via local population health needs assessment and other local sources of intel/data/information.

System Level

- Transitioned to Partnership Boards and new structures.
- Pro-actively identifying the links between key strategies and place delivery (eg dementia care, end of life, personalisation, children's services, adult social care)
- Championing the use of insights to drive change including supporting community research.
- Driving an approach to identify sentinel markers that measure what matters and demonstrate the impact of place based approaches including integration indicators
- Oversight of discharge transformation and delivery.
- Identifying and resolving new and complex challenges around regulatory requirements and integrated provision.
- Modelling behaviours of distributed leadership and development of mutual accountability.
- Influencing infrastructure enablers to support integrated delivery across partners
- Championing collaborative working, prevention, early intervention and health inequalities in every Place project and workstream at local and system level.
- Initiated ambitious transformation programme – diagnostic phase amount to commence.

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5 year roadmap: priorities, milestones and measures of success

SEE APPENDICES FOR DETAILED ROADMAPS

Developing the JUCD Provider collaborative

Governance and delegation

Boards understand what decisions the collaborative can take; any schemes of delegation from boards to collaboratives are clear.

Leadership

Board members and NEDs have a clearly defined role and actively support collaboration

Resourcing and leadership

The collaborative is well-resourced to deliver benefits at scale. Shared provider leadership roles where this supports integration

Working with partners

Collaborative has strong relationships with partners and other collaborations

Clinical Pathways

Improving health outcomes and population health

Health inequalities in access, experience and outcomes are reduced via evidence informed, measurable actions that are frequently monitored

Clinically led programmes of change

Clinical input shapes transformation programmes, led by multi-disciplinary clinical leaders.

Sustainable clinical services

Effective systems to identify & address fragile services, with options implemented

Clinically and financially sustainable model of care

Collaborative has a clinical strategy aligned to wider ICS strategy

Provider collaborative priorities and measures of success

Clinical Pathways Enablers

Workforce/ People Services collaborative

Using resources and capacity flexibly where necessary. Staff of each collaborative member feel able to work collaboratively with partner organisations

Estates

Reduced total system sqm and numbers of premises. Health and care estate is fit for purpose and supports integrated care model.

Pharmacy

Pharmacy operations are integrated to make best use of resources, increase productivity and efficiency as demonstrated by benchmarking

Oversight of performance, delivery and transformation programmes

Improve outcomes, sustainability, productivity

Continuously innovating, contributing to the design & delivery of ICS objectives & design of the forward plan, with clear lines of accountability and regular performance reviews and routine support.

Efficiency & productivity through collaboration & at scale models

Financial risks & savings shared across members. Improved benchmarks of productivity/GIRFT/MHosp.

Corporate Efficiencies

Corporate efficiencies/back office functions

Clinical support and corporate functions are delivered jointly where efficient and savings are effectively reinvested

Developing Place Operating model

Place Partnership Boards

Fully established Place Partnership Boards (City and County) with clear responsibilities in relation to IPE, local places, HWB structures and other partnership functions.

Integrated Place Executive

Driving the Integrated Care Strategy, successful delivery of population health improvements and integrated care

Local Place Alliances

Working to a shared partnership agenda Clear LPA scope and remit. Consistent of member input System enabler support provided. Delivering local improvements in services and outcomes

Resourcing and leadership

Success demonstrated by the fact that it becomes neither possible nor necessary to identify whether someone is working for 'place'

Integrating and transforming services

Team up (existing)

Full implementation of existing Team up programme

Team Up (expansion)

Improvements made across whole pathway of care supporting locally developed improved experience, outcomes and cost effectiveness.

Discharge Transformation

Positive discharge flow patient experience and outcomes delivered by matched capacity and demand and effective care processes. System confidence supporting reduced reliance on bedded care.

Provider Collaboration

Maximised opportunities to use resources flexibly and collaboratively between partners

End of Life

TCB

Strengths based approaches

TCB

Living well- CMHF

TCB

Role re Fuller response / implementation

TBC

Place priorities and measures of success

Enablers

Business Intelligence

Data strategy and function effectively supports and delivers a population health management system to ensure care coordination and integration is informed by population health data and analytics

Workforce

Place based workforce strategy (including new skills / roles to support integrated care)
Maximise opportunities within place delivery of the 'one workforce' approach.

Estates

Place based estates strategy to serve places not organisations

.

Finance

Funding model and distribution of resources that supports population health Place based planning and integrated provision.
Delegated responsibility enacted

Population outcomes

Understanding need

Place (at all levels) is driven by a clear understanding of population health needs and its role in addressing those

Prevention

Maximising opportunities to increase prevention across place functions through integrated partnership working

Inequalities

Maximising opportunities to reduce inequalities across place functions through integrated partnership working

Working with communities

Stakeholder engagement is assured including with VCSE partners, embedding co-production with local service users and amplifying the voice of the least heard.

Integrated Care Strategy

Structure and approach

Clear mechanisms that enable oversight and support by the IPE to delivery of the strategy on behalf of ICP

Age well / die well Key Area of Focus (IPE responsible)

Delivery against agreed evaluation measure (to be determined in first phase)

Leadership, accountability, roles and responsibilities

Leadership and accountability: strategic direction

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- The ICB is a strategic commissioner and a facilitator of integration
- The PCLB along with Place design the operating model for integrated care, deliver operational performance and improvement/transformation and provide assurance on this to the ICB
- The provider collaborative takes an increasing role in overseeing collective planning and delivery of improvement and transformation activities across the system, delivery is led by providers and the place partnerships working in concert
- System Delivery and Programme Boards become more important as units of system planning and delivery
- Shift from a culture of individual organisations developing improvement and efficiency plans to more focus on system programmes of work, although the role that individual organisations play in delivering operational improvement and productivity as well as financial savings will still be key
- As place and the provider collaboratives progress to more formal accountability for the oversight of integrated care we will need to re-calibrate our relationship with one another and the ICB

System Roles

ICP Leads on:

- Integrated care strategy
- Population Health
- Prevention and wider determinants of health

ICB Leads on:

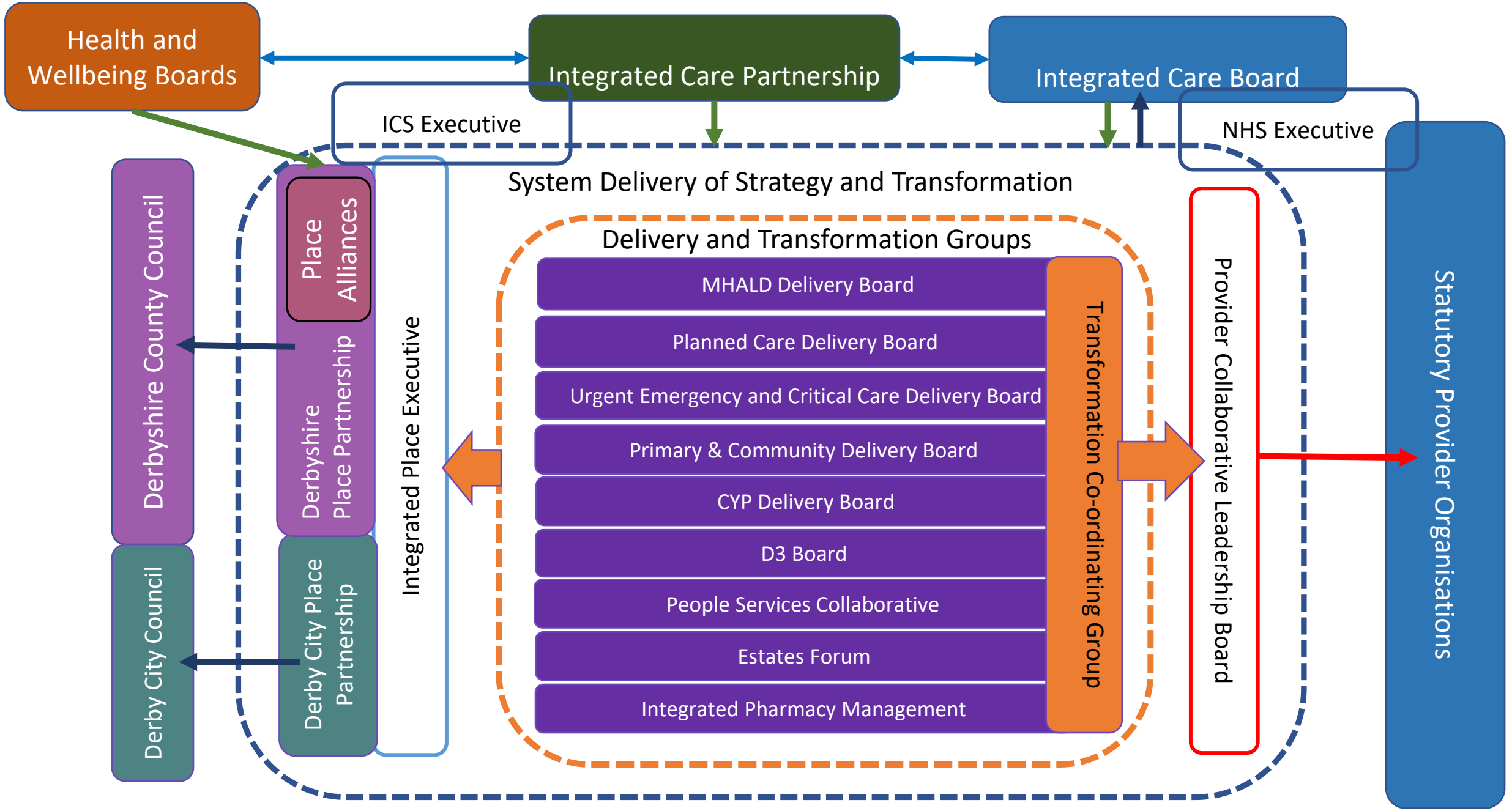
- Facilitating integrated care models
- Strategic commissioning (delegating budgets, setting outcomes)
- Assurance framework for place and provider collaborative
- Provider performance management
- System strategic and operating plan
- System financial plan including allocation of resources

Place leads on:

- Co-ordinating delivery of integrated care strategy
- Understanding and responding to population needs
- reducing health inequalities at the level of communities
- operating model for integrated care at place
- delivering improvement and transformation across places (e.g. Community Transformation)
- engaging communities and wider stakeholders including the VCSE and residents

Provider collaborative leads on:

- delivering sustainable, safe care
- reducing inequalities of access, improving outcomes along pathways
- operating model for integrated care at scale
- co-ordinating and overseeing improvement and transformation plans across system (host role)
- delivery of specific improvement and transformation priorities
- system financial efficiency



Governance diagram showing transformation and delivery function & relationship between PCLB, IPE & system groups

Summary Place Operating Model

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- One Integrated Place Executive (IPE) to co-ordinate and deliver the set of activities that are best done once. These include for example:
  - Identifying Place priorities from system strategic plans
  - Planning, and overseeing the integration and co-ordination of integrated health and care services.
  - Managing relevant whole system transformation programmes.
  - Interface with provider collaborative and delivery boards to determine the implications for local provision.
  - Hold delegated resources and accountability from the ICB
  - Identifying and addressing system / inter-agency barriers to integrated care.
- Two Place Partnership Boards (City & County) drawing priorities from, and influencing priorities in:
  - Integrated Care Strategy
  - Joint Health & Well-being Board Strategies
  - NHS Integrated Care Board plan
  - Joint Forward Plan
- Local Place Alliances responsible for the local co-ordination and delivery.

How place and provider collaboratives will work together

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- Neatly delineating responsibilities and lead areas between place and provider collaborative doesn't accurately describe the **overlap and interdependencies** between different roles.
- All providers are also place partners. Key is having the right work led by the right groups.
- Develop an approach **to population health management** which enables both place and provider collaborative groups to use data to identify issues that need to be addressed and develop appropriate plans in response to this, which jointly deliver against the objectives in the integrated care strategy and which are complementary and comprehensive. Co-ordinated by place.
- Maintain **oversight of system transformation and delivery programmes** through PCLB but recognise place leads on significant element of strategic transformation
- We will **co-ordinate decision** making using system programme and transformation groups and quarterly shared discussions between IPE/PCLB
- Principle of **subsidiarity** is important, **decision making should be delegated** as close to the work as possible
- Use NHS Executive Team/ICS Executive where required for **shared decision making** with ICB and/or local authorities

Leadership and resources to deliver

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- ICB funds and employs a number of roles supporting the place structures and Delivery Board programmes as well as place clinical leadership. Future resources and job roles need to reflect accountability and be aligned to place or provider structures and direction.
- Leadership is often an ‘add-on’ to operational roles for providers and this can hinder progress. We need sufficient resources to be able to release people to lead on our main change programmes, supported by sufficient project management capacity. Resourcing this needs to be done across the system, including the ICB’s contribution
- The provider collaborative will identify shared executive leads for collaborative work and over time develop substantive shared roles
- Provider boards and NEDs role within the collaborative should be enhanced alongside greater delegation to the collaborative
- Operational service managers at local place level should be formally supported to work together.

Delegation – live 'case studies'

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Mental Health

- Current delegation to the MH Delivery Board is informal. Budgets and financial reporting are managed at ICB level. MHALDB has some decision-making around contracting decisions
- Exploring formal delegation of both commissioning and responsibility for delivery
- Potential models include 'service integrator' model in place in BSol ICB
- MH provider leads management of budget, performance and delivery providing assurance to ICB

Musculo-skeletal

- Build on existing service redesign to bring together acute and community triage, referral assessment and treatment models
- Multiple providers involved in pathway including independent sector
- Alliance model proposed
- Providers have delegated responsibility for manging single shared budget to meet patient needs
- Delegation of commissioning responsibilities to a joint committee of providers being explored with the ICB

Working with system partners including our ask of the ICB

Our ask of the ICB

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- **Review governance and delegation** across the ICS to support the direction of travel and ambition described here, co-producing pathway to delegation for providers and place
- develop clear **framework for assurance** & evaluation that recognises adaptive, **progressive approach in relation to roles and responsibilities** and sets out how the ICB will gain assurance on delivery of delegated functions
- **Align appropriate ICB resources** to support Place and Provider Collaborative responsibilities and workplan priorities
- **Develop commissioning strategy for primary care** to ensure that there is a sustainable model of general practice
- Lead work to **develop a financial framework** for devolving budgets and managing financial decision making across the system including budgets for programmes and at place level
- **Enhance collaborative commissioning approaches** to support delivery of integrated care

Working with partners

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- Place will lead on relationship with local authorities, communities and VCSE
- Provider collaboratives will identify specific areas where direct engagement is needed e.g., VCSE alliance input to pathways, service reconfigurations and maintain regular engagement with Health and Wellbeing Boards
- A commitment from **all partners to resource place and system work**, giving staff autonomy and mandate to give support to agreed programmes of work
- Develop and embed use of **community insights** in both place and provider work
- **'Zip up' Health and Wellbeing connectivity** from neighbourhood to Board.
- Strengthen the **roles and relationships of PCNs** within each local place.
- Strengthen the **roles and relationships of district and borough councils** within each local place.
- Provider collaborative will ensure strong **link to other collaboratives** e.g. EMAP, and regional specialised commissioning
- Requires **communication and engagement support** from both ICB and local authorities

Closing reflections

Closing reflections

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- Does the system support the operating model – integrating care through place, provider collaboration and programme?
- Are our delivery priorities and milestones ambitious enough?
- Do they represent the key changes required to develop an integrated care model?
- Is there appetite, energy and trust to support the strategic direction in relation to distributed system leadership and delegated accountability and resources?
- We propose some dedicated development time for ICB plus place, provider collaborative and programme leaders to co-produce the next steps.

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Appendices

Appendix 1 - PCLB work programme priorities and milestones to 2027
Appendix 2 - IPE work programme priorities and milestones to 2027

Appendix 1 – Provider collaborative priorities for delivery

Area of Focus	Evolution and development of JUCD provider collaborative	Clinical pathway design	Clinical pathway enablers	Corporate efficiencies	Oversight of performance delivery and transformation
Short Term (6 months)	Clarify and confirm governance, accountability reporting to enable delivery of current priorities and responsibilities Engage with Boards, NEDs and governors Alignment with place as part of integrated care mandate	Initiation of first phase projects: MSK and orthopaedics & Speech and Language Therapy Evidence review and engagement to identify clinical priorities for years 2 and beyond, focus on fragile services Aligning clinical strategies across providers	Workforce Digital Established programme structures, priorities and workplans in place	Review benchmarking to identify opportunities for joint working to deliver efficiencies Reducing agency spend	Continue to develop Delivery Board and Transformation structures Lead transformation planning and contribute to Joint Forward Plan Address resource gaps in PMO and programme areas
Medium Term (2 years)	Enact delegation from ICB and provider boards as required to enable priorities. Communications and engagement with stakeholders and public Articulate medium – long term strategy as part of JFP iteration Shared provider leadership roles OD with Boards – risk and gain sharing	Workplan to address fragile clinical services (priorities and roadmap to be agreed) Agree shared strategy for clinical collaboration Second phase priorities agreed and in implementation phase First phase priorities show impact	Pharmacy Estates Workforce Digital ? Review pathology model	Agree operating model for corporate functions – in house/consolidated/outsourced Develop business cases and implement agreed changes Shared functions begin to deliver improved value	Provider collaborative workplan fully developed and reflected in DB and other plans Determine cross cutting and strategic transformations to deliver clinical strategy/sustainability Delivery Boards managing 'shadow' budgets and efficiency targets OD and skills development
Long Term 2025 - 2027	Play full part in delivering PHM approach, working alongside place Models of collaboration/integration/consolidation in place, driven by shared strategy	Second phase priorities show impact. Progress to deliver shared clinical strategy, including reconfigured clinical operating models Embedded ways of monitoring change programmes and developing rolling plans reflecting PHM approach	Estates strategy reflects integrated operating model and agreed areas of clinical collaboration/consolidation. Implementation is delivering efficiencies in the use of estate	Consolidated model of corporate services in place reflecting integrated operating model	Provider collaborative leads on system delivery including performance, accountability and assurance to ICB Transformation and delivery plans reflect shared clinical strategy and place programmes

Collaborative Priorities - Milestones and Measures of Success: Developing the JUCD Provider

	Measures of Success	Milestones – 6 months	Milestones 2 -3years	Milestones 2025-27
Governance and delegation	Boards have a clear understanding of what decisions the collaborative can take; any schemes of delegation from boards to collaboratives are clear.	Clarify & confirm governance, accountability reporting to enable delivery of current priorities & responsibilities. Explore modes of delegation e.g. service integrator model MHALD, Alliance model MSK. Align with place as part of integrated care mandate.	Approve provider collaborative roadmap and work programme for years 2-5. Implement formal delegation/models of collaboration as appropriate and amend PCLB partnership agreement. Agree assurance and accountability arrangements with ICB. Contribute to iterations of ICS Joint Forward Plan.	Governance and delegation are reviewed alongside the continued development of the collaborative and ICS architecture. Significant change to delivery and contracting models e.g. lead providers/service integrators in place to support PC objectives and ICS strategy.
Leadership	Board members and NEDs have a clearly defined role and actively support collaboration	Engagement with NEDs and Governors. Away time with Chairs and CEs to confirm collaborative ambition		
Resourcing and leadership	The collaborative is well-resourced to take timely decisions to deliver benefits at scale	Confirm resources required for year 2-3, agree business case/finding for agreed roles. Agree with ICB how existing roles can be reshaped to align to integrated care model/new ways of working.	OD to create multi-disciplinary teams to deliver workplan. Sufficient leadership in place to deliver on collaborative priorities, drawn from existing teams where possible	Staff in provider organisations are enabled to work collaboratively, with clear priorities and improvement approach in place.
Resourcing and leadership	Shared provider leadership roles where this supports the model for integration	Confirm ongoing core team resource requirements and funding.	Formalised shared leadership roles where these support operating model and change priorities	

Collaborative Priorities - Milestones and Measures of Success: Clinical pathways

	Measures of Success	Milestones – 6 months	Milestones 2 - 3years	Milestones 2025-27
Improving health outcomes and population health	Provider Collaborative programmes demonstrably include evidence informed measurable actions to reduce health inequalities and prioritise prevention on access, experience and outcomes. The Collaborative has systems in place to frequently monitor and identify potential unwarranted variation	First phase priorities agreed MSK and SLT, project teams and PIDs in place. Benefits realisation mapped, Begin to engage on second phase priorities. Develop approach to PHM, Prevention and Health inequalities aligned to system approach	First phase priorities begin to deliver impact. Agree second phase priorities &programme plans including metrics. Develop approach to reviewing data to identify opportunities, quality and safety.	PHM and systematic approach to identifying areas for improvement embedded within PC.
Clinically led programmes of change	Clinical input shapes transformation programmes, l ed by multi-disciplinary clinical leaders.	Working with CPLG, engage of fragile services and other clinical priorities	Clear clinical priorities set out with delivery plans including metrics and impact	Second phase priorities show impact PCLB oversees clear change programme for clinical services
Sustainable clinical services	Collaborative has effective systems to identify and address fragile services. Collaborative has implemented options to address fragile services within the system	Workshop to identify fragile services. Agree priorities for collaborative solutions, develop clinically led proposals for change	Workplan to address fragile services developed and implemented, Work with ICB to align approach to quality and safety across the ICS.	Workplan fully implemented, further review of fragility and agreement of any more structural solutions to support resilience, quality and sustainability
Clinically and	Collaborative has a clinical strategy aligned to wider	Align clinical strategies to identify areas for	Develop medium/long term clinical strategy for	Clinical strategy reflected in transformed model of

Collaborative Priorities - Milestones and Measures of Success: Clinical pathway enablers

	Measures of Success	Milestones – 6 months	Milestones 2 -3years	Milestones 2025-27
Digital, Data and Technology	Shared digital solutions used where this achieves efficiencies, information sharing or joint working and regular evaluation of digital solution effectiveness and seeking out further opportunities.	**Digital** – infrastructure work programme completed and opportunities for efficiencies, collaboration and shared solutions identified. **Data** – shared analytics and data platforms to inform strategic and operational planning and delivery. **Technology** – digitally enabled tools and technology evidence based programme established to inform care delivery	Digital infrastructure programme priorities being implemented and organisational change process established. High quality, accessible data and intelligence tools to support surveillance and reduce unwarranted variation in health and wellbeing Evidence based decision making, backed by high quality data analysis, is seen as business as usual across the ICS. Evidence based digitally enabled care is embedded in service delivery across the ICS and supported through a digitally included process to address inequalities.	Digital infrastructure maturity being realised and collaborative approach ensuring continuous system development and improvement. ICS has a fit for purpose data architecture and reporting capability. Decision markers are informed and supported with evidence required to affect change and improve population health and wellbeing. Use of digital tools and technology widespread across the system. Innovation programme introduced to review new tools and technology to understand benefits to care delivery.

Collaborative Priorities - Milestones and Measures of Success: Clinical pathway enablers

	Measures of Success	Milestones – 6 months	Milestones 2 - 3years	Milestones 2025-27
Workforce/People Services collaborative	Collaborative is able to use member and partner resources and capacity flexibly where they are most needed, creating efficiencies and savings. Staff of each collaborative member feel safe, empowered and supported to work collaboratively with partner organisations	Accelerate recruitment collaboration, development of options Support Domiciliary Care International Recruitment Digital ESR roadmap agreed	Project Derbyshire Digital - ESR enhancement - Derbyshire digital road map Develop a Derbyshire approach to People Scaling for transactional efficiencies Shared recruitment option in place	People Scaling approach fully rolled out across JUCD Shared model of people services in place Staff enabled to work across collaborative partners
Estates	Reduced total system sqm and numbers of premises. Health and care estate is fit for purpose and supports integrated care model.	Estates group refreshed, linked in with review of clinical and back office services. Agree opportunities to reduce void space and exit leases	Shared estates strategy that reflects operating model and clinical strategy. Programme to release efficiencies in place with dedicated capacity to deliver	Estates strategy implemented, increasing efficiency of use, reflecting clinical strategy and shared delivery models
Pharmacy	Pharmacy operations are integrated to make best use of resources, increase productivity and efficiency as demonstrated by benchmarking	Identify opportunity using benchmarking and best practice evidence	Agree model for collaboration, business case and implementation including governance	Review impact of changed model and identify further opportunities for improvement

Collaborative Priorities - Milestones and Measures of Success: Corporate Efficiencies

	Measures of Success	Milestones – 6 months	Milestones 2 - 3years	Milestones 2025-27
Corporate efficiencies/back office functions	Clinical support and corporate functions are delivered jointly where this creates efficiencies and savings are effectively utilised to support wider population health objectives.	Establish working group. Review benchmarking. Identify opportunities within ICS and agree priorities.	Develop preferred model and business cases for agreed priorities. Implement agreed models for shared services (consolidation/joint venture/WOS/outsource)	Identify further opportunities for improvement, reflecting emerging integrated care and clinical model. Back office functions fully integrated where this releases benefits.

Collaborative Priorities - Milestones and Measures of Success: Oversight of performance, delivery and transformation programmes

Objective	Measures of Success	Milestones – 6 months	Milestones 2 - 3years	Milestones 2025-27
Design and deliver pathways that improve outcomes/improve sustainability/productivity	Collaborative continuously innovates and contributes to the design and delivery of ICS objectives and design of the forward plan.	Agreed process for transformation and delivery planning for 2023/2024. Driven by data and evidence, this forms part of JFP	Review of JFP. Ongoing use of data and benchmarking to inform and prioritise delivery board plans	Provider collaborative leads on system delivery including transformation plan
Design and deliver pathways that improve outcomes/improve sustainability/productivity	All members and partners understand lines of accountability in the PC; members feel able to hold each other to account. Collaborative regularly reviews performance & delivery, members act to disclose and address issues, members support each other to use best practice and improvement approaches.	Programme reporting process including escalation agreed and implemented, including PCLB, IPE and NHS ET Confirm and clarify governance and accountability arrangements relating to transformation and delivery .	Improvement plans across organisations aligned with delivery board and programmes of work to ensure co-ordinated approach to delivery across the system.	Clear accountability to ICB for performance and delivery. Transformation plans identified for 'at scale' changes that address system priorities
Improve efficiency and productivity through collaborative working and at scale models of clinical and corporate services	Financial risks and savings associated with specific programme delivery shared across members. Improved benchmarks of productivity/GIRFT/MHosp	Transformation plans are formulated to address productivity and cost savings	Plans implemented and begin to show impact on delivering better value services Risk and gain sharing approach agreed	Plans implemented and begin to show impact on delivering better value services

Appendix 2 – Place priorities for delivery

Area of Focus	Operating Model	Integrating and Transforming Services	Enablers of Integrated Care	Population Outcomes	Co-ordinating delivery of Integrated Care Strategy
Short Term (6 months)	Partnership Boards up and running IPE focus shifting to co-ordination role and addressing barriers. Local Place Alliance functions reviewed and adjusted. Leadership roles confirmed Agreed role in relation to HWB plan / function delivery.	Prioritised response to care gaps (and operational place requirements) eg falls, anticipatory care Diagnostic completed and provides sound case for change Discharge funding plan to address pressures whilst transformation programme developed Clarity and alignment re Fuller	Increase understanding of existing enabler plans and implications / opportunities Framework for 'measuring what matters' finalised. Finance / workforce / digital working with Place to develop place based approach to enablers Shadow oversight of BCF	Clarify Place role re PHM with lead, DPHs and CMO Identify key actions that Place can take to respond to, and embed the insights framework approach. Ensure Partnership Board and IPE are giving space to the LPA messages from their communities.	Establish reporting / escalation process and agree approach to strategy evaluation. Ensure system build measures that give parity of attention to strategy alongside immediate pressures Implementation plan for Age Well / Die well lead by Place
Medium Term (2 years)	Delivery plans developed at Place Partnership Board and LPA level reflecting flow of priorities from system and local needs. Enabler priorities fully aligned to supporting Place objectives. Commissioning and finance strategies supporting Place delivery Increasing level of resource aligned to Place working	Comprehensive community transformation implementation programme underway driving resource allocation and providing tracked benefits. (including anticipatory care MDT working, fully integrated community crisis response and step up / step down capacity and flow)	Digital strategy fully informed by Place priorities and delivering impact. Place based workforce strategy (including new skills / roles to support integrated care) Place based estates strategy to serve places not organisations Increasing autonomy / flexibility across joint budgets	To be confirmed informed by Integrated Care strategy priorities, role of Place in relation to delivery of Health & Wellbeing priorities and learning from first 6 months.	Assess progress. Determine need to review Strategy (in light of any new JSNAs or national guidance.) Delivering against established measures and 'course correcting' as appropriate informed by views of public, users, staff and data metrics Maintain focus on 'how' effective integrated system working is (not just outputs)
Long Term 2025 - 2027	Review operating model – opportunities for alignment. Respond to any national changes and review.	Improvements made across whole pathway of care supporting locally developed improved experience, outcomes and cost effectiveness. Embedded approach to continuous evaluation and adaptation	Place based planning and integrated provision. Delegated responsibility enacted	Fully embedded population health approach – driven by data and insights and responded to though local integrated approaches.	Delivery of change for the 3 'key areas of focus from 23/24 have impacted on how JUCD routinely addresses population outcomes, care and resource gaps

Collaborative Priorities - Milestones and Measures of Success: Developing Place Operating model

	Measures of Success	Milestones – 6 months	Milestones 2 - 3years	Milestones 2025-27
Place Partnership Boards	Fully established Place Partnership Boards (City and County) with clear responsibilities in relation to IPE, local places, HWB structures and other partnership functions..	Both Partnership Boards operating to new Terms of Reference. Undertake development work to establish effective relationships. Agreed process for agenda setting between partnerships and IPE	Place Partnership Board Delivery plan developed reflecting flow of priorities from system and responding to place / neighbourhood needs.	Review operating model – opportunities for alignment. Respond to any national changes and review.
Integrated Place Executive	Functioning as a pivotal role in the ICS – driving the Integrated Care Strategy, creating the environment for successful delivery of population health improvements and integrated care	Adjust focus towards identifying and addressing system / inter-agency barriers to integrated care, interface with other components of ICS, supporting strategy delivery plans and overseeing the co-ordination of integrated services.	Increasing influence on enabler priorities and individual organisations' strategies and plans. Commissioning and finance strategies supporting Place delivery	
Local Place Alliances	Working to a shared partnership agenda Clear LPA scope and remit Consistent of member input System enabler support provided. Delivering local improvements in services and outcomes	New relationship established with Place Partnership Board, Local Operational Teams developed. Increased clarity of expectations.	Local Place Alliance delivery plan developed reflecting flow of priorities from system and addressing local place / neighbourhood needs	
Resourcing and leadership	Success demonstrated by the fact that it becomes neither possible nor necessary to identify whether someone is working for 'place'	Place is appropriately resourced with Place leadership / support roles plus staff in partner organisations are enabled to work collaboratively with time and resource; autonomy and mandate to give support to Place.	Increasing level of resource from all partners aligned to place working.	

Collaborative Priorities - Milestones and Measures of Success: Integrating and transforming services

	Measures of Success	Milestones – 6 months	Milestones 2 -3years	Milestones 2025-27
Team up (existing)	Full implementation of existing Team up programme	Prioritised response to care gaps (and operational place requirements) eg falls, anticipatory care	Integration within expanded Team Up programme	
Team Up (expansion)	Improvements made across whole pathway of care supporting locally developed improved experience, outcomes and cost effectiveness.	Newton diagnostic completed and provides sound case for change, prioritised interventions and assessment of readiness.	Comprehensive implementation programme underway driving resource allocation and providing tracked benefits.	Embedded approach to continuous evaluation, learning and adaptation.
Discharge Transformation	Positive discharge flow patient experience and outcomes delivered by matched capacity and demand and effective care processes. System confidence supporting reduced reliance on bedded care.	Agree funding plan for use of 'wrong' capacity to address pressures whilst transformation programme developed and implemented.	Progress made against transformation plan ambitions	No delays, capacity matching need and no 'failure demand'
Provider Collaboration	Maximised opportunities to use resources flexibly and collaboratively between partners	Develop proposals for change	Implemented changes and have increasing flexibility across pathways.	
Need to add End of life, strengths based approaches, living well- CMHF, role re Fuller response / implementation				

Collaborative Priorities - Milestones and Measures of Success: Population outcomes

	Measures of Success	Milestones – 6 months	Milestones 2 -3years	Milestones 2025-27
Understanding need	Place (at all levels) is driven by a clear understanding of population health needs and its role in addressing those	Clarify Place role re PHM with lead, DPHs and CMO Ensure relevant Place level data to support Partnership and local delivery plans	To be confirmed informed by Integrated Care strategy priorities, role of Place in relation to delivery of Health & Wellbeing priorities and learning from first 6 months.	Fully embedded population health approach – driven by data and insights and responded to though local integrated approaches.
Prevention	Maximising opportunities to increase prevention across place functions through integrated partnership working	Place role in response to strategy key area of focus and plan response.		
Inequalities	Maximising opportunities to reduce inequalities across place functions through integrated partnership working	Work with relevant leads to determine Place role in response to Core20 Plus5 priorities. Ensure informed delivery plans		
Working with communities	Stakeholder engagement is assured including with VCSE partners, embedding co-production with people who use our local services and amplifying the voice of the least heard.	Identify key actions that Place can take to respond to, and embed the insights framework approach. Ensure Partnership Board and IPE are giving space to the LPA messages from their communities.		

Collaborative Priorities - Milestones and Measures of Success: Enablers

	Measures of Success	Milestones – 6 months	Milestones 2 -3years	Milestones 2025-27
Digital	Shared information on individuals to support care delivery (DSCR & DiSc) Digitally enabled care and technology enabled care readily available.	Increase understanding of existing plans and implications / opportunities for integrated place based working	Digital strategy planning and implementation fully informed by Place priorities.	
Business Intelligence	The Data strategy and function effectively supports and delivers a population health management system to ensure care coordination and integration is informed by population health data and analytics	Framework of indictors 'measuring what matters' established and routinely reported against. BI link resource for Place identified.	Significantly strengthened and embedded BI support to Place. Places developed to self support where possible.	
Workforce	Maximise opportunities within place delivery of the 'one workforce' approach.	Understand existing plans and implications / opportunities for integrated place based working	Have mapped totality of place workforce. Influenced new skills / roles to support integrated care delivery.	
Estates	Place based workforce strategy (including new skills / roles to support integrated care)	Understand existing plans and implications / opportunities for integrated place based working	Place has role to review/ approve estates plans. Partners seek opportunities to utilise their own estate for Place benefit.	
Finance	Funding model and distribution of resources that supports population health Place based planning and integrated provision. Delegated responsibility enacted	Finance capacity working with Place to develop approach. Financial data reporting spend on a population basis. Shadow oversight of BCF, relevant SDF and Community Futures Fund. Mirrored by Public Health Grant.	Increasing autonomy across budgets. Make recommendations to the ICB for appropriate integrated / community services and joint commissioning budgets	

Collaborative Priorities - Milestones and Measures of Success: Integrated Care Strategy

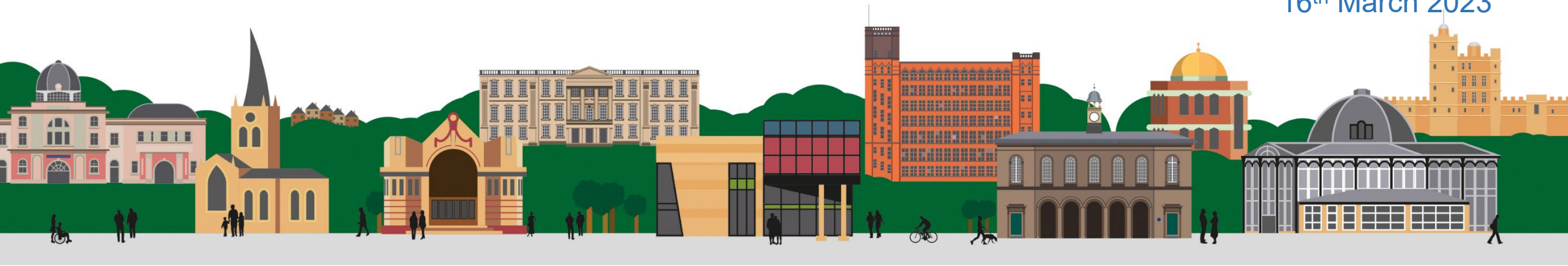
	Measures of Success	Milestones – 6 months	Milestones 2 - 3years	Milestones 2025-27
Structure and approach	Clear mechanisms that enable oversight and support by the IPE to delivery of the strategy on behalf of ICP	Establish reporting / escalation process Agree approach to evaluation Ensure system build measures that give parity of attention to strategy alongside immediate pressures	Assess progress. Determine need to review Strategy (in light of any new Joint Strategic Needs Assessments or national guidance.)	
Age well / die well Key Area of Focus (IPE responsible)	Delivery against agreed evaluation measure (to be determined in first phase)	Develop implementation plan – incorporating 'actions from integrating and transformation services' priorities. Establish approach to hearing from staff, patients and carers	Delivering against established measures and 'course correcting' as appropriate informed by views of public, users, staff and data metrics	
Enablers		Assess ability of existing delivery plans to meet needs of the Key Areas of Focus	Maintain focus on 'how' effective integrated system working is (not just outputs)	

Joined Up Care Derbyshire

Integrated Commissioning

Julian Corner, Non-Executive Member (Population Health & Strategic Commissioning & Public Partnerships)

16th March 2023



NHS

The Derbyshire VCSE sector Alliance

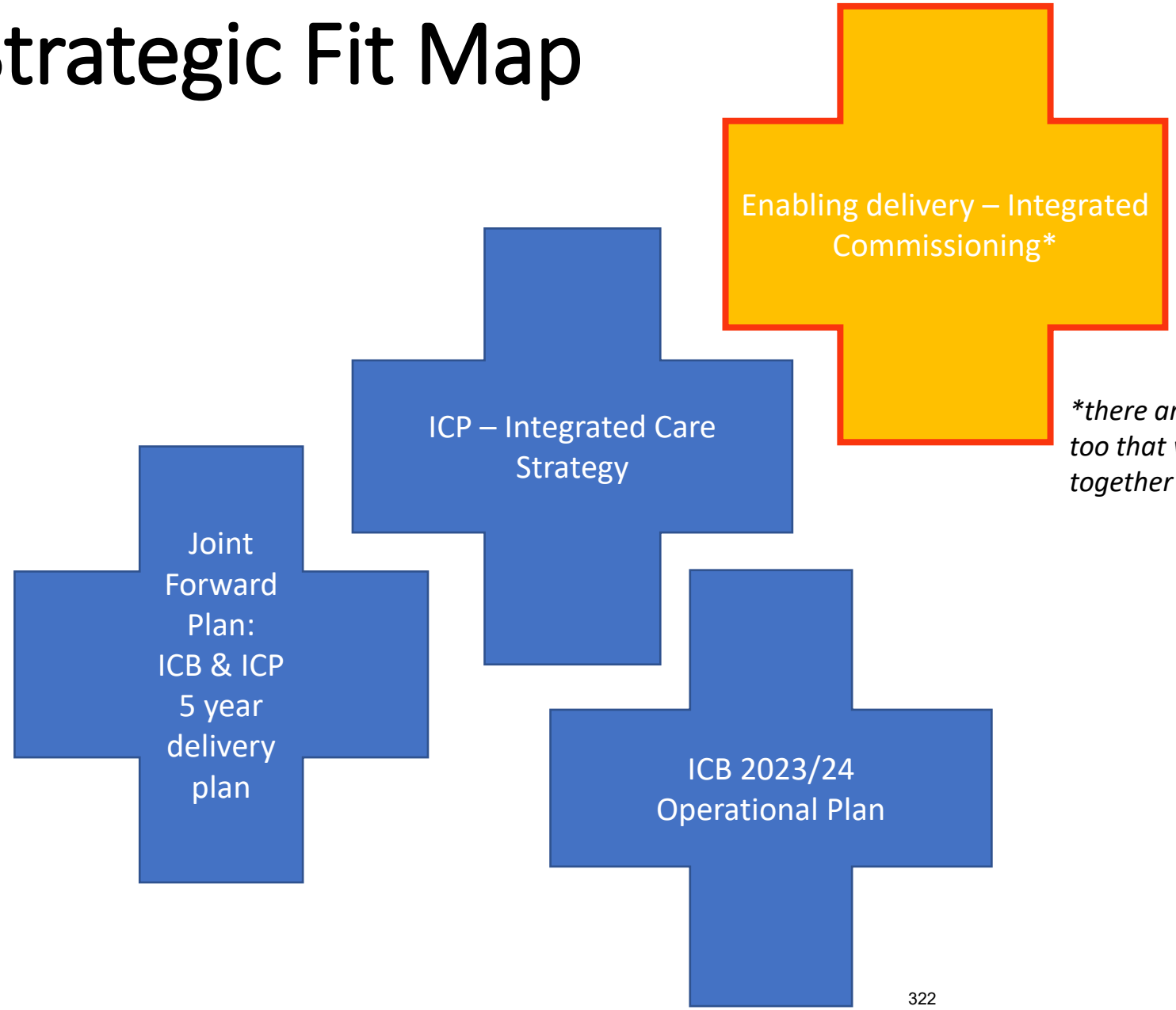
Derby City Council

DERBYSHIRE County Council

Context

- Leadership of our Population Health and Strategic Commissioning Committee (PHSCC) has been asked to set out the next steps in developing our integrated commissioning approach
- This work is still underway and we are sharing some of the headlines from our discussions to date
- Further updates will be provided as the work progresses and it is proposed that this is significantly aligned to the development of our Joint Forward Plan through Q1 of 2023/24.

Strategic Fit Map



**there are other enablers too that we need to 'fit' together*


Areas we have begun exploring

Questions Posed

Against the ultimate aim of improving overall health outcomes for the population of Derby and Derbyshire, what/who is/are:

- The Key Purpose/s of the *Integrated Commissioning* approach,
- The key Strategic Objectives of the *Integrated Commissioning* approach,
- The key priority areas in the Short (6 Month - March 2023), Medium (2 Year - March 2024/25) & Longer (five-year) terms for the *Integrated Commissioning* approach,
- The key "Milestones" and "Measures of Success" against the priority areas in the Short (6 Month - March 2023), Medium (2 Year - March 2024/25) & Longer (five-year) terms for the *Integrated Commissioning* approach,
- The model of Leadership (including capacity), Accountability, Responsibility, Delegations and Partnership required to deliver the Integrated Commissioning strategy in the Short, Medium and Longer terms (to include considerations regarding Strategic versus Local commissioning functions and also the specific roles of the ICB, ICP and HWBBs in this regard) and
- The approach to risk identification and mitigation; what are the key risks as currently viewed and how they will be mitigated?

Our Stand-Back Position – Integrated Commissioning

1. The ‘end state’ overall (next slide) is delivering a high quality sustainable health, care & well-being system that serves the community in Derby City and Derbyshire.
2. The end state will be delivered by the reduction of health inequalities and improved health outcomes for our community.
3. These will be enabled by preventative approaches, effective targeting of resources on needs and population cohort, services that are designed around the experiences of people, and integration of services into adaptive systems.
4. These will be enabled by models of population health management and integrated care that draw all of the parts into a whole (or system) so that each citizen is engaged with the right approaches at the right time by the right organisation.
5. These will be enabled by insightful data, organisational collaboration, service design, public engagement, systems analysis and clear planning/milestones/success measures.
6. The purpose of Integrated Commissioning is to keep us focused on 2 and 3 above when we are making any decision, ensuring that everything covered by 4 is brought to bear.
7. As such, Integrated Commissioning is the rudder that keeps us all moving in the agreed direction. It’s a discipline of thought and action to which we keep returning when the winds knock us off course.
8. The above will lack meaning though if we don’t have the agreed direction, so it is always reliant on us have very clear objectives and approaches against 2 and 3. There is further work to do on this point and ensuring that our direction remains clear in all of our forums, discussions and outputs.

End State – what are our objectives?

- We are **reducing health inequalities and delivering effective primary and secondary prevention** in Derby and Derbyshire
- We have effective services in place to provide care and support which meets the desired **improvement in health outcomes**
- Our agreed health improvement outcomes have been **developed and influenced by our communities**
- We have a **shared understanding** on what is important for our local people, and consider together how to creatively support better health and wellbeing
- We have a consistent approach to **resource prioritisation** based on population needs as apposed to organisational needs
- We know what our **ongoing risks** are which may prevent or hinder our progress and we have **mitigating plans** in place to manage them
- We consider our commissions to be **good value for money** and best use of the funding available to us, based on evidence based intervention
- We have a culture of **trust**, **shared ownership** and **willingness to take risks** together for the overall benefit of our local population.
- How will we know and track – clear metrics?
- What is new and different in our approach e.g. evidence of effective collaboration, shift to preventative interventions and building on local assets and strengths, how it feels for our people?

What is Integrated Commissioning (purpose)?

Integrated Commissioning is:

- **An ICP function** with clarity of ICB specific elements, ICP and broader than ICP
- Describing the **future state** and **building a consensus** for the change needed to get there
- Identifying **needs** and **gaps** associated with health outcomes, inequalities and understanding root causes
- **Prioritising** the areas of focus – resource allocation
- **Collaborative planning** & **shared outcomes** development
- **Undertaking impact** assessment, **monitoring** and **evaluation**
- Undertaken in **partnership**
- **Involving risk** and **reward** mechanisms for the partners involved
- Part of a **bigger picture** of contributions to improve the health of our population, with an understanding of what the wider work is and how it connects.

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- Part of a **bigger picture** of contributions to improve the health of our population, with an understanding of what the wider work is and how it connects.

Key Priority Areas

- Strategic commissioning priorities and interventions which reduce our “front door” pressure and release resources to deliver prevention, reduce health inequalities & improve quality.
- Specific integration examples that we work up and test new approaches against
- Supporting the mobilisation / delivery of the 3 key areas of our integrated care strategy – be clear what we are enabling through integrated commissioning
- Progressing our engagement and partnership with VCSE sector – targeted work on procurement and contracting approaches starting
- Linking this to the Population Health Management approach
- Establish and approach to prioritisation that can deliver measurable improvement
- Work out our delegation approach for commissioning to better define the strategic commissioning role of the ICB

Risks and barriers – what will prevent or hinder our progress making?

- Continued short term operational issues which divert our resources and attention away from our longer term ambitions
- Regulatory requirements which may reduce our flexibility
- Organisational priorities trumping system ones
- Poorly designed processes and governance
- Risk averse behaviours / lack of risk appetite at Board level
- Funding in the ‘wrong’ places and lack of flexibility to alter this
- Lack of incentives or lack of changes in contractual approaches & financial underpinning to support a different approach.

What next?

- Achieving our “stand-back position” described at the outset through:

  - The key priority areas will be fleshed out to include clear milestones, deliverables and dates (the “what's”)
  - The work to develop the Joint Forward Plan over the next 3 months will help us to be clearer on how Integrated Commissioning will act as a valuable enabler to delivering integrated care
  - Our PHSCC strategy development session in April will take the work forward with a particular spotlight on Population Health Management planned
  - Feedback from the Board will inform our thinking and we will keep that discussion going here, bringing back tangible examples of our progress and a clear plan of intended achievement.

Joined Up Care Derbyshire

Integrated Assurance

Sue Sunderland, Non-Executive Member (Audit & Governance)

16th March 2023

The Task

Joined Up Care Derbyshire

Meetings and discussions have been held with Trust Chairs, Audit Chairs and also with Trust secretaries to explore the below:

- The key strategic themes of assurance required across the ICB/NHS & Integrated Care System (ICS)
- The key specific areas of focus within these theme areas over the short, medium and long terms
- The specific assurance duties and aspirations of the ICB, NHS provider trusts and the ICP (Integrated Care partnership of the ICS) in their regard
- The specific duties of NHSE with regards to provider regulation and oversight and what are the expectations upon ICBs to implement them
- The areas of overlap between these organisationally specific duties and aspirations

Emerging Themes

Joined Up Care Derbyshire

- We discussed the need to **avoid duplication** and ensure that system assurance adds genuine value to the delivery of the key areas of transformation across the system . It was noted that to achieve this we (the system) would need to have **good reporting based on quality information** that enables good conversations and constructive challenge.

- It is recognised that the **ICB has a new and emerging role in system oversight** as part of the National Oversight Framework, and that the characteristics of what good oversight in this context would be useful to explore.

- A system governance model should **focus on system goals and transformation** in both the short and longer team, with a principle of light touch reporting.

- It was recognised that the Hewitt review could provide some guidance to systems in the area of governance and assurance, with the findings and recommendations due to report sometime during March.

Agreed Next Steps

Joined Up Care Derbyshire

- Create a map of the current sources of assurance in place across the system, and understanding any areas of duplication or gaps. Understand how this links to and help inform the work underway to develop a system BAF.

- Understand how these sources of assurance and reporting are being used or not.

- Provide clarity on the “Big Ticket” areas are that the system is seeking assurance on.

- Review and further develop the principles and values to create a mutual accountability framework linked to the work underway with Clever Together to develop the strategic framework.

Appendix 3

NHS
Derby and Derbyshire
Integrated Care Board

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Chief Executive's Office
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Cardinal Square
10 Nottingham Road
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DE1 3QT

Tel: 01332 888080
www.derbyandderbyshireicb.nhs.uk

30 November 2022

Sent via email – zara.jones@nhs.net
chris.weiner@nhs.net
julian.corner@nhs.net

Dear Julian, Zara, & Chris,

Following a review of the "*Next Steps in Strategic Development*" at the Integrated Care Board on 20th of October 2022, I am writing to you with a specific "ask" with regards to developing the next steps in our "*Integrated Commissioning*" approach.

In following the precedent set under the former JUCD approach, the ICB board is committed to playing its part in improving overall health outcomes for the population of Derby and Derbyshire (including improving life expectancy and healthy life expectancy rates). As we appreciate, the determinants of health are broad and go beyond those directly related to the provision of NHS services; they are also subject to the influence of Health Inequality that exists across our system.

Therefore, to influence change in these overall outcomes, the NHS in Derby & Derbyshire must be clear on the actions it must take but also be clear on the actions it will take in partnership with other agencies, particular alongside those partners in the Integrated Care Partnership (ICP) and the Health and Wellbeing Boards(HWBBs). To be effective we must ensure we develop our integrated Commissioning approach that not only sets out the strategic commissioning priorities for the ICB & ICP to consider but also appreciates the commissioning decisions that need to be taken closer to our communities through the *Places* that serve them directly.

At the board session, we reviewed positively the progress made to date by the former *Strategic Intent Executive Group (SIEG)* and its four key workstreams (Joint Commissioning, Population Health & Health Inequalities, Health Protection and Clinical Policy), established through the prior JUCD construct and led by the Strategic Intent Executive Group (SIEG). However, the board also recognised the growing importance of the now formed *Population Health & Strategic Commissioning Committee (PHSCC)* of the ICB, *The NHS Executive Team for Derby & Derbyshire (NHSET)* and *The ICS Executive Team (ICSET)* as key groups that will further the Integrated Commissioning agenda, providing the ICB & ICP with strategic insights they will require whilst also supporting *Integrated Care* development across the system by appreciating the commissioning functions that will be best served if undertaken more locally.

Given these developments, it is important that we set out a refreshed mandate for taking forward this important work; to stimulate the development of this new mandate, the ICB board, in good faith, has posed a series of key questions that it would now like you to consider (through the relevant groups that you lead within) and duly report back to the board the outputs of your deliberations (ideally to occur during the last quarter of the 22/23 financial year).

The key areas of question are set out below and the outputs will inform the approach taken in the overall NHS Derby & Derbyshire five year strategy and inform the overarching ICP and HWBB strategies.

Questions for Consideration

Against the ultimate aim of improving overall health outcomes for the population of Derby and Derbyshire, what/who is/are:

- The Key Purpose/s of the *Integrated Commissioning* approach,
- The key Strategic Objectives of the *Integrated Commissioning* approach,
- The key priority areas in the Short (6 Month - March 2023), Medium (2 Year - March 2024/25) & Longer (five-year) terms for the *Integrated Commissioning* approach,
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- The model of Leadership (including capacity), Accountability, Responsibility, Delegations and Partnership required to deliver the Integrated Commissioning strategy in the Short, Medium and Longer terms (to include considerations regarding Strategic versus Local commissioning functions and also the specific roles of the ICB, ICP and HWBBs in this regard) and
- The approach to risk identification and mitigation; what are the key risks as currently viewed and how they will be mitigated?

Next Steps

With your support, I shall kindly ask Helen Dillistone (helen.dillistone@nhs.net) to work with you to coordinate the above and plan the forward date for the outputs of this conversation to return to the ICB board for consideration.

I very much look forward to understanding the ambition that comes from the co-creation of a refreshed mandate in this area; please do not hesitate to contact me directly or indeed, Chris Clayton, ICB Chief Executive (chris.clayton2@nhs.net) if you would like to discuss this further.

With best wishes,

John MacDonald
Chair
NHS Derby and Derbyshire Integrated Care Board

Cc Helen Dillistone, Executive Director of Corporate Affairs, NHS Derby and Derbyshire ICB

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 097

Report Title	Integrated Care Strategy Update							
Author	Kate Brown, Director Joint Commissioning & Community Development							
Sponsor (Executive Director)	Tracy Allen, Chief Executive Officer, Derbyshire Community Health Services NHS Foundation Trust							
Presenter	Tracy Allen, Chief Executive Officer, Derbyshire Community Health Services NHS Foundation Trust							
Paper purpose	Decision	☒	Discussion	☒	Assurance	☐	Information	☐
Appendices	Appendix 1 – Draft Integrated Care Strategy							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Integrated Care Partnership Board - 8th February 2023							

Recommendations
The ICB Board are recommended to: • **NOTE** the draft strategy and the actions underway to produce a final version; • **AGREE** with the direction set out within the strategy; and • **NOTE** the role of the ICB in supporting delivery of the strategy.
Purpose
The draft strategy is being shared with the Board for information. It was supported by the Integrated Care Partnership (ICP) on the 8th February 2023 and a final version of the strategy will be produced for consideration by the ICP in April 2023. The purpose of the Derby and Derbyshire Integrated Care Strategy is to set out how the NHS Local Authority, Healthwatch, and Voluntary Sector organisations will work together to improve the health of Derby and Derbyshire citizens, and further the transformative change needed to tackle system health and care challenges.
Background
The draft Strategy has been compiled in line with the guidance available on the Gov.UK website - Guidance on the preparation of integrated care strategies. The approach to addressing the legal requirements included within this guidance is summarised in the Draft Strategy.

The Strategy is informed by and will complement joint strategic needs assessments (JSNAs) and joint local health and wellbeing strategies. The Health and Wellbeing Boards remain responsible for producing these and will continue to have a vital role at Place.

A range of senior colleagues from the NHS, local authorities, Healthwatch and the VCSE sector have been part of working groups to develop the brief, framework, and approach for the Draft Strategy. This broad involvement has been very helpful in testing the proposed content and whether it is framed in a way that aligns with other system strategies and plans.

Report Summary

The Draft Strategy recognises that the current environment is challenging, and that we cannot expect key constraints to diminish in the near future. However it notes that there is much more that can be done within these constraints, by working differently, and that this Strategy will seek to identify how we can exploit these opportunities, building on examples of where we do things really well in Derby and Derbyshire and to understand how actions, partnerships and behaviours that have led to successful outcomes, can accelerate our plans for integrated care.

Four strategic aims for integrated care in Derby and Derbyshire were approved by the ICP Board in December 2022. These are pivotal to the development of the Strategy:

1. Prioritise prevention and early intervention to avoid ill health and improve outcomes.
2. Reduce inequalities in outcomes, experience, and access.
3. Develop care that is strengths based and personalised.
4. Improve connectivity and alignment across Derby and Derbyshire, to ensure people experience joined up care, and to create a sustainable health and care system.

The population health and care needs of Derby and Derbyshire are a fundamental driver for the Strategy. The Draft Strategy includes a summary of Joined Up Care Derbyshire (JUCD) priority outcomes and indicators, which focus on increasing life expectancy, increasing healthy life expectancy, and reducing inequalities. These are based upon development work within the system, our JSNAs and Health and Wellbeing Strategies and align with outcomes included in Local Authority plans. A section is also included on proposals relating to health protection arrangements

A main thrust of the Draft Strategy is the need to focus on enabling actions that are critical to the development of high quality and sustainable integrated care and our response to the stated population health and care needs. These actions are summarised in the document under enabling functions such as workforce, digital and data, and population health management, as well as broader themes including governance and system-wide organisational development.

There are three key areas of focus proposed in the Draft Strategy that span prevention, early intervention and service delivery. They are not framed as priorities, as they are not necessarily regarded as being more important than other topics. Instead they have been chosen by senior responsible owners from across the System as ideal areas to test our strategic aims and ambitions for integrated care, in response to population health and care needs. They are categorised under the headings of Start Well, Stay Well, and Age/ Die Well:

1. Start Well – To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness.
2. Stay Well -–To improve prevention and early intervention of the three main clinical causes of ill health and early death in the JUCD population - Circulatory disease, respiratory disease and cancer.
3. Age/ Die Well – To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will

prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximise a return to independence following escalations

The methodology for developing community insight is summarised in the Draft Strategy, along with a commitment to develop standard processes to ensure that when JUCD strategies, developments and change programmes are being formulated leaders demonstrate how they have used both JUCD data on population outcomes/ indicators and insights to shape their objectives, engagement approach and expected benefits.

A 'System Insights Group' and an 'Engagement Workstream for the ICS Strategy' are in place with representation from health, local authorities, Healthwatch and the VCSE Alliance. Under the workstream an Insights document has been produced to collate high-level themes drawn from existing engagement and insights. This forms part of the JUCD insight's library.

These themes and the insights included were considered by Senior Responsible Officers and teams when they selected their key areas of focus for this Strategy under the headings - Start Well, Stay Well and Age Well.

The Draft Strategy was presented with information on the three key areas of focus with the wider public via the Derbyshire Dialogue Forum (15 February 2023) and is being shared with local organisations and forums through a series of presentations February – March.

The proposed next steps around engaging on the Draft Strategy include:

- plans to hold online engagement events for each of the 3 areas allowing leads to present information in an accessible way and invite comments about what actions are needed to achieve the ambitions set out and capture these to inform plans Support these conversations through our Online Engagement Platform, with opportunities to continue to ask questions and make suggestions;
- if appropriate create surveys for each area to gather feedback from a wider cohort of people targeted as required;
- facilitate and support conversations between programme leads and local community groups who express interest in the key areas of focus, helping to ensure we do not just rely solely on people having digital access, using existing groups and forums where possible, with support from the VCSE sector; and
- ensure feedback/ insight from these conversations is listened to, considered, and actioned through the implementation plans for the three key areas of focus.

As a key partner in the Integrated Care Partnership the ICB has vital role, ensuring its structures, functions and key decisions are aligned with supporting development and delivery of the strategy.

Identification of Key Risks

Delivery against the draft strategic proposals will support mitigation of a number of ICB risks:

- SR6 – there is a risk that the system does not create and enable One Workforce to facilitate integrated care;
- SR7 – there is a risk that decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required; and
- SR9 – there is a risk that the gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcomes.

Has this report considered the financial impact on the ICB or wider Integrated Care System?		
Yes ☐	No☐	N/A☒
Details/Findings		**Has this been signed off by a finance team member?** Not applicable to this report.

Have any conflicts of interest been identified throughout the decision making process?
None identified.

Project Dependencies

Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☒	N/A☐	Summary: Strategy driven by insights and engagement planned

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
None identified.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable to this report.					

Draft

Derby and Derbyshire

Integrated Care Strategy

For consideration by the ICP Board

08 February 2023

Contents

Foreword

Integrated care systems provide a positive opportunity for Derby and Derbyshire residents to receive joined up care and support to meet their health and care needs.

Derby City Council and Derbyshire County Council have responsibility for a range of social care and public health functions that support our residents to live well. Our two local authorities are working alongside NHS colleagues, Healthwatch, district and borough councils and the voluntary and community sector to deliver integrated care for our residents.

The Covid pandemic and cost of living pressures have negatively impacted the health of our population in so many ways. Our budgets and services are experiencing challenges and pressures on a regular basis. Our workforce is going the extra mile every day.

Integrated care is not a solution in itself; however it does allow us to develop new ways of working, utilise new technology, maximise the skills of our precious workforce to create new opportunities to collaborate and work together. It will not be easy but there is a shared local commitment to do all we can within the resources available to do our best for Derby and Derbyshire.

Our Integrated Care Strategy summarises the first steps on the journey and describes how we will further grow and develop our shared approaches. There is huge ambition and commitment across the City and County to get this right for our communities. Delivering against the proposals in this strategy has the potential to help us provide a more preventative approach to health, tackle inequality and improve outcomes for local residents.

As Joint Chairs and Vice Chair of the Derby and Derbyshire Integrated Care Partnership we hope that you find the information useful, engaging and that it provides a clear understanding of the journey we are on and what we want to achieve by doing more together for our local populations.

Cllr Carol Hart
Cabinet Member for Health and Communities – Derbyshire County Council
Chair of the Derbyshire Health and Wellbeing Board

Cllr Roy Webb
Cabinet Member for Adults, Health and Housing – Derby City Council
Chair of the Derby Health and Wellbeing Board

John MacDonald
Chair of Derbyshire Integrated Care Board

1. Introduction

1.1 Purpose of this document

This document has been produced for consideration at the Integrated Care Partnership (ICP) Board on 8 February 2023. It is a first draft of the Derby and Derbyshire Integrated Care Strategy and builds on the Framework Document considered by ICP Board members on 7 December 2022.

The purpose of the Joined Up Care Derbyshire (JUCD) Integrated Care Strategy is to set out how Local Authority, NHS, Healthwatch, and Voluntary Sector organisations will work together to improve the health of Derby and Derbyshire citizens, and further the transformative change needed to tackle system health and care challenges.

The final draft of the Strategy will be produced for consideration by the ICP Board in April 2023. The approved version will then be published in line with national guidance, with a copy provided to each partner local authority and the Integrated Care Board.

A summary of the Strategy will also be produced to accompany the final document. This will be designed to communicate the key elements in a shorter and more simplified manner with the use of infographics and easier to understand language. It will also convey the relationship between this Strategy and other key planning documents and priorities, so that staff and citizens can see how the Integrated Care Strategy and its strategic aims align with health and wellbeing and other key strategies.

The Strategy will not be static, the national guidance requires that *Integrated care partnerships must consider revising the integrated care strategy whenever they receive a joint strategic needs assessment*. Therefore further versions of the Strategy will be produced and published in line with this requirement. To this end the Strategy should be regarded as a starting point for assessing and improving the integration of care.

1.2 Impact of this Strategy

In developing this Strategy a question consistently posed by the team leading its production has been *'what will not happen if we do not have this Strategy, what are the gaps it is seeking to fill'?*

The aim is to develop a document that describes both a high-level strategic intent and the practical steps the Derby and Derbyshire System will take together to provide care that is more integrated, and which provides better outcomes for citizens, in response to population health and care needs.

In response to the question stated above, the Integrated Care Strategy will impact in the following ways:

- **Collaboration and collective working -** The collaborative work to develop the Strategy has helped to strengthen partnership working and engagement between local authorities, the NHS, the VCSE sector and Healthwatch, that will prove beneficial beyond the remit of the Integrated Care Strategy and should act as a springboard for better collective working moving forward. In short, the way in which we are developing this Strategy is just as important as the content.

- **A joined up approach to strategic enablers** - The Strategy captures for the first time the key, enabling actions that are critical to the development of high quality and sustainable integrated care, and identifies key areas of focus to test these actions.

- **Agreement on key areas of focus to test our strategic aims and ambitions for integrated care -** The process for developing the Strategy has resulted in system-wide agreement on three key areas of focus that will help deliver key population health and service delivery outcomes, they are:

  - **Start Well** - To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness

  - **Stay Well** - To improve prevention and early intervention of the 3 main clinical causes of ill health and early death in the JUCD population - Circulatory disease, respiratory disease and cancer

  - **Age/ Die Well** - To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations

- **Engagement -** It is critical that the improvements expected as a result of this Strategy are meaningful and impactful to citizens. The strategic approach to engagement developed by JUCD, which includes key principles and frameworks will be key to success. It sets out how we will listen consistently to, and collectively act on, the experience and aspirations of local people and communities. The Integrated Care Strategy provides an ideal opportunity to test and further develop this approach.

1.3 National Guidance on the preparation of Integrated Care Strategies

The guidance currently available on the Gov.UK website is the same as referenced in the December 2022 Framework Document. Please refer to that document or the guidance itself (Guidance on the preparation of integrated care strategies) for further information.

Legal requirements
The legal requirements stated in the guidance are included below along with a statement on the compliance of the Draft Strategy against these requirements.

Legal requirements stated in July 2022 Guidance	Current status for Draft Strategy
The integrated care strategy must set out how the **'assessed needs' from the joint strategic needs** assessments in relation to its area are to be met by the functions of integrated care boards for its area, NHSE, or partner local authorities.	Three key areas of focus emanating from 'assessed needs' have been selected as a focus for the Strategy and to test the strategic aims and ambitions for the development of integrated care, with implementation to be overseen by the ICP. The Joint Forward Plan will describe how other 'assessed needs' will be met.

In preparing the strategy, the ICP must, in particular, consider whether the needs could be more effectively met with an arrangement under **S75** of the NHS Act 2006.	The governance arrangements for the three key areas of focus will consider S75 arrangements.
The ICP **may include a statement on better integration of health or social care services with 'health-related' services in the strategy**.	It is proposed that the wording included in this Strategy document should meet the requirement stated.
The ICP must have regard to the **NHS mandate** in preparing the strategy.	The NHS Mandate is referenced in this draft Strategy, however at the time of writing the 2023/24 Mandate has not been published. The three key areas of focus will incorporate relevant requirements of the Mandate and the Joint Forward Plan is likely to play a more substantive role in responding to the Mandate, given its broader remit and its focus on delivery.
The ICP **must involve in the preparation of the strategy: local Healthwatch organisations** whose areas coincide with or fall wholly or partly within the ICP's area; and people who live and work in the area.	Derby and Derbyshire Healthwatch organisations have been involved through the Communications and Engagement Group for the Strategy (please see **Section 6** for work to date), through their membership of the ICP Board and through separate conversations with the team leading the development of the Strategy. Moving forward Healthwatch will play a key role in the finalisation and delivery of the Strategy, for example by: • Ensuring authentic conversations with citizens help shape and drive work programmes for the key areas of focus and enabling plans • Feeding into evaluation work, ensuring the many different 'voices' of citizens are listened to when assessing progress and the impact of changes made to services.
The **ICP must publish the strategy** and give a copy to each partner local authority and each ICB that is a partner to one of those local authorities.	The final version of the Strategy (April 2023) will be published in line with the guidance.
ICPs must consider **revising the integrated care strategy whenever they receive a joint strategic needs assessment**	This will be done when new JSNAs are received and when new health and wellbeing strategies are agreed.

1.4 Aligning the Integrated Care Strategy

The Strategy will complement joint strategic needs assessments and the joint local health and wellbeing strategies. The health and wellbeing boards remain responsible for producing both of these documents, and these will continue to have a vital role at Place.

The ICP will need to ensure that the Strategy facilitates subsidiarity in decision making, ensuring that it only addresses priorities that are best managed at system-level, and not

replace or supersede the priorities that are best done locally through the joint local health and wellbeing strategies.

References are included in this document to illustrate how the development of the Strategy is being aligned with other system strategies and plans and where further work may be required. Please see **Appendix 1** for a visualisation of how health strategies link together.

Guidance has recently been released (NHS England » Guidance on developing the joint forward plan) to support integrated care boards (ICBs) and partner organisations develop their first 5-year joint forward plans (JFPs) with system partners. The guidance includes the following statement:

*..we encourage systems to **use the JFP to develop a shared delivery plan for the integrated care strategy** (developed by the ICP) and the joint local health and wellbeing strategy (developed by local authorities and their partner ICBs, which may be through HWBs) that is supported by the whole system, including local authorities and voluntary, community and social enterprise partners.*

Conversations are currently being held in the System to discuss the JUCD approach to production of the JFP and the relationship with the implementation of this Strategy.

1.5 Hallmarks for the Strategy

The hallmarks agreed through the Framework Document have been used to help guide the development of this Draft Strategy:

- There is an inclusive approach to developing the content
- The development of the Strategy and its recommended actions is based upon a strong culture of collaboration between JUCD organisations and alliances.
- We will develop a broad and deep engagement approach to inform the further development of the Strategy and relevant implementation plans
- This is a strategy for JUCD, not for regulators, and the process of developing it, should be as important as the content of the Strategy itself
- We will develop content that can be converted into statements which mean the public can easily understand how this Strategy will make a difference to them (*to be done following agreement of the Draft Strategy*).

1.6 Involvement and engagement in the development of this framework document

A range of senior colleagues from the NHS, local authorities, Healthwatch and the VCSE sector have been part of working groups to develop the brief, framework, and approach for the Draft Strategy, following the update on the development of an Integrated Care Strategy provided to the ICP Board in October 2022. This broad involvement has been very helpful in testing the proposed content and whether it is framed in a way that aligns with other system strategies and plans.

1.7 Format and content of the document

References are included in this document to national and system strategies/ plans that are relevant to the development of this Strategy – please see **Section 2**. Minimal content has

been included on these to keep the content of this document focused. The strategic aims for the Strategy are also included in this section**.**

The population health and care needs of Derby and Derbyshire are a fundamental driver for the Strategy. **Section 3** includes a summary of JUCD priority outcomes and indicators. These are based upon joint strategic needs assessments and health and wellbeing strategies and align with outcomes included in Local Authority plans. A section is also included on proposals relating to health protection arrangements.

A main thrust of the Strategy is the need to focus on strategic enablers that are critical to the development of high quality and sustainable integrated care in response to the stated population health and care needs. These enablers are summarised in **Section 4**.

There are three 'key areas of focus' proposed in **Section 5** spanning prevention, early intervention and service delivery. They are not framed as priorities, as they are not necessarily regarded as being more important than other topics. Instead they have been chosen by senior responsible owners from across the System as ideal areas to test our strategic aims and ambitions for integrated care, in response to population health and care needs. They are categorised under the headings of Start Well, Stay Well, and Age/ Die.

The plans for these key areas of focus will include ambitions that span multiple years and for many metrics we may not see attributable improvement until the medium to long term. Delivery plans will need to explain the connections between improvements to be achieved in the short-term (for example in responding to health and care annual operating plan requirements) and ones that will be achieved in the medium to long term, and to also show how they fit together. The Joint Forward Plan will be helpful in this regard.

Other key issues flagged by the ICP and ICB Boards that will be integral to the work arising from this Strategy include addressing health inequalities, the further development of population health management and maximising the NHS contribution to tackling wider determinants of health.

Section 6 summarises the JUCD approach to engagement and the use of insights, and the outline plan for engagement on the Strategy and the key areas of focus.

Section 7 outlines the need and intent to evaluate strategy implementation, including the impact of plan delivery for the three key areas of focus. The content is under development and will be updated for the final version in April 2023.

2. Strategic Context

2.1 National context

The Health and Care Act 2022

The Health and Care Act 2022 put new requirements on NHS and Local Authorities, including the requirements to produce an Integrated Care Strategy, set up an Integrated Care Partnership and establish an Integrated Care Board.

NHS Mandate

The ICP must have regard to the NHS Mandate, alongside guidance from the Secretary of State, when preparing the Integrated Care Strategy. The 2023-24 Mandate and accompanying objectives are awaited.

The NHS Mandate will help inform this Strategy; however it is by its nature NHS centric and some of its content is quite operational, and therefore the primary response to the Mandate will be through the Joint Forward Plan.

National focus on prevention and early intervention

There have been recent calls from national organisations for an increased focus on prevention and early intervention, which echo one of the strategic aims for this Strategy - *Prioritise prevention and early intervention to avoid ill health and improve outcomes.*

The paper published in January 2023 Joint vision for a high quality and sustainable health and care system | Local Government Association provides the views of the Local Government Association, the Association of Directors of Adult Social Services, and the NHS Confederation and endorses the approach outlined in this Strategy:

"Our three national organisations agree that our vision for all partners in the health and care system must focus first and foremost on promoting the health, wellbeing and prosperity of our citizens. This vision is relevant to all of us, whether we need care, support or treatment now or in the future, provide unpaid care for family members, work in social care or health, or run businesses that contribute to health and wellbeing outcomes. It focuses on:

- *maximising health and wellbeing and preventing or delaying people from developing health and social care needs*
- *redirecting resources so that when people need treatment, and short term support they are assisted to make as full a recovery as possible, restoring their health, wellbeing and independence*
- *maximising independence and wellbeing for people with ongoing heath and/or social care needs by working with them to put in place the care and support that works for them."*

2.2 JUCD Strategic context

Introduction

It is recognised that the current environment for health and care is very challenging on a number of fronts including the lived reality of workforce capacity and wellbeing challenges, Covid related backlogs, and financial constraints. And in the context of this Strategy we cannot expect these challenges to diminish in the near future.

There are other System plans that will better describe approaches for dealing with the issues of today and the need for near-term responses, and whilst it is not the intention to downplay or disregard these challenges in developing this Strategy, it is important for the System to also identify what can be done more effectively and efficiently by integrating resources and by working differently, through medium and long-term lens. Therefore through this Strategy we will seek to identify and exploit such opportunities.

It will be important to build on examples of where we do things really well in Derby and Derbyshire and to understand how actions, partnerships and behaviours that have led to successful outcomes, can accelerate our plans for integrated care, and to help build an

appreciative inquiry approach to the development of the Strategy and subsequent implementation plans. In the final version of the Strategy examples of good practice aligned to the key areas of focus and strategic enablers will be incorporated into the document.

The following sub-sections include references to local strategies and plans that need to be considered when developing integrated care. It is not a simple landscape, and at the current time there are multiple, relevant strategies or plans under development, in response to government, NHS and local requirements. A common goal for colleagues working across the System in this space should be to assess other, relevant planning exercises and collectively to try and develop a coherent logic for how the documents align with each other. **Appendix 1** provides an infographic that seeks to help in this regard, and this will be developed further in the final version of the Strategy.

ICS System Development Plan

The ICS System Development Plan is a recent document and includes four strategic priorities (using the NHS stated aims for ICSs). We have agreed that for the Integrated Care Strategy we should build out from the content included in that Plan and have strategic aims for the development of integrated care, that can sit alongside the stated strategic priorities for the ICS, these strategic aims are;

- **Prioritise prevention and early intervention to avoid ill health and improve outcomes**
- **Reduce inequalities in outcomes, experience, and access**
- **Develop care that is strengths based and personalised**
- **Improve connectivity and alignment across Derby and Derbyshire, to ensure people experience joined up care, and to create a sustainable health and care system**

Joint Forward Plan

Section 1 outlined the guidance for Joint Forward Plans, released by NHS England in December 2022, and the initial conversations in relation to the Integrated Care Strategy.

JUCD Operational Plan 2023-2024

Prevention, access and productivity are key themes/ requirements that are driving the 2023-24 operational plan, which responds to guidance released by NHS England. Whilst the Integrated Care Strategy will also focus on other themes (as reflected in the strategic aims), it will also be important that the SROs for the key areas of focus to examine contributions to improvements in access and productivity, as well as prevention.

Local Authority Plans 2022-2025

Please see **Section 3** for an outline of how outcomes, ‘must do’s’ and ‘headline initiatives’ from these plans align with the stated population health and care needs.

Adult social care and children’s strategies

Relevant stated priorities in local strategies covering adult social care and children' services need to align with the aims for the integrated care key areas of focus to support our ambitions for collaboration and integration.

Health and wellbeing strategies
Please see **Section 3** for reference to the Derby City and Derbyshire health and wellbeing plans and the alignment between these, the JSNAs, and current work to develop a Health Inequalities Strategy.

Anchor Institutions
The work of the Derby/ Derbyshire Anchor Partnership needs to be incorporated into the design and delivery plans for this Strategy.

The two local authorities, local NHS organisations and JUCD, Derby County Community Trust and the University of Derby are signatories to an Anchor Charter, and together with Rolls Royce, are members of Derbyshire's founding Anchor Partnership. Together they aim to use their collective influence to help address socio-economic and environmental determinants and enable and facilitate community wealth building, working together through the Derby and Derbyshire Health and Wellbeing Boards and the Integrated Care Board.

The Anchor Partnership has agreed to initially focus its combined influence and actions on the following two impact areas – workforce and access to work, and social value in procurement. Anchor workshops have commenced in recent months with relationships established through communications colleagues in each organisation.

It will be important to consider how best to align Anchor Partnership actions with the work emanating from this Strategy on key enabling functions and across the Start Well, Stay Well, and Age/ Die Well areas of focus.

3. Population Health and Care Needs

3.1 Introduction

Work has been undertaken by system colleagues to develop a set of JUCD priority population outcomes and key indicators (known as Turning the Curve) based upon the Derby and Derbyshire Joint Strategic Needs Assessments. These focus on increasing life expectancy, increasing healthy life expectancy, and reducing inequalities. The system outcome priorities/ indicators have been chosen because they are key drivers of the conditions that cause ill health, premature mortality, and inequalities in these, with the biggest causes of death in our population being cancer, respiratory and circulatory disease. This is reflected in emerging work to develop a JUCD health inequalities strategy which reflects the Core20Plus5 NHS England approach to reducing inequalities.

The Derbyshire and Derby Health and Wellbeing Strategies are to be updated during 2023. The content for this document and the needs outlined in this Section are therefore based upon the existing health and wellbeing strategies.

3.2 Life expectancy and healthy life expectancy

The health of a population can be described using healthy life expectancy and life expectancy statistics, and health inequalities can be starkly demonstrated by illustrating the difference in length of life, and how many of those years are spent in good health. Please see **Table 1** below for a summary of the differences in Derby and Derbyshire.

Table 1

	Derby	Derbyshire
Life Expectancy at Birth [inequality gap*], in years		
Female	82.1 [10.1]	83.0 [7.4]
Male	78.6 [10.2]	79.6 [8.3]
Healthy Life Expectancy At birth, 2017-19 [inequality gap, 2009-13*], in years		
Female	62.0 [19.2]	61.3 [13.5]
Male	59.9 [18.7]	61.1 [13.7]

**Life Expectancy at Birth statistical measures estimate the average number of years a new-born baby would survive if they experienced the age-specific mortality rates in this area throughout life. Healthy life expectancy describes reported years in good health. The gap describes the difference between the least and most deprived populations.*

The inequalities illustrated in **Table 1** are distributed differently across the area. Poorer outcomes are linked to areas of socio-economic deprivation and certain groups including, but not limited to, those from Black, Asian, and Minority Ethnic backgrounds, with serious mental illness, living with disabilities, LGBTQ+ people and those currently homeless.

The emerging work to develop a JUCD health inequalities strategy incorporates a review of the drivers of ill-health and mortality, the inequalities which exist between and within communities and sets out desired population outcomes, and priority indictors for affecting outcomes and inequalities – Please see **Section 3.3**.

3.3 Our desired population outcomes

The following statements have been developed locally to describe if the population were living in good health, it would be experienced as follows:

- **Start Well** - Women have a healthy pregnancy, children are born safe and well into a nurturing and secure relationship with care givers, with good nutrition, access to health care, social care, and education. Children thrive and develop positive and healthy relationships.

- **Stay well** - All citizens live a healthy life, can make healthy choices, and are protected from harm. They maintain quality of life and recover well from ill health or injury.

- **Age well and die well** - Citizens thrive and stay fit, safe, and secure into older age. They maintain independence and actively participate in society. They have a personalised, comfortable, and supported end of life.

3.4 System wide population indicators

The following 'Turning the Curve' indicators have been recommended as important 'markers' on the way to improving high-level outcomes. They address direct risk factors for the main causes of death, illness, and inequalities, including mental health:

1. **Reduce smoking prevalence**
2. **Increase the proportion of children and adults who are a healthy weight**
3. **Reduce harmful alcohol consumption**
4. **Improve participation in physical activity**
5. **Reduce the number of children living in low-income households**
6. **Improve air quality**
7. **Improve self-reported wellbeing**
8. **Increase access to suitable, affordable, and safe housing.**

JUCD has also identified additional indicators to reduce specific inequalities in the system drawing on local data and NHS recommendations*. See below for the "Plus 5" indicators (clinical areas of focus which require accelerated improvement).

- **Maternity:** ensuring continuity of care for 75% of people from Black, Asian and minority ethnic communities and from the most deprived groups**.**
- **Severe mental illness (SMI) and Learning Disabilities:** ensuring annual health checks for 60% of those living with SMI or learning disabilities**.**
- **Improving Vaccination uptake:** reducing inequalities in uptake of life course, COVID, flu and pneumonia vaccines
- **Early cancer diagnosis:** 75% of cases diagnosed at stage 1 or 2 by 2028.
- **Hypertension case-finding:** to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke

* https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/

***Note**: Guidance on Core 20 Plus 5 for CYP has recently been issued nationally and will require consideration. Five clinical areas of focus are asthma, diabetes, epilepsy, oral health, and mental health with specific actions recommended.*

3.5 Derby City Council Plan

A number of the outcomes and ‘must do’s’ under the four focus areas included within the Derby City Council Plan align to and support health and wellbeing plans, and the desired population outcomes and priority health indicators stated above. For example the following are referenced:

- Cleaner air and lower CO2
- Decent, sufficient, and affordable housing with an emphasis on the homes of vulnerable people
- Reducing inequalities and wealthier and healthier residents
- Health and wellbeing strategy with a focus on childhood obesity and public health statutory requirements
- Provide effective strategic leadership to drive stronger integration of health, housing, community, and social care agendas, safeguarding adults that need it
- Establish a citywide Prevention Strategy, focusing on building independence using individual and community assets

3.6 Derbyshire Council Plan

Within the Derbyshire plan one can see how the stated ‘headline initiatives’ align with health and wellbeing plans, and the desired population outcomes and priority health indicators, examples include:

- Working with partners to benefit the health and wellbeing of people in Derbyshire by better integrating health and social care and developing the Better Lives transformation programme
- Driving forward the ambitious improvements in Children’s Services to positively strengthen outcomes for children and young people
- Work with people with learning disabilities, recovering from mental ill health and, or autism to develop Council services to ensure they are tailored to meet individuals needs and help people achieve their personal goals
- Work with partners to enable individuals and communities to lead healthier and happier lives, accessing support when and where they need it to encourage physical activity, help people stop smoking and manage their weight
- Help and empower more young people with disabilities to be independent in their transition to adulthood

In addition the council has published its “Best Life Derbyshire” Strategy in 2023 with a focus on people with lived experience being able to define the outcomes they want from social care.

3.7 Health protection

Integrated care partnerships are asked to consider health protection in their integrated care strategy, with system partners including UKHSA, local authorities and the NHS who, among other bodies, have health protection responsibilities to deliver improved outcomes for the population and communities served. Health protection includes:

- Infection and prevention control (IPC) arrangements within health and social care settings

- Tackling antimicrobial resistance
- Reducing vaccine-preventable diseases through immunisation
- Assurance of national screening programmes
- Prevention activities related to health protection hazards such as needle exchanges for blood-borne viruses (BBVs)
- Commissioning of services for response to health protection hazards (such as testing, vaccination and prophylaxis) and to tackle health protection priorities (such as tuberculosis or BBV services)
- Emergency preparedness, resilience and response (EPRR) across all hazards
- Other health threats determined as priorities

The Directors of Public Health (DsPH) have the duty, under the Health and Social Care Act (2012), to be assured that the local health protection system is working effectively and to ensure that the health of the population is protected. This is sought through the Derby and Derbyshire Health Protection Board, chaired by one of the DsPH and reporting to the Health and Wellbeing Boards; an arrangement that has been in place since 2013. The development of the integrated care system is an opportunity to ensure this is embedded within the local health and care system.

Work is underway to identify key areas of work that require system support, these include:

- Developing the infection prevention and control system
- Ensuring a successful and safe transfer of the responsibility to commission immunisation services
- Ensuring oversight of screening programmes is appropriately linked to the system
- Improved connection for existing strategies e.g. air quality
- Pathway improvements for individuals with complex health protection needs e.g. those with TB who have no recourse to public funds

The following strategic actions have been identified:

- Request a commitment from the ICP to sponsor a review of the governance and architecture for health protection in Derby and Derbyshire.
- Produce a health protection strategy for Derby and Derbyshire to clarify and drive the work of the Health Protection Board and establish agreed outcome measures.
- Review the three key areas of the focus for the Integrated Care Strategy and identify prioritised health protection actions. Secure commitment from the SROs to include these actions as an integral element of their work plans, and to work with Public Health colleagues on their resolution.
- Ensure health protection priorities are included within the appropriate workstreams, and that progress is reported to the Health Protection Board.

4. Strategic Enablers

4.1 Introduction

A key thrust of this Strategy is to focus on enabling actions that are critical to the development of high quality and sustainable integrated care and our response to population health and care needs. These have been grouped as follows:

- System architecture and governance
- System shared purpose, values, principles, and behaviours
- Enabling functions and approaches

4.2 System architecture and governance

Through this Strategy we will strive to ensure there is a 'parity of attention' on health inequalities, population health, and prevention within system reporting and governance arrangements, to ensure clarity and visibility on how we track our ambitions for our Start Well, Stay Well, Age/ Die Well key areas of focus, and wider improvement actions.

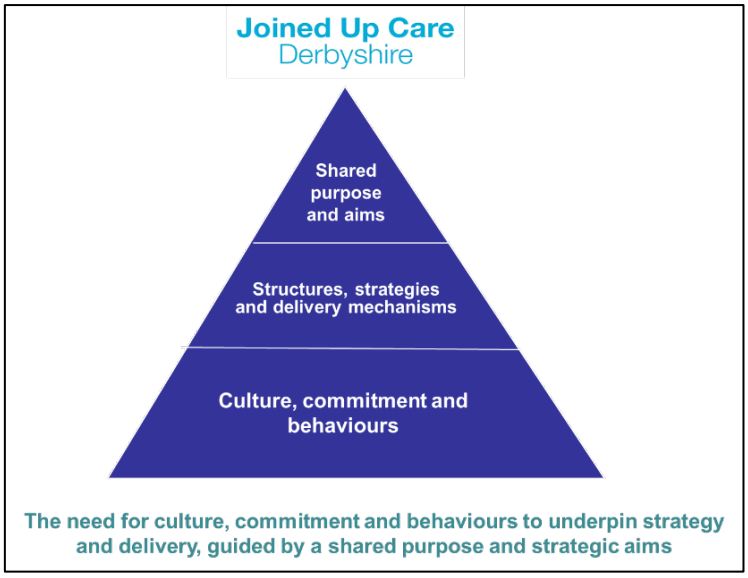
This objective needs to be set in the context of current work taking place to establish a renewed mandate to guide next steps for our collective "Integrated Care" approach, and JUCD governance architecture. A series of guiding questions to the Provider Collaboration at Scale and the Provider Collaboration at Place movements have been asked to help inform the renewed mandate.

Currently the two Place Partnerships and the Integrated Place Executive provide the primary governance arrangements for the Integrated Care Strategy on behalf of the ICP. In this context the role of the ICP in supporting and overseeing the delivery of this Strategy needs to be established, post approval of the final document.

Further consideration is also required in relation to how the Strategy's key areas of focus are governed. All three of the proposal documents described issues with current governance and delivery arrangements that will need to be addressed if benefits are to be maximised. There also needs to be feedback loop processes for how the agreed plans are continually informed by health and wellbeing plans and JSNAs, and vice versa.

4.3 System shared purpose, values, principles, and behaviours

Many of the key strategic enabling actions that are intended to support improvement through practical and transactional solutions, may not succeed, without significant underlying changes in behaviours to support a one-system approach, due to established processes and organisational sovereignty issues. A simple over-arching framework to ensuring a balanced approach is included below.



In the absence of a whole system, shared set of values and principles to underpin the development and delivery of the Integrated Care Strategy then consideration should be given to this, alongside organisational development support that may be required to facilitate the process, to ensure that the Strategy is built on sustainable cultural foundations.

Where success has been achieved in developing integrated care to date, it is important to reflect on the conditions that facilitated the success, both transactional and cultural. Work will take place to gather and review this intelligence to inform further engagement, with leaders, staff, and the public.

Work will now commence to scope how a set of shared values and principles to underpin the development and delivery of the Integrated Care Strategy could be developed.

4.4 Enabling services and approaches

Strategies and improvement plans for enabling functions and approaches should encompass all organisations/ alliances in the System (unless not deemed relevant) and support the achievement of our strategic aims for integrated care.

The content under this Section seeks to summarise current strategies and improvement plans and also flag key constraints that will need to be addressed. The following enabling functions and approaches are included:

- Workforce
- Digital and data
- VCSE sector
- Carers
- Strengths based approaches
- Population health management
- Commissioning
- Quality drivers
- Estate

Primary care is refenced in Section 4.5.

There is already alignment between some of the content in this section and the content in Section 5, where aims and constraints are stated for the key areas of focus selected to test and mobilise this Strategy. This reflects the fact that there is already considerable joint working taking place across the System. The leadership for each of the key areas of focus will be expected to work closely with enabler leads to further this alignment and to develop work programmes that will help to test enabling strategies and improvement plans in real world situations and gather learning to inform continuous improvement.

The content in the following sections (**4.4.1 to 4.4.9**) has been co-produced with JUCD leads for the functions and services covered.

4.4.1 Workforce

Our vision for the JUCD workforce is:
"Anyone working in health and care within Derby and Derbyshire feels part of one workforce which is focused on enabling our population to have the best start in life, to stay well and age well and die well. Our workforce will feel valued, supported and encouraged to be the best they can be and to achieve the goals that matter to them wherever they work in the system."

Key enablers to achieving the vision include:

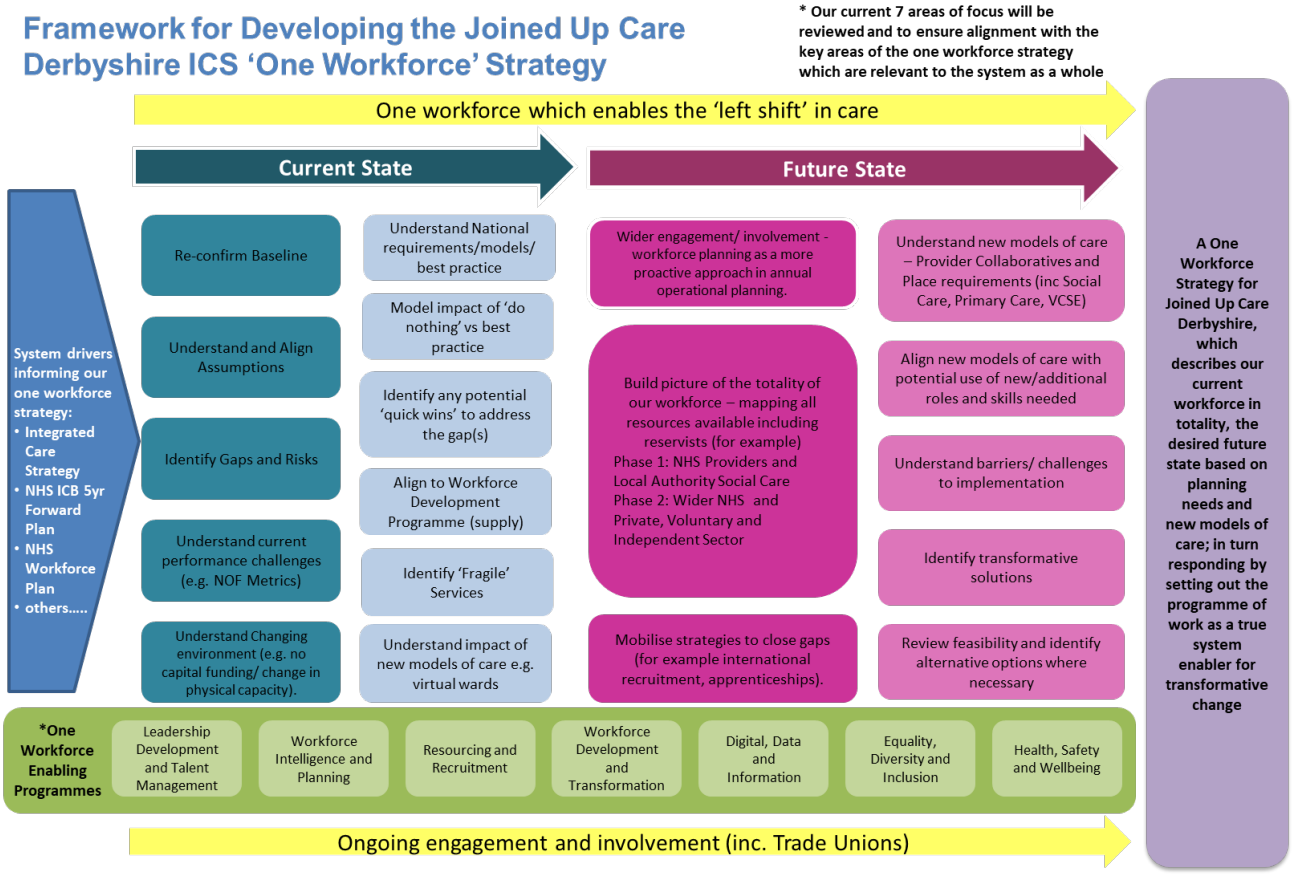
- A single point of access for new recruits, with a "no wrong door" approach to seeing people as a system asset, to be deployed wherever their skills fit best
- An integrated system rather than organisational approach to assessing workforce supply requirements
- Unified approach to leadership and talent development and OD
- An inclusive talent approach as the driver for recruitment and development
- Consistency of People Services offers, regardless of employing organisation - "One People Service across all places"
- Use of technology to enable ease of movement between organisations and reduce non value adding processes
- Clearer sense of common purpose and agreement on priorities for where we can work together, share resources
- Prioritisation of investment in training and development in prevention, personalisation and health inequalities

Some of the key challenges, and constraints to achieving the vision and our integrated care strategic aims include:

- Lack of dedicated workforce expertise to support integration
- Better understanding of the current workforce in the scope of this plan, what the requirement will be in light of the integrated care strategy and a joint approach between service leads and People Services to develop plans to bridge the gap using new approaches to skill mix, expanding/ introducing new roles and deploying staff closer to service users
- High percentage of social care staff who are in the PVI sector and therefore harder to influence in terms of workforce planning and development
- Fragmented and short-term nature of funding streams for workforce transformation and development
- Lack of trust in processes and governance between statutory sector partners and between statutory sector and VSCE

Current areas of focus therefore include delivering the conditions that will enable a JUCD 'one workforce', spanning health and local authority organisations; leadership development at a system level; the Joined Up Careers initiative; and the 'Quality Conversations' training programme which develops a strength based, personalised mindset for health and care staff.

The following infographic summarises our framework for developing the JUCD 'One Workforce' Strategy. We will need to align and embed this framework as part of the work programmes for the key areas of focus included in **Section 5**. Feedback on the Workforce vision, and the framework, through this Draft Strategy will help to further develop the approach.



4.4.2 Digital and data

The Digital and Data strategic aims and delivery priorities will support and enable the System to work towards the realisation of its strategic priorities and desired population outcomes through:

- **The ability to share citizen/patient information** to support care delivery across health and social care, including;
  - **Derbyshire Shared Care Record (DSCR).** The deployment of the DSCR will be expanded to include hospices, care homes, community pharmacies and other commissioned health and social care providers services. The DSCR provides clinicians and professionals with the most up to date patient/ citizens information to support the delivery of optimal care.

  - **Front Line Digitisation; Electronic Patient Record (ePR**). To enable collaborative working, deliver faster care, pathway redesign, reduced clinical risk and Population Health Management a new ePR will be deployed across our acute hospitals.
  - **Digitising in Social Care (DiSC)** – the implementation of digital social care record for care homes and domiciliary care providers, technology to support falls prevention and other technology evidence to enable citizens to be supported in the place they call home
- **A data architecture to enable population health management to be embedded** across the system to inform service planning and delivery. The ambition is to create a holistic view of citizens that incorporates wider determinants of health to improve physical and mental health outcomes.
- **Digitally enabled care delivery using tools and technology** to improve citizens knowledge and understanding to take greater control of their health and care
- **Digital and data innovation to support technology enabled care pathways** to augment care delivery, efficiency, and citizen/ patient/ staff experience
- **Digitisation of the wider health and social care economy** to improve care and opportunity for future interoperability and data sharing
- **Supporting and developing our citizens and workforce** in the use and adoption of digital services
- **Ensuring an inequity is not created** for those that are impacted. As we push our 'digital by default' vision we must ensure an inequity is not created for those that are impacted by the following barriers:
  - access issues
  - equipment, broadband connectivity, wifi, affordable data packages

This activity will be informed and prioritised through a systemic use of the nationally mandated and benchmarked 'Digital Maturity Assessment' and 'What Good Looks Like' tools.

4.4.3 VCSE sector

Nationally it is recognised that the VCSE sector is a vital cornerstone of a progressive health and care system and is critical in the delivery of integrated and personalised care and helping to reduce health inequalities. The National Development Programme – *Embedding the Voluntary Community and Social Enterprise (VCSE) Sector within Integrated Care Systems (ICS) 2022/2023,* which JUCD is part of, describes how;

"ICSs should ensure their governance and decision-making arrangements support close working with the sector as a strategic partner in shaping, improving and delivering services, as well as developing and delivering plans to tackle the wider determinants of health. VCSE partnership should be embedded as an essential part of how the system operates at all levels. This will include involving the sector in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans."

Locally, our ambition is for the VCSE sector to be considered as a key enabler for integrated care. It already makes a significant contribution to health and social care through complementary as well as mainstream provision, often supporting people who are under the radar of statutory services. This was particularly evident during the pandemic. VCSE organisations can also support, engage and articulate the needs of both communities of place, interest and condition.

The integrated care strategy provides an opportunity for a less transactional relationship with the VCSE sector where it can contribute at all points of the planning cycle; helping to define needs through soft intelligence, helping to design services so that they meet the needs of communities, as well as offering new and cost-effective approaches to service delivery.

Engaging this contribution will improve services for local people but there are challenges to making this happen that need to be addressed through the implementation of this Strategy and wider system actions. Some of these are listed below and a commitment to tackling these challenges is a key recommendation to the Integrated Care Partnership:

- Building understanding between sectors and changing culture and behaviours
- Supporting and developing the paid and volunteer workforce
- Involving such a large and diverse number of VCSE organisations in a defined ICS structure and communicating with them
- Finding investment, commissioning and support approaches that will make the most of what local VCSE organisations have to offer and develop longer term relationships
- Stimulating greater VCSE sector engagement and delivery in key system initiatives such as hospital discharge
- Enabling communities of place, condition and interest to shape services
- Building the capacity of VCSE organisations

How the VCSE sector will be embedded in the ICS and the processes and culture necessary to make this happen will be captured in a Memorandum of Understanding to be signed off and adopted by ICS partners.

4.4.4 Carers

The Derbyshire Carers Strategy has recently been refreshed (‘2022 Refresh’). The priorities within the Strategy are:

- Improving carer health and wellbeing
- Information and advice
- Carer employment and financial wellbeing
- Early identification and support
- Young carers
- Services and systems that work for carers
- Involving carers as experts
- Recognising and supporting carer in the wider community

System wide adoption of the priorities and pledges set out within the ‘Carers Strategy Refresh’ will ensure its greatest impact in effectively supporting unpaid family carers. Leads for the key areas of focus and relevant enablers (including workforce) for the Integrated Care Strategy will be expected to commit to the pledges within the Carers Strategy and to develop action/ delivery plans to help to realise the significant benefits to carers to improve their health and wellbeing and to support them effectively in their caring role.

4.4.5 Strengths based approaches

Strength based approaches already feature as a facilitative method for catalysing change and improvements in JUCD services. For example, Derby City Council has implemented a strengths based approach based around 8 principles, with the aim of achieving stability and reducing risk for children and young people, and to encourage the involvement of children and young people and their families in decision-making so that they are more in control of

the support they receive and thereby their everyday lives. And a strengths based approach is a key feature of the Team Up approach, and Derbyshire County Council's "Best Life Derbyshire" strategy for social care.

What is a strengths based approach?
Taking a strengths based approach simply means helping people find their own solutions and to create change through their own strengths and the assets available to them. It works at any level, individual, team or system.

Why is it required?
"The dysfunctions of the traditional management system keep many organizations in perpetual fire-fighting mode, with little time or energy for innovation. This frenzy and chaos also undermines the building of values based management cultures."

(Peter Senge – The Fifth Discipline)

Strengths based approaches build resilience, motivation and self-sufficiency. They have been proven to be significantly more effective than traditional deficit based approaches at creating lasting change and continuous quality improvement. This is especially so in complex adaptive systems such as health and care, or in getting the best out of a highly educated workforce.

At the current time when burnout is high amongst the workforce, approaches that build motivation and resilience are essential. Finding a way through this will require a relentless focus on our strengths, supporting people to find their own solutions and trusting them to make their own decisions.

How can it be applied?
There are many successful models and initiatives that use strengths based approaches. These include coaching, appreciative inquiry, human learning systems, quality conversations, local area coordination, Think Local, Act Personal, the 'What Matters to You' movement, personalisation, human learning systems and Team Up Derbyshire. However deficit based approaches still predominate in health and care.

Champions training for a selection of acute, LA, DCHCS, VCSE staff has been arranged from December 2022, with the aim of embedding strength- based approaches in practice, improving communication / understanding across the system and exploring system risk.

It is proposed that we create, implement, and embed strengths based approaches across Joined up Care Derbyshire working as an integral element of a system-level organisational development strategy.

4.4.6 Population health management

Population health management (PHM) uses data and information to understand what factors are driving the physical and mental health in the population and in communities. Better understanding through better use of data then helps to improve the health and wellbeing of people now and into the future. It seeks to reduce health inequalities and addresses the wider determinants of health through collaborative partnership working.

A Derbyshire-wide systematic approach to PHM is being developed and pilot activity to test the different approaches has been undertaken at a local level in four different parts of

Derbyshire. Learning from these pilots will inform next steps and the approach will be developed through the course of 2023, utilising system intelligence and insights, and the adoption of an analyse, plan, do, review approach to all interventions.

There are strong links between PHM and the Turning the Curve approaches. The next steps of the PHM work will focus on the Turning the Curve actions to improve the overall health of local populations.

Effective PHM requires data, data sharing agreements and digital enablers to facilitate effective outcomes. Significant development work is required across the system, including linking with digital, information governance and analyst colleagues.

4.4.7 Commissioning

Commissioning and funding allocations are key enablers for achieving our strategic aims and the objectives outlined by leaders for the key areas of focus included in this Strategy. This is likely to result in the System facing difficult decisions, given the current financial context and the expected need for increased resources to be targeted at prevention and early intervention activities.

There are currently extensive collaborative commissioning and joint funding arrangements, but we recognise the need to review and refresh these, seeking opportunities to 'consider whether the needs could be more effectively met with pooled budget arrangements under **S75** of the NHS Act 2006.

Colleagues leading the three key areas of focus will be asked to recommend changes in commissioning and funding arrangements that they have assessed are necessary to achieve the aims and objectives agreed for their areas. and more generally in this Strategy, including the need for an increased focus on prevention and early intervention.

It is indicated that there will be more flexibilities within national guidance for collaborative use of resources and we will review the opportunities that they will present to support delivery of the Strategy.

4.4.8 Quality drivers

Key areas of focus will include:

- Collaborative working between system partner patient experience and patient engagement teams to improve connectivity and alignment
- Bringing together system partners to align quality and equality impact assessments (QEIA) to develop care services that meet the needs of our population
- Bringing together health & social care partners to review and implement learning from LeDeR reviews
- Reducing health inequalities for people with learning difficulties by bringing together system partners to increase the use of annual health checks with their local GP service
- In collaboration with system partners, NHS England, and the Kings Fund, we are a pilot system in leading a project to look at experience of care across an ICS

4.4.9 Estate

NHS and local authority services in Derby and Derbyshire are provided in multiple settings and in multiple buildings. These services and buildings need to be fit for purpose in terms of

being safe and appropriate environments for everyone who uses them. This takes a great deal of forward planning to ensure we are providing the right kind of accommodation to meet the evolving requirements of health and care services. By having the right kind of environments we can help to tackle health inequalities, promote a sense of wellbeing from being in well-designed spaces, reduce the carbon footprint involved in constructing, running and maintaining buildings, and ensure we are meeting our targets on sustainability.

The estate is a key enabler in delivery of the long-term plan; helping the System to transform by optimising the use of the estate, which can adapt to changing service models, and promote co-location and multiple occupancy of buildings with patient, people, places and partnerships as key drivers.

The main priorities of the Estates Strategy are:

- Transform places and services - prioritise & maximise the use of the best quality estate, which is modern, agile and fit for purpose to support patient care
- A smaller better, greener public estate - Create an estate which is more efficient, effective and sustainable through optimisation
- Partnership approach - Work with our partners to strengthen collaboration and benefit from multi agency working

4.5 Primary care

Primary care is at the heart of communities (GPs, HVS, GPs, dentists, pharmacists, opticians, community nursing) and acts as a first point of contact for the people accessing the NHS/ gateway to the system.

Every day, more than a million people nationally benefit from the advice and support of primary care professionals, however; there are real signs of genuine and growing discontent with primary care – both from the public who use it and the professionals who work within it. Access to general practice is at an all-time low, despite record numbers of appointments and primary care teams are stretched beyond capacity, with staff morale at a record low. Primary care as we know it may become unsustainable in a relatively short period of time.

<u>A vision for integrating primary care</u>
The Fuller Stocktake (released May 2022) is a new vision for integrating primary care, improving the access, experience and outcomes for communities, which centres around three essential offers:

- Streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
- Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

The key areas of focus and implementation plans for the Integrated Care Strategy will need to encompass the vision summarised above.

4.6 Difficult questions

A desired output for the final Strategy is to have a consensus on the 'difficult questions' that face the System if our strategic aims and service objectives are to be delivered. Some of these potential questions have already been floated in discussions regarding development of the Strategy and have included the following:

- How ambitious can we be on 'pooled funding'? What is the realistic scope of pooling resources from across constituent organisations?
- What do we collectively think joint commissioning could or should achieve?
- How can our financial planning support a shift to prevention?

Work is also underway to review JUCD examples of good integrated care practice to understand the difficult issues or decisions that have been overcome and to draw out key themes that may be helpful for our key areas of focus to learn from.

It is anticipated that supporting leaders and their teams to overcome generic and high impact challenges will need to be an active role for the governance arrangements described in **Section 4.2**, on the basis that the resolution for at least some of these issues will need to be elevated above local decision-making arrangements.

5. Key Areas of Focus

5.1 Introduction

There are three key areas of focus spanning prevention, early intervention and service delivery. Please see **Sections 5.2 to 5.4** for summary information on each.

They are not framed as priorities, as they are not necessarily regarded as being more important than other topics. Instead they have been chosen by senior responsible owners from across the System as ideal areas to test our strategic aims and ambitions for integrated care, in response to population health and care needs. They are:

- **Start Well** - To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness

- **Stay Well** - To improve prevention and early intervention of the 3 main clinical causes of ill health and early death in the JUCD population - Circulatory disease, respiratory disease and cancer

- **Age/ Die Well** - To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations

After the Strategy is approved, the focus will immediately shift to delivery, and the work programmes that will be responsible for realising benefits. A set of common requirements

will be produced to guide the work, and this will support the Integrated Place Executive in managing delivery of the Strategy on behalf of the ICP Board. There is of course significant work already underway across the System within the scope of the three areas of focus and this will be built on as part of the process.

Additional programme resource will be required to drive, support and co-ordinate this work, alongside delivery of the development plans for the enabling functions and services.

5.2 Start Well area of focus

Aim

To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness.

Rationale for inclusion as a key area of focus
It is important that children and young people can 'Start Well'. This aim links directly to the JUCD ambition to ensure *People have a healthy pregnancy, children are born safe and well into a nurturing and secure relationship with care givers, with good nutrition, access to health care, social care and education. Children thrive develop positive and healthy relationships.* The overall approach will be preventative.

The Children and Young People's Delivery Board will undertake a pathway approach, incorporating prevention and early intervention that ensures connectivity across the system, and supports the Board's vision to *provide a seamless health, education and social care pathway for children and young people in Derby and Derbyshire - one that enables all children and young people to be healthy and resilient and, if support is needed, enables them to plan their care with people who work together, allowing them to achieve the outcomes that are important to them.*

The work will include a focus on the 20% most deprived population. The emerging 'plus' groups for this priority are teenage parents, homeless families, looked after children, children born at a low birthweight (due to factors during pregnancy), and children with special educational needs.

Derby, Derbyshire Child Health Profiles and benchmarking nationally indicates the need for this priority, and we are engaged with Healthwatch to ensure support for this priority from children, young people and their families. And a recent community consultation undertaken by Derby Health Inequalities Partnership exploring perceptions of health and inequalities, highlighted a key theme of respondents wanting to 'break the cycle 'of poor health in their communities with a focus on children and young people's health.

This priority is supported nationally via the requirements in the NHS Long term plan, 'Core 20 PLUS 5 for CYP' to reduce health inequalities and SEND (special educational needs and disabilities) statutory requirements. It is also aligned locally to the ICS strategy (overarching, in development), Health and Wellbeing Boards priorities (City and County), 'Turning the Curve' Priorities, Children and Family Learners Board priorities (Derby), Childrens Partnerships Priorities (County), Safeguarding Partnership, Healthwatch and local insight.

Key issues that will need to be addressed

- Improving staff retention and development is critical to success
- Service commissioning and provision is currently fragmented, and this priority will provide the momentum for better connectivity across the system and more effective and efficient working
- Existing governance is fragmented by organisation. Giving the CYP Delivery board greater authority and responsibility would ensure decision making is reflective of whole system impact and focus on the long-term vision of both JUCD and the Delivery Board
- Importance of setting behaviours in young children and setting foundations for good health
- A seamless pathway approach to support and care with empowerment given to children, young people and their families from an early age will ensure efficiency is achieved, and the effectiveness of service delivery will be improved
- A review of the current workforce position (including the VCSE sector), the need to map future staffing, describe the shift required, and ensure plans are developed to achieve the shift needed
- Digital and data, particularly the sharing of data across the system will be critical to success, with access to timely and sub-system level data to inform planning. Information governance processes are key to enable effective information sharing across agencies
- Maximising the beneficial impact of communication and engagement

Suggested measures for improvement

- School readiness: the % of children achieving a good level of development at the end of reception.

This is published nationally and annually in the Public Health Child Health Profile data that is measured at the end of Reception year. It includes several dimensions and is impacted by a range of sub-indicators: those related to the family (maternal mental health, homelessness, family income and parental education), the child (low birth weight, health status and immunisation rates) and services (quality and availability of funded early education) among many others.

5.3 Stay Well area of focus

Aim

To improve prevention and early intervention of the 3 main clinical causes of ill health and early death in the JUCD population - Circulatory disease, respiratory disease and cancer.

Rationale for inclusion as a key area of focus

To prioritise prevention and collectively contribute to ill-health avoidance and improve outcomes for the local population.

The Population Health Management Steering Group has expressed a clear intention to reduce inequalities in outcomes, experience, and access. For example, identifying groups experiencing inequity of access to preventative services, and using this insight to inform subsequent targeted action to redress this.

Reducing morbidity from the three clinical conditions selected through a prevention approach will reduce and manage the demand on resources required for treatment of later stage disease, thus improving the sustainability of the health and care system.

There will be a focus on modifiable behaviours for both mortality and morbidity, across the range of diseases/ conditions, which contribute the most to mortality/ morbidity respectively.

Mortality:

1. Tobacco
2. High systolic blood pressure
3. Dietary risks

Morbidity:

1. High BMI
2. Tobacco
3. High fasting plasma glucose

Preventing ill health is beneficial for population wellbeing and reduces demand for NHS services and was identified in The Marmot Review as a key objective to reducing health inequalities and its associated social and economic costs. Preventative interventions such as cardiac rehabilitation have been shown to reduce non-elective admissions and early cancer diagnosis leads to increased survival and reduces financial impact, both on healthcare resources but also on an individual's ability to work and support their family.

Local insights identify prevention as a priority, for example:

- *"People welcome the move to focusing on the wider determinants of health but feel that priorities still reflect improvements in services, rather than wealth, education, and prevention."*

Key issues that will need to be addressed

- Existing governance and delivery arrangements are currently organisation centred which can inhibit system collaboration and added value of working across organisations to a single, shared aim. In addition, partners (such as the VCSE sector) and those beyond the local organisational system are key to a prevention approach
- Shift of funding, resources, and people towards a preventative focus, where health outcomes are influenced earlier in both clinical and non-clinical pathways
- Coordinated and joined up communications support for health promotion activities
- Strong productive partnerships across JUCD and broader partners, including education, the police and the criminal justice system, transport services, and local employers
- Workforce - the need for effective processes that enable staff to move between organisations and productively function in an organisation other than their employer
- Digital and IT - Flexible IT infrastructure, with shared access to drives, documents, records and data sets
- Simplify referral routes into services and enable effective self-referral to all services which the patient is motivated to engage with
- Population Health Management is a key enabler to this prevention priority
- Exploring the potential to co-locate services, regardless of the providing organisation

- Engagement with carers is key to understand the barriers they experience, for both their own health and wellbeing, along with those they care for

Suggested measures for improvement

Long term outcomes:

- Contribute to reducing the life expectancy gap between the most and least deprived people in Derby and Derbyshire, given that the three clinical conditions selected contribute the most to the local life expectancy gap.

Short-medium term outcomes:

- Identify and subsequently reduce identified inequalities in access to associated services, experience and outcomes from each service, for each condition.

Progress will be monitored against a set of metrics by demographic profile (a draft set has been produced). It is anticipated this will be agreed by System partners, including identifying those directly aligned to a specific partner (e.g. smoking cessation rates), along with those that some/ all partners can contribute to (e.g. referrals to smoking cessation services).

5.4 Age/ Die Well area of focus

Aim

To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations.

Rationale for inclusion as a key area of focus

A key ambition is a 'left shift' of care so that focus is increased on maintaining functioning and independence. Prevention and proactive identification of patients, combined with risk stratification, and effective care planning provides the best approach to supporting those patients and carers who have the most complex needs; this enables them to take an active part in decisions concerning their health and wellbeing and subsequently reducing the demand for health and social care services. When more critical episodes of care occur it is necessary to have responsive integrated community provision available so that acute admissions happen when it is the best option, not because it is the only option.

A fundamental principle of the proposed programme of work (and the leadership and delivery through place based working) to respond to this priority is a strength based approach in terms of the individual, the teams that are supporting and the communities they are part of.

The main vehicle for improving outcomes in this priority area is building integrated local planning, service responses and support in the community (including statutory services, VCSE, independent care providers, individuals and communities). Whilst the value of more integrated, locally delivered care will benefit many (if not all) groups it is particularly evident for those living with frailty and at the end of life.

The selection of this priority builds on engagement with the population over a number of years which has identified themes in terms of what is important to them, to keep them well, and their expectations from services. Derbyshire people have identified being able to stay in their own home for as long as it is safe to do as the most important thing to help them keep their independence and stay healthy as they get older (Healthwatch Report – 2019).

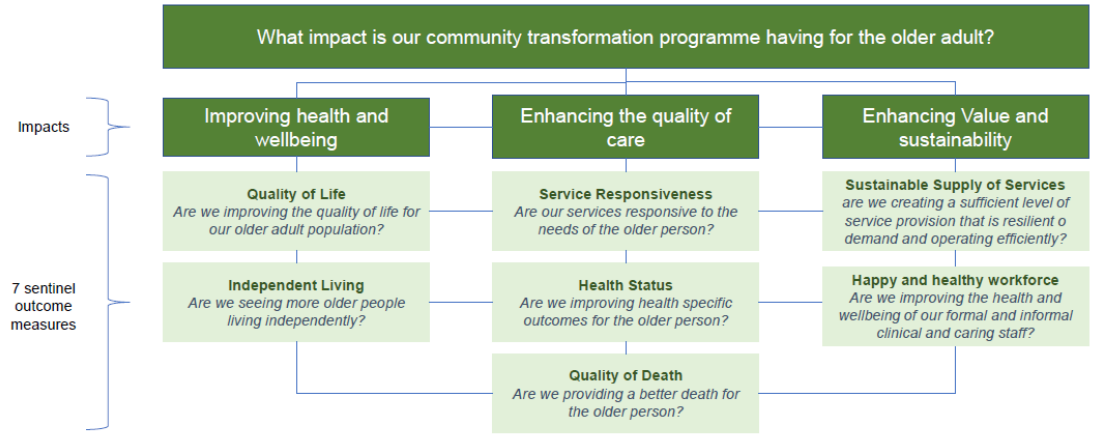
Key issues that will need to be addressed

- Support when navigating health and care – 'no wrong door' - Any point of access to the health and care system should be able to direct the user or carer to the right place
- Joined-up communication – tackle conflicting information, the need to repeat information and inconsistencies, helping staff understand the wider needs of the service user and carer, beyond the condition they are seeking help for
- Working together to reduce the potential tension regarding organisational sovereignty as demonstrated through individual policies, procedures, cultures etc. alongside the need for teams of people to work together with shared processes
- Trust – between groups of staff, and also service users' confidence in staff as advocates. Addressing the impact that existing cultures across organisations and teams have on the ability to make this shift will be an important factor to consider
- Governance mechanisms established through Place and a number of connected programmes of work needs greater ownership, visibility and system backing, if we are to affect the longer term necessary shift to improved population health and slow growth in demand. Our current governance structures don't always effectively support 'distributed responsibility' and working across teams
- The form and pace at which new financial models and mechanisms for collaborative commissioning can be developed and which may need differential allocation. Ensuring commissioning processes are aligned and reward the right things
- Further developments in workforce planning to better meet the needs of the population who are ageing or at the end of their lives
- The ability to access and update a single record to support the care of an individual, and to prevent individuals and their carers having to repeat information to many agencies and staff having to waste time updating multiple systems
- An embedded model for using Population Health Management data to plan and target provision
- The VCSE sector is vital in understanding and meeting the needs of this population
- Co-location of teams that are working together / serving the same cohort
- Ongoing and increasing commitment to ensuring subsidiarity and local determination of delivery

Suggested measures for improvement

It is proposed that 'measurement activities' for this priority are organised under 7 sentinel outcome measures – please see figure below.

There is also a National Integration Index planned to be rolled out in 2023 that will help us understand the level of integration and the impact / benefits experienced by citizens.



6. Engagement

6.1 JUCD approach to engagement

Gathering insight from our diverse population about their experiences of care, their views and suggestions for improvement of services, and their wider needs in order to ensure equality of access, and quality of life is a key component of an effective and high performing Integrated Care System (ICS). These insights, and the diverse thinking of people and communities will be essential to enabling JUCD to tackle health inequalities and the other challenges faced by our health and care system.

As a result, JUCD has developed a strategic approach to engagement, which includes key principles and frameworks that will underpin our ways of working. It sets out how we will listen consistently to, and collectively act on, the experience and aspirations of local people and communities within JUCD. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

Our Ambition is:

- To embed our work with people and communities at the heart of planning, priority setting and decision-making to drive system transformation work, ensuring the voices of patients, service users, communities and staff are sought out, listened to, and utilised resulting in better health and care outcomes for our population
- To recognise that relationship building is important to increase trust and improve involvement and needs to be considered on a planned, systematic, and continuous basis, with the required investment of time
- To ensure continuous engagement that reflects this new relationship with the public, capitalises on those emotional connections and brings people and communities into the discussion rather than talks to them about the decision

In order to ensure a systematic approach, our engagement with people and communities is supported by several frameworks. These frameworks are in different stages of development and co-production with system partners, including people and communities, and are outlined below:

Governance Framework -
This examines the structures that provide the interface between people and communities at all levels of the ICS, allowing insight to feed into the system, to influence decision making. This is also about making sure appropriate assurance frameworks are in place for ensuring we implement the principles outlined in our Engagement Strategy across the system. It includes our Patient and Public Partner Programme, our Guide to Patient and Public Involvement in the ICS, and the development of our Public Partnership Committee.

Engagement Framework – This includes the methods and tools available to all our system partners to support 'continuous conversations' with people and communities in transformational work to improve health and care services. This includes our Citizens' Panel, Online Engagement Platform, PPG network, Readers Panel, Public and Patient Insight Library and Derbyshire Dialogue. The model we use for our Patient and Public Insight Library, has been promoted by NHS England as good practice, and a template has been created to allow other systems to duplicate it.

Co-production Framework - This is our work to embed, support and champion co-production in the culture, behaviour, and relationships of the ICS, including senior leadership level. Drawing together good practice from around the system we plan to co-produce a co-production framework and are in the process of setting up a task group, which will include patient and public partners.

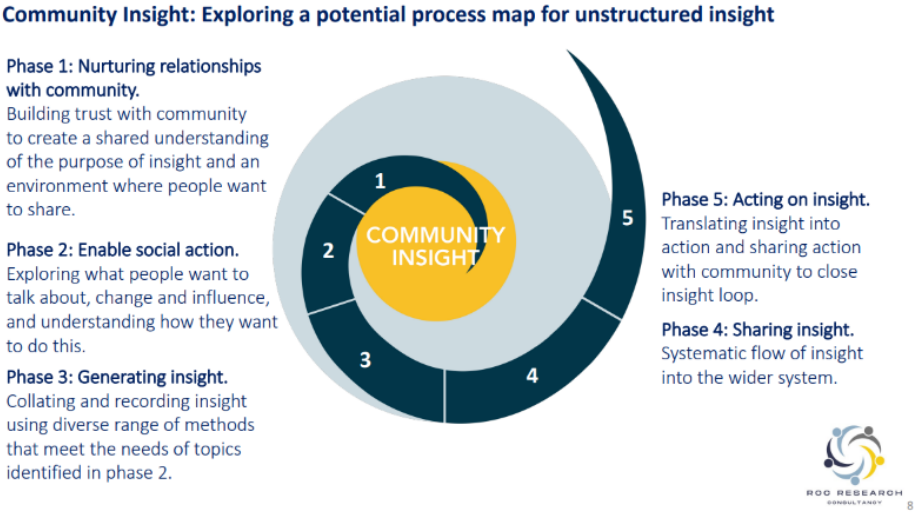
Evaluation Framework – This is being created to allow us to reflect on and examine our public involvement practice and the impact this has both on our work, but on our people and communities. The Evaluation Framework will outline how we will measure and appraise our range of methods, and how this will support ongoing continuous improvement.

Insight Framework - The Insight Framework is the most exciting development so far and looks at how we identify and make better use of insight that is already available in local communities to inform the work of the ICS.

Many communities already have established mechanisms of finding out what's important to people, with regards to their wants, needs and aspirations. We will be seeking to harness and examine that insight and present it in a way that will enable the ICS to listen to and take action, to truly put the voice of people and communities at the heart of decision making.

This approach is about authentic collaboration with communities without a pre-set agenda and will require that we are brave and believe that people know what they need to be well and happy. It will also require us to align our governance structures to support community led action.

A key part of the Insight Framework is our process map outline which outlines 5 phases, please **see figure below**. We plan to co-produce what good looks like in all 5 phases of our model, and then build on strengths-based approaches that are already out there in communities to support them to overcome the barriers that we know they currently encounter. This work will be centred around Place and support the ambition to be a social model that is outcome driven and strength based; focussing on the assets of individuals and communities and developed with them through local leadership.



6.2 Approach undertaken to support the development of the Integrated Care Strategy

An ‘Engagement Workstream for the ICS Strategy’ was created in July last year with representation from health, local authorities, Healthwatch and the VCSE Alliance. This workstream has overseen the development of an 'Insights Document' that has pulled together insight that has been gathered throughout the system over the past 12 months into one place and which highlights high-level themes under the following headings - Integration, Health Inequalities, Quality/Improvement, Strengths Based/ Personalised Care and Health Protection, and Understanding Public Behaviours, Choices, and Attitudes. This was made possible due to the existence of our Patient and Public Insight Library.

This Insight Document has been considered by SROs and teams as part of the evidence base for the selection of key areas of focus for this Strategy under the headings - Start Well, Stay Well and Age Well.

Subject to the agreement of this Draft Strategy the next steps are summarised as follows:

- Present and discuss the Draft Strategy and communicate the selection of the three key areas of focus with the wider public via the Derbyshire Dialogue Forum (15 February 2023), and with local organisations and forums through a series of presentations February – March.
- Co-produce I/ we statements to help communicate the ambitions of the Strategy and the key areas of focus.
- For the three key areas of focus – Hold an initial Derbyshire Dialogue on 15 February to outline the purpose and content of the strategy, and then initiate a process of continuous engagement including the following steps:

    - Hold online engagement events for each of the 3 areas allowing leads to present information in an accessible way and invite comments about what actions are needed to achieve the ambitions set out and capture these to inform plans.
    - Support these conversations through our Online Engagement Platform, with opportunities to continue to ask questions and make suggestions.
    - Create surveys for each area to gather feedback from a wider cohort of people targeted as required.
    - Facilitate and support conversations between programme leads and local community groups who express interest in the key areas of focus, helping to ensure we do not just rely solely on people having digital access, using existing groups and forums where possible, with support from the VCSE sector.
    - Ensure feedback/ insight from these conversations is listened to, considered, and actioned through the implementation plans for the three key areas of focus.

7. Evaluation

7.1 Introduction

Once the ICP has approved and published the Integrated Care Strategy a process for overseeing delivery progress will be required. This could include, if appropriate, identifying, and evaluating the impact that the Strategy has had on commissioning and delivery decisions from multiple perspectives, including providers, citizens, communities, and those engaged in the production of the strategy.

7.2 Measures

In **Section 3** population health and inequalities indicators are referenced. These measures will need to be considered as part of the evaluation process, alongside other measures specific to the key areas of focus, some of which are referenced in **Sections 4 and 5**.

It is noted that there is national work underway by the CQC and by the King's Fund to develop qualitative and quantitative integration measures, through an "Integration Index". JUCD is a pilot site for this work, and this should support evaluation efforts. We will draw on outputs from this work as they emerge and use these to engage local stakeholders.

7.3 Evaluation and impact

It is proposed that evaluation can be considered at two levels:

Evaluation of the Strategy: including a high level consideration of progress against the strategic aims, and an assessment of how successfully other intentions included in the Strategy have progressed, including ambitions for organisational development at a system level and a focus on behaviours and culture to ensure that the Strategy is built on sustainable cultural foundations.

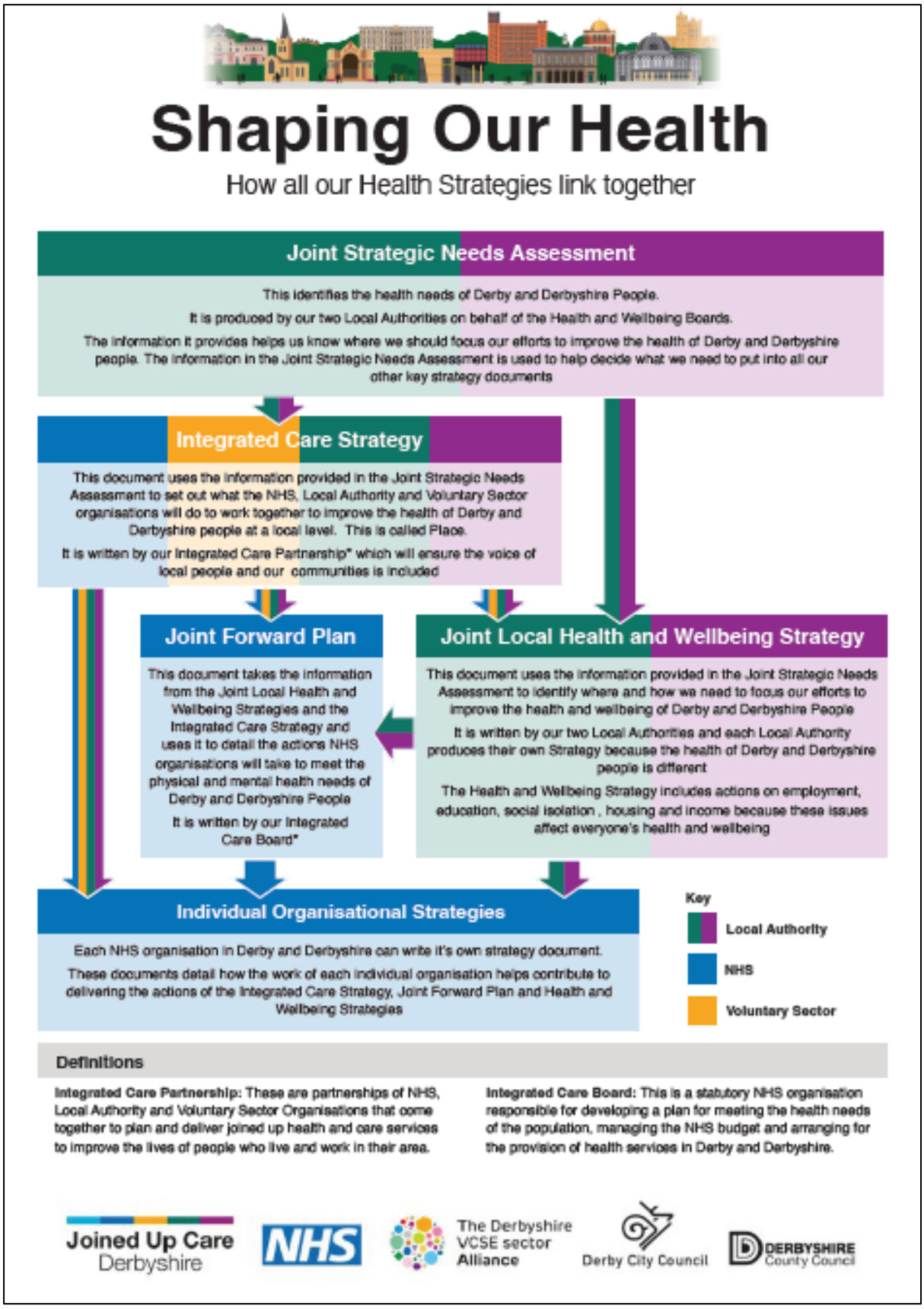
Evaluation of the key areas of focus and key enabling functions: SRO led work on evaluation methodology and measures, to track implementation against objectives.

7.4 Evaluation support

The ICP/ IPE will need to consider whether external input into evaluation would provide additional benefits to those gained via local evaluation routes for evaluation of the Strategy. Options are being explored through fact-finding contacts with The King's Fund, the Social Care Institute for Excellence, and the "Leading Integration Peer Support Programme" run jointly by the NHS Confederation, the Local Government Association and NHS Providers.

The SROs for the three key areas of focus will need to assess existing and potential options for external support. This should include the involvement of Healthwatch and align with the engagement approach and particularly the work on citizen Insights.

Appendix 1 – How our health strategies and the Joint Forward Plan link together



NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 098

Report Title	Operational Plan Submission							
Author	Cath Benfield, Deputy Director of Finance, DCHS Craig Cook, Director of Acute Commissioning, Performance and Contracting, ICB Sukhi Mahil, Assistant Director – Workforce Strategy, Planning and Transformation, JUCD Samuel Kabiswa, Assistant Director, Planning and Performance, ICB Craig West, Acting Associate Chief Finance Officer, ICB							
Sponsor (Executive Director)	Zara Jones, Executive Director or Strategy & Planning Amanda Rawlings, Chief People Officer Keith Griffiths, Executive Director of Finance							
Presenter	Zara Jones, Executive Director or Strategy & Planning Amanda Rawlings, Chief People Officer Keith Griffiths, Executive Director of Finance							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☒
Appendices	Appendix 1 – Operational Plan Submission							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Not Applicable.							

Recommendations
The ICB Board are recommended to **DISCUSS** and **NOTE** the Operational Plan Submission.
Purpose
The report provides the ICB Board with an overview of the ICB's Operational Plan submission.
Background
The NHS England 2023/24 priorities and operational planning guidance which was issued on the 27th January 2023, requires the ongoing need to recover core services and improve productivity, making progress in delivering the key NHS Long Term Plan ambitions and continuing to transform the NHS for the future.

Report Summary
In response to NHS England's 2032/24 priorities and operation planning guidance, the report provides an overview of the approach the ICB are taking in their operational plan submission for 2023/24. This approach is grouped into three main themes: • Prevention • Access • Productivity The guidance acknowledges that prevention and the effective management of long-term conditions are key to improving population health and curbing the ever-increasing demand for healthcare services. Following initial work, the key areas of focus will include: • Activity Output – an increase in delivering more work to acute, community and primary care; • Workforce – increasing workforce numbers; • Financial Gap – achieving a target of £144.4m • Performance – reducing waiting times and increasing access to community health services The presentation can be found at Appendix 1.
Identification of Key Risks
Not applicable to this report.

Has this report considered the financial impact on the ICB or wider Integrated Care System?		
Yes ☐	No☐	N/A☒
Details/Findings		**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision making process?
Not applicable to this report.
Project Dependencies
Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable to this report

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Not applicable to this report.					

NHS
Derby and Derbyshire
Integrated Care Board

Operational Plan Submission

2023/24 Operational Plan

Zara Jones – Executive Director of Strategy & Planning
Amanda Rawlings – Chief People Officer
Keith Griffiths Executive Director of Finance

The National Ask

NHS England's '2023/24 Priorities and Operational Planning Guidance' outlines these priority areas of focus for the NHS:

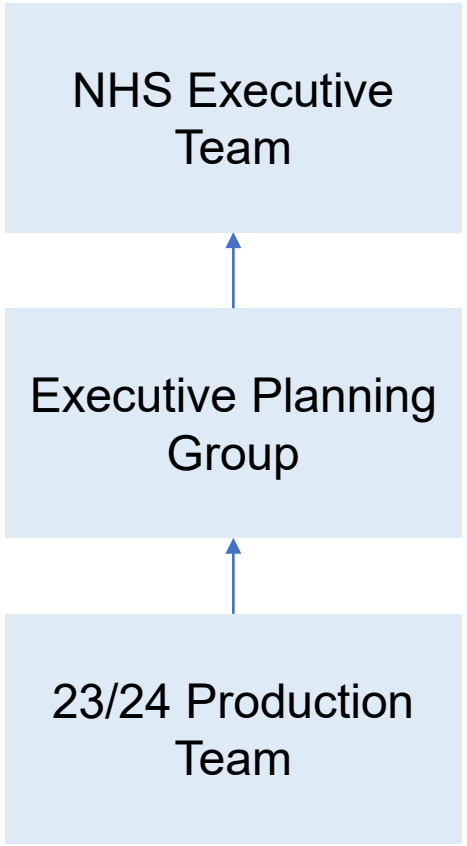
- Recover our core services and productivity
- As we recover, make progress in delivering the key ambitions in the Long-Term Plan (LTP)
- Continue transforming the NHS for the future
- Urgent and emergency care recovery plan
- GP access recovery plan including plan to increase GP direct access
- Maternity and neonatal services

Who's involved in the process for creating our plan?

Derby and Derbyshire Integrated Care Board

The Operational Plan for 2023/24 is being drawn together by leads from across all ICB parties – including:

- Programme Delivery Leads (Mental Health, Planned Care & Cancer, Urgent and Emergency Care
- Community and Primary Care Senior Management
- Provider Planning Leads
- Functional: Finance, Workforce, Improvement



Executive decision making on ICB operational planning priorities and associated objectives.

Leads the production of the ICB's Operational Plan.

Time limited group stood up to co-ordinates works necessary to deliver the operational plan

Approach

Derby and Derbyshire Integrated Care Board

Our guiding principles, local priorities and goals for improvement are grouped under three main themes which are broadly aligned with the emerging pillars in the ICS currently being developed and will form the basis of our Joint Forward Plan.

These are:

- **Prevention:** with areas identified to bring about a better primary, secondary and tertiary offering to help alleviate the failure demand which is currently dominant across many non-elective care pathways.
- **Access:** with goals identified to improve specific general elective, cancer, mental health, general and dental practice, and address health inequalities and differences in health outcomes.
- **Productivity:** to encapsulate the enabling functions of workforce, finance, capital/estates, digital, integration, ways of working etc.

The guidance acknowledges that prevention and the effective management of long-term conditions are key to improving population health and curbing the ever-increasing demand for healthcare services.

Key messages arising from our initial work…

NHS Derby and Derbyshire Integrated Care Board

- **Activity output:** We are planning to deliver more work in 2023/24 relative to what we delivered in 2022/23 across the Acute, Community and Primary Care Sectors.
- **Workforce:** Initial work proposes a 5% increase in total substantive positions across the main NHS Providers and 8% increase in the General Practice workforce.
- **Financial gap to achieve target of breakeven:** £144.4m.
- **Performance:** We are currently working through the detail of how we deliver the following objectives in 2022/23:
  - Having nobody waiting over 65 weeks for their elective treatment by March 2024.
  - Reducing the number of people waiting longer than 62 days for their first definitive treatment for cancer.
  - Ensuring that at least 76% of A&E attenders are admitted and/or discharged within 4 hrs – which requires lower bed occupancy in 23/24 to facilitate better flow through the hospital to support.
  - Increasing access for a range of community health services.

Issues that we are currently working through as we firm up our plan for next year

Derby and Derbyshire Integrated Care Board

- Confirm and challenge piece to test operating assumptions and correct any inconsistencies
- Developing credible implementation plans to support the improvements we are planning to make
- Establishing an operational plan that uses our existing capacity more productively to deliver the activity output required to improve performance
- Enhancing discharge capacity to support better acute flow – both in the NHS and across both Local Authorities

Current position on Finance following Draft Submission

Derby and Derbyshire Integrated Care Board

- As at 10.03.23, the system financial gap has moved from £149.5m to £144.4m. There is more work to be done across the system to improve this position further in time for final submission
  - Conversations are challenging but ongoing across the system finance community
- The initial capital plan for 23/24 is over committed by 55%. To reduce this down to the allocated level of funding will incur significant risks across all organisations. There are 3 groups working through the level of capital delays/deferrals and risks to obtain a compliant plan
- Finance follows the activity and workforce modelling. It still appears that JUCD has a significant challenge increasing productivity levels
  - This needs to be understood from a technical perspective for accuracy
  - If this is correct, the productivity improvement needs to go further

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 099

Report Title	Report into Maternity Services at University Hospitals of Derby and Burton Foundation Trust (UHDBFT)							
Author	Chris Weiner, Executive Medical Director							
Sponsor (Executive Director)	Chris Weiner, Executive Medical Director							
Presenter	Chris Weiner, Executive Medical Director							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☒
Appendices	Appendix 1 – UHDBFT Independent thematic report by the Healthcare Safety Investigation Branch							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	ICB Quality and Performance Committee, 23RD February 2023							

Recommendations

The ICB Board are recommended to **DISCUSS** and:

- **NOTE** the Healthcare Safety Investigation Branch (HSIB) report;
- **NOTE** the delegation from the ICB Quality and Performance Committee to the Local Maternity and Neonatal Services (LMNS) Board of the responsibility for receiving and gaining assurance on University Hospital of Derby and Burton Foundation Trust's (UHDBFT) response to the HSIB report; and
- **THANK** the affected families for their generosity in agreeing to this review. Their generosity will help the Derby City & Derbyshire NHS improve quality of care for future pregnant women.

Purpose

The purpose of this report is for service quality improvement.

Background

During 2022, UHDBFT identified a cluster of seven serious incidents in maternity services. These occurred between January 2021 and May 2022. Each case had been investigated individually by the Trust internally or through a HSIB investigation. During the investigations, UHDBFT had identified that the perceived cluster might be related to a very rare cause of maternal collapse called 'amniotic fluid embolism'. The Trust contacted the ICB to request external expertise to review the cases, provide assurance that no quality concerns were being missed, and ensure that opportunities to prevent future serious incidents had been fully identified. Having sought the advice of NHSE Midlands, the HSIB was secured to undertake the review.

Report Summary

The review found that at the point the seven women experienced their collapse or cardiac arrest, there were no identified common themes that directly impacted on all outcomes. Safety recommendations have been made where the findings identified during the exploration of the themes were considered to be contributory to one or more events. The review found that it is not possible to know if a different approach to safety investigation and implementation of learning, or a different safety culture within the maternity unit could have influenced a different pathway of care prior to the critical events.

HSIB identified 5 safety recommendations (page 5 of the report) and 10 safety prompts (pages 5-7). The safety recommendations identified are for the Trust to:

1. ensure there is a clear process for declaring a massive obstetric haemorrhage, and that following an emergency call a cascade notification alerts the pre-defined group of staff, as defined in RCOG guidance, to support the safe and timely provision of care;
2. follow national guidance in the use of a universal 2222 call for all emergency calls;
3. ensure that communication and support, with women and/or families who have experienced a significant event around the time of birth, continues in the postnatal period to ensure women receive the required holistic care;
4. ensure that communication and support, with women and/or families who have experienced a significant event around the time of birth, continues in the postnatal period to inform immediate and ongoing learning;
5. ensure that following a patient safety event, a robust rapid review takes place, involving the woman and family involved wherever possible, to identify opportunities for learning in a timely way.

The report is going through internal governance meetings within UHDBFT. It is expected to be discussed at their public Board meeting March 14th 2023.

The report has been discussed at the ICB Quality & Performance Committee (23/02/2023). This committee:

- received and discussed the report;
- delegated responsibility to the LMNS Board to receive the response from UHDBFT to the HSIB report; and
- delegated responsibility for ensuring assurance on the timely and effective delivery of the UHDBFT response plan to the LMNS.

Identification of Key Risks

This report describes the methodology of the review and provides findings, safety recommendations and prompts that provide opportunities to the Trust for learning. The use of prompts are questions for the Trust to consider how risks may be mitigated in areas that require further local exploration.

Has this report considered the financial impact on the ICB or wider Integrated Care System?

Yes ☐	No☐	N/A☒
Details/Findings		**Has this been signed off by a finance team member?** Not applicable to this report.

Have any conflicts of interest been identified throughout the decision-making process?					
Not applicable to this report.					
Project Dependencies					
Completion of Impact Assessments					
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**	
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**	
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**	

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☒	No☐	N/A☐	**Summary:** Patient involvement in the creation of the HSIB report.

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
None identified.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable to this report.					

HSIB

HEALTHCARE SAFETY INVESTIGATION BRANCH

WWW.HSIB.ORG.UK

UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST

Independent thematic report by the
Healthcare Safety Investigation Branch (HSIB)

Final report February 2023

Contents

Section 1. Executive summary

This Healthcare Safety Investigation Branch (HSIB) review was commissioned by the NHS Derby and Derbyshire Integrated Care Board (the ICB) and agreed with the University Hospitals of Derby and Burton NHS Foundation Trust (the Trust). HSIB was asked to undertake a thematic review of a specific number of maternal death and maternal collapse events that occurred between January 2021 to May 2022.

In accordance with the terms of reference (ToR) following the tabletop review, HSIB shared with the ICB and the Trust an immediate concern in relation to the quality of the rapid reviews (72-hour reports) the Trust had undertaken following a patient safety event. The review did not identify from the evidence provided or as part of the observational visit any information outside the scope of the review that required escalation to other relevant authorities.

The review found that at the point the seven women experienced their collapse or cardiac arrest, there were no identified common themes that directly impacted on all outcomes. Safety recommendations have been made where the findings identified during the exploration of the themes were considered to be contributory to one or more events. The review found that it is not possible to know if a different approach to safety investigation and implementation of learning, or a different safety culture within the maternity unit could have influenced a different pathway of care prior to the critical events.

This report describes the methodology of the review and provides findings, safety recommendations and prompts that provide opportunities to the Trust for learning. The use of prompts are questions for the Trust to consider how risks may be mitigated in areas that require further local exploration.

Themes that were identified in two or more of the events were explored further during interviews and observational work at the Trust. Not all the themes identified impacted on the outcome for the women involved.

HSIB has ensured the reflections and feedback from the women and families involved are at the centre of the review. Their concerns and feedback are presented in this report.

Findings

1. The Trust merged in 2018; inconsistencies remain in the guidelines between the two maternity units at the Trust.
2. The review found there had been a prolonged period of fragmented leadership since the Trust's merger, with many changes in the leadership structure, particularly in the midwifery leadership team.
3. The Trust has significant midwifery staffing gaps, this impacted on communication and on the experience of the women. The staffing gaps did not directly impact on the events included in this review.
4. The review found that staffing within maternity service at the Trust was and remains challenging; the review learned the reasons for this were multiple and included short and long-term sickness, the retention of staff, and difficulties in recruiting new staff members.
5. The review learned that there are vacancies at consultant level within the anaesthetic department and this, coupled with the increased demands on the department for staff to add additional operating lists to support the COVID-19 elective recovery plan, the ability to staff for additional theatre lists is challenging.
6. The review heard two new substantive obstetric consultant posts had recently been funded and were much needed and welcomed additions to the team.
7. The review learned that the presence of two experienced specialty doctors working together during an elective caesarean birth list, was a recent change to support both the delivery of safe care and the efficiency of the list to reduce potential delays. This approach also facilitates the anaesthetic team to be able to take breaks during the session.
8. The review heard that staff were passionate about providing a high-quality service for women and most of them pulled together to support one another. Staff are keen to develop and improve the maternity service at the Trust.
9. The review learned that there is a clear structure in the pharmacy department at the Trust, with an experienced medication safety officer that reports directly to the chief pharmacist leading on medication safety and policy. The clinical pharmacists appear to be well integrated into clinical specialities including obstetrics and the operating theatres.

10. There was some learning identified around the preparation of medication before elective procedures and around the documentation of the administration of medications. In the seven events reviewed, it was noted that the documentation did not support all aspects of the administration of medicines.
11. The review encountered difficulties in navigating local guidance and this may impact on the staff's ability to provide care or medication in line with local and national best practice.
12. The review found there were significant opportunities for the Trust to optimise process elements of the management of a massive obstetric haemorrhage (MOH). Workarounds were often employed as the current processes were either not clear to all staff or did not support the rapid activation of an alert to summon all the required staff to an emergency.
13. The review found areas of documentation were not completed in full or were missing altogether. A theme identified was no designated scribe for the emergency, this meant key areas of care were not clearly identifiable; this can affect the recollection of those present and the ability to identify learning after an event.
14. The review found both the emergency and elective theatre environments to be calm, spacious, and modern environments. The review heard that anaesthetic cover and staff wellbeing was being addressed and this was improving.
15. The review identified that at the time of the observational visit there were ongoing discrepancies between the clocks in the elective operating theatre – this was a finding in one of the HSIB maternal death investigations and had previously been shared with the Trust.
16. The review found examples of communication which led to non-engagement with and an unwillingness to involve the women and their families in decisions about their care. There was limited evidence of follow up care for the women or their families once they were discharged from the hospital.
17. The review learned that staff faced barriers to effective communication primarily due to a perception of hierarchy amongst the disciplines involved in maternity care. This meant care planning and communication was not always effective within the multi-professional team.
18. The review heard examples of positive communication; some stated that communication during their pregnancy care had been satisfactory with many of

the women and/or families stating their community midwifery care was “excellent”. Most of the women and/or families also commended the communication within the theatre, intensive care unit (ICU) and the high dependency unit (HDU) stating that staff were particularly “kind, calming and compassionate”.

19. The review learned that once the women and/or families had been discharged from the hospital the communication was “unbelievably poor”.
20. The review found that communication with women and/or families after the event did not support them to understand what they had experienced and found that they felt “abandoned” by the Trust in the postnatal period.
21. The review found there was primarily a kind and compassionate culture amongst front-line staff; the review heard many examples of colleagues covering extra shifts and staying longer to support each other.
22. The review learned that staff felt the kind and compassionate culture was not universally reflected in all of the senior team, particularly from some of the obstetric team. The review heard evidence of intimidation, bullying, incivility, poor behaviours, and poor role modelling. This topic was a significant theme for almost all who were interviewed or who contacted the review directly and it is on that basis that this has been included in this report.
23. The review found no evidence that absence of training or out of date training impacted on the care provided to the women in the seven events reviewed. The review did not identify concerns about the competency of anaesthetic, obstetric or midwifery staff involved in the events.
24. The review learned that until the summer of 2022 the maternity safety review process was a “closed process, inconsistent and held erratically”, “they [the obstetric team] certainly weren’t open to other specialities, assumptions were made on their behalf” and only since then have the people who provided the care been invited to attend reviews.
25. The review learned that, in recent months, there has been a new approach to governance, and this has been welcomed by all specialities. There is a conscious effort to move away from blame and concentrate on a systems approach to safety investigations at the Trust.
26. The review considers that robust action planning and prompt addressing of the learning from previous HSIB recommendations, may have had an impact on the

outcome for the women who received care during the seven events included in this thematic review.

HSIB safety recommendations

1. The Trust to ensure there is a clear process for declaring a massive obstetric haemorrhage, and that following an emergency call a cascade notification alerts the pre-defined group of staff, as defined in RCOG guidance, to support the safe and timely provision of care.
2. The Trust to follow national guidance in the use of a universal 2222 call for all emergency calls.
3. The Trust to ensure that communication and support, with women and/or families who have experienced a significant event around the time of birth, continues in the postnatal period to ensure women receive the required holistic care.
4. The Trust to ensure that communication and support, with women and/or families who have experienced a significant event around the time of birth, continues in the postnatal period to inform immediate and ongoing learning.
5. The Trust to ensure that following a patient safety event, a robust rapid review takes place, involving the woman and family involved wherever possible, to identify opportunities for learning in a timely way.

HSIB safety prompts

1. Staff need to feel their leadership teams are kind, compassionate and lead by example. Staff benefit from feeling the wider multi-professional team is pulling in the same direction.
    - What leadership training, coaching and support is the Trust providing for their leadership teams?
    - Is there an opportunity to improve/increase the multi-professional learning to allow teams to develop their relationships?
    - Are multi-professional teams encouraged to plan service provision together, rather than working in silos?
2. The review learned there is now a blood fridge in the gynaecology theatre complex.
    - Is there a barrier to having one located on labour ward?

- What work is being undertaken to support learning in view of previous HSIB MOH safety recommendations?

3. The review learned it was difficult to navigate local guidelines and that there were different maternity guidelines between sites.
    - How do the staff navigate the guidelines?
    - Are they easy to find?
    - What are the barriers to formulating Trust wide guidance?
4. The review learned pre-preparation of medication was common within the elective theatre environment.
    - Has consideration been given to providing the theatre team with pharmacy pre-prepared syringes?
5. The review learned that during six of the seven events, it was not clear who was maintaining a helicopter view of the emergency.
    - What is taught on obstetric emergency study days?
    - What are the barriers to accurate, contemporaneous scribing?
    - Is there a process in place to call for additional consultant level support during an emergency?
6. The review learned there was inconsistency in completing MOH proformas.
    - How do the staff find the proforma?
    - Is it easy to find?
    - What are the barriers to accessing or completing the proforma?
7. The time on the theatre clocks and equipment in theatre differ.
    - Are there any barriers to ensuring the times are synchronised?
    - Is there a checklist at the start of each procedure to acknowledge any discrepancies within the clocks within an operating theatre?
8. There is a “nervousness” amongst staff at the implementation of a Saturday elective caesarean birth list within the gynaecology theatres within the Trust.
    - Is the Trust aware of the feelings amongst staff?
    - What plans are being undertaken to mitigate the risks of being remote from the labour ward on a weekend?
    - Is there an opportunity for some elective caesarean births for women booked at the Derby site to occur at the Burton site during the working week?

- Is there an opportunity for elective caesarean births that are required to be done at the weekend to use one of the labour theatres?

9. Staff felt a kind and compassionate culture was not universally reflected in all of the senior team, particularly from some of the obstetric team.
    - Is the Trust's executive board aware of the culture and behaviours within the unit?
    - Are there any plans to hold insight or civility training within the Trust?
    - How are staff empowered to raise concerns in psychologically safe environment?
10. Staff shared they had little confidence in the maternity governance process at the Trust.
    - How is the Trust executive board assured they have a full understanding of patient safety events within the maternity service?
    - How do the executive and non-executive board level maternity safety champions make themselves available to hear from all members of the maternity multi-professional team?

A note of acknowledgement

The review would like to acknowledge the women and their families who generously shared their time, thoughts, and reflections to support the findings within the report. These events have had an overwhelming and enduring impact on their lives and those of their families.

The women and their families, although spoken to individually shared a collective aim of wanting to identify learning to ensure that what happened to them will not happen to other women and their families in the future.

The review recognises the impact of these events on the staff directly involved and those who work within the environment in which the events occurred. They have candidly shared their experiences of working within the Trust, their reflections, and their wish to learn and implement change. The review acknowledges the considerable staffing and capacity pressures the wider healthcare system has been and continues to experience.

HSIB wishes to thank all the women, families and staff involved in the review.

Section 2. Background

At the end of October 2022, the Healthcare Safety Investigation Branch (HSIB) was approached by the Derby and Derbyshire Integrated Care Board (the ICB) in agreement with the University Hospitals of Derby and Burton NHS Foundation Trust (the Trust). This was to undertake an independent thematic review following a maternal death and a short time later a cluster of maternal collapses during an 8-week period. In addition, HSIB proposed including the two maternal deaths which had occurred in 2021 to establish if any systemic related themes were present across all seven events. All the maternal deaths had been reported to HSIB in line with the organisation's referral criteria; two of the investigations have been completed, with final reports shared with the Trust and the families; the maternal death investigation from 2022 remains in the final stages of quality assurance.

HSIB received agreement from the Department of Health and Social Care (DHSC) to undertake the review of the three maternal deaths and the four maternal collapses.

NHS England (NHSE) was aware of the review and was supportive of it being undertaken.

During the period January 2021 to May 2022, three maternal deaths and four maternal collapses occurred within the Trust.

Maternal death

Maternal death: death of a mother while pregnant or within 42 days of the end of the pregnancy*, from any cause related to or aggravated by the pregnancy or its management, and not from accidental or incidental causes.

- Direct: deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above. This excludes cases of suicide.
- Indirect: deaths from previous existing disease or disease that developed during pregnancy, and which was not the result of direct obstetric causes, and which was aggravated by the physiological effects of pregnancy in the perinatal period (during or within 42 days of the end of pregnancy).

*Includes giving birth, ectopic pregnancy, miscarriage or termination of pregnancy.

Maternal collapse

Maternal collapse is a rare, life-threatening event, with a wide-ranging aetiology. The outcome primarily for the mother, and the fetus, depends on prompt and effective resuscitation. Maternal collapse is defined as an acute event involving the cardiorespiratory systems and/or central nervous systems, resulting in a reduced or absent conscious level (and potentially cardiac arrest and death), at any stage in pregnancy and up to 6 weeks after birth. If maternal collapse which is not as the result of cardiac arrest is not treated effectively, maternal cardiac arrest can then occur (RCOG, 2019).

The table below gives an overview of each of the events explored in this thematic review. To maintain confidentiality of the women and families involved, limited information is provided, and each event is referred to numerically.

	Location of event	Elective or emergency caesarean birth	Outcome
Woman 1	Home - > emergency department at Royal Derby Hospital (RDH)	Emergency	Maternal death
Woman 2	Home - > Labour ward theatre, RDH	Emergency	Maternal death
Woman 3	Gynaecology theatre	Elective	Maternal death
Woman 4	Labour ward theatre	Emergency	Maternal collapse
Woman 5	Gynaecology theatre	Elective	Maternal collapse
Woman 6	Labour ward theatre	Emergency	Maternal collapse
Woman 7	Gynaecology theatre	Elective	Maternal collapse

The ICB had commissioned an external review of one maternal death and four events of maternal collapse in June 2022.The initial review undertaken did not provide sufficient assurance to the ICB or the Trust.

After the initial meeting, HSIB held regular planning meetings with the ICB and the Trust and agreed a process and approach that supported the women and/or families, the Trust and staff within the maternity and anaesthetic services.

Terms of reference (ToR) were developed and agreed between HSIB and the ICB who commissioned the review to be undertaken. Once agreed they were shared with the Trust and the women and/or families involved.

The HSIB review team consisted of clinical (medical and non-medical) and non-clinical investigators, all highly experienced, senior professionals with considerable knowledge of performing investigations and healthcare reviews with a safety science lens. The team included expertise from obstetrics, obstetric anaesthetics, intensive care medicine, midwifery, pharmacy and a medical examiner. Many of the team remain in, or have recent experience of, clinical practice within the NHS. If clinical advice was required outside of the review team's expertise this would be sought as required.

The HSIB's Head of Family Engagement worked closely with the communication teams at the ICB and the Trust to advise on the communication approach and support for women and/or families.

The Trust was asked to provide dedicated resource to support contact with the women and/or families and has been prompt and responsive to all requests from HSIB for information.

HSIB initially undertook a two-day tabletop review of all the events to identify the key themes and areas where further enquiry was required. For the areas of interest that were seen in two or more of the events under investigation, the review made plans to explore the area further by observation or through conversations with staff, women and/or families.

Following this tabletop review, HSIB shared with the ICB and the Trust an immediate concern in relation to the quality of the rapid reviews (72-hour reports) the Trust had undertaken following a patient safety event. The Trust recognised the concerns raised and was able to demonstrate changes already in progress within the maternity governance team.

HSIB worked with the Trust to undertake two days of observational work, primarily within the elective theatre environment, and held multiple conversations with staff. At the end of the two days the team fed back to key senior staff the initial high-level findings. This was followed by a subsequent meeting with the ICB and the Trust's executive team to share further detail of the initial findings. HSIB did not identify any additional areas that required immediate escalation following the observational visit and conversations with staff.

2.1 Purpose of the review

The purpose of the thematic review was primarily to consider if there were any additional opportunities for learning or identification of patterns or issues which had not previously been identified. Key themes or similarities within the events were reviewed in detail to ascertain if there had been any harmful impact on care delivery.

Both qualitative (information received from conversations, interviews, incident reports, walkarounds and photographs), and quantitative data (dashboards, audits, etc) were used by the review.

2.2 Limitations of the review

The review was specifically tasked with reviewing the above seven events. The review initially performed a tabletop exercise to review the clinical records that were made available to the team. A full in-depth analysis of the entire care pathway for each woman was not possible due to the timeframe constraints of the review.

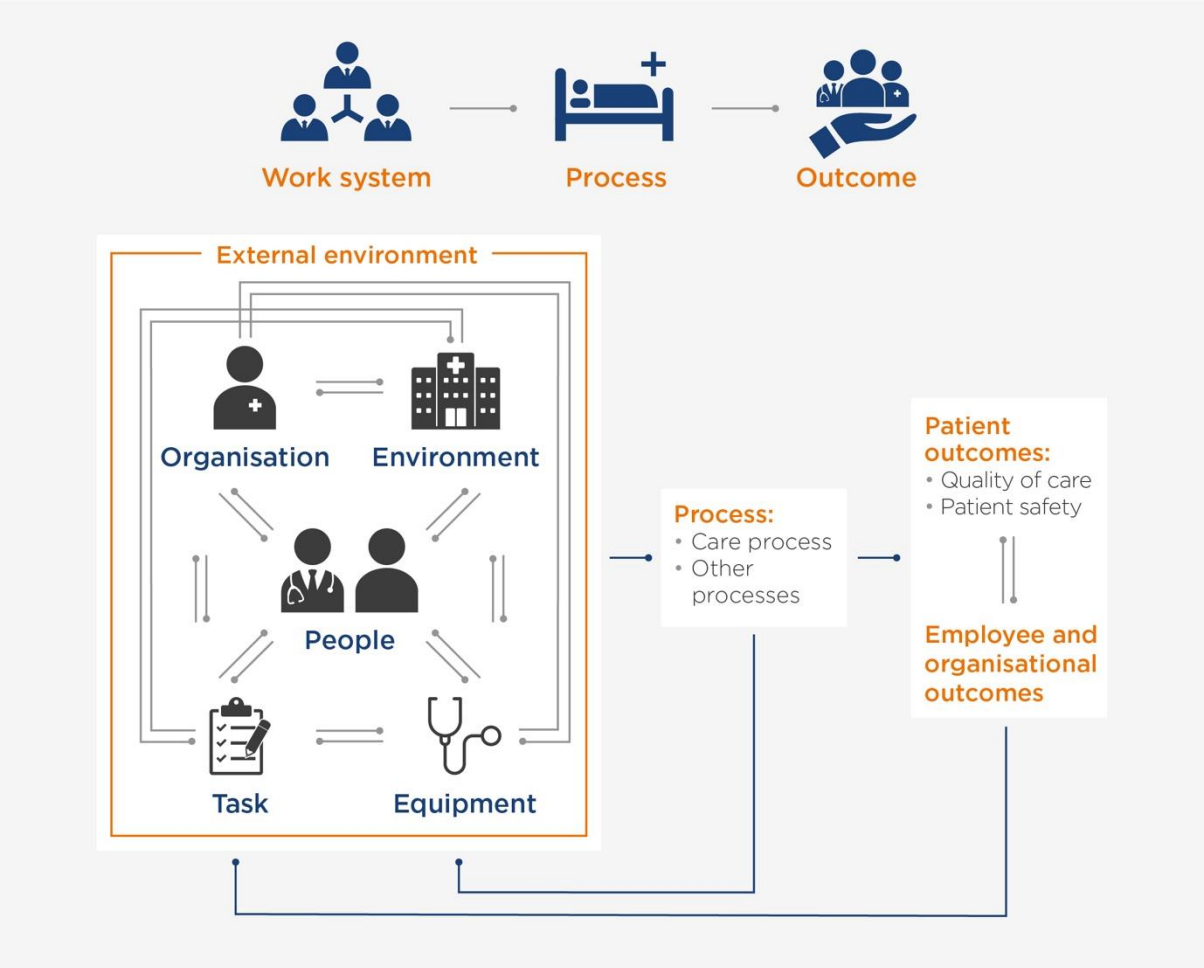
During the planned site visit the team requested and was given access to specific clinical areas. The team was escorted at all times which enabled introductions to be made and staff to be aware of the purpose of the visit. The limitations of this approach potentially reduced the ability of the review team to speak with staff freely and independently. The review team considered the site visit felt choreographed. For example, staff in the gynaecology theatre stated they had been given two middle grade anaesthetists for the elective caesarean birth list and "that never happened".

2.3 Investigation process and methodology

In order to consider findings and formulate any recommendations for the immediate and sustainable improvement of care and service provision, the review used the Systems Engineering Initiative for Patient Safety (SEIPS) (Carayon et al, 2014) to

support the analysis of collected evidence. This allowed the review to form a clear understanding of the work systems involved and how they contributed to processes and outcomes.

Figure 1: A representation of the SEIPS framework



In addition, the review team:

- Spoke with the women and/or their families to help gather their experiences and reflections on their care.
- Established the factual circumstances regarding the events from reviewing the available, relevant documentation.
- Engaged with staff working in the maternity setting, including the theatre environment.
- Undertook observational work within the elective caesarean birth environment.
- Interviewed those with:

    - detailed understanding of relevant maternity processes and procedures, particularly around massive obstetric haemorrhage (MOH)
    - experience of implementing maternity processes and procedures in practice
    - leadership responsibilities.
- Reviewed local and national guidance.
- Spoke with the local maternity voice partnership team.

The analysis of the above supported the identification of the most significant safety factors and safety issues that contributed to the events being investigated. The review will highlight key findings and give prompts to the Trust. Where required, safety recommendations will be made.

2.4 Engaging with women and/or families

Following initial conversations with the Trust, a request was made that all women or families from the seven events being considered were contacted by the patient experience team. The purpose of this contact was to introduce that a review was going to take place and to ask for permission for HSIB staff to contact them to discuss this further. These contacts took place between Friday 18 November and Monday 21 November 2022. Initial contact by the HSIB review team could not be made until consent was obtained for contact details to be passed to HSIB.

The review team is aware that other women and families who have had or are currently involved in a patient safety investigation at the Trust may have concerns when they become aware of this review. This may also be relevant for other women and families that have been affected by a patient safety incident at the Trust or are service users of the maternity provision. Due to the prescriptive terms of reference for this review wider consultation was not possible. The impact of this review on the wider local population has been discussed with and is being considered by the Trust and the ICB.

Once the women or families were contacted and agreement was obtained for contact details to be shared, the Trust provided all relevant contact details to HSIB together with any requests regarding the timing and method of contact. All seven women or families agreed for HSIB contact.

The review was aware of the possible impact of contacting women or families after a significant period of time had passed and of the support that they may have required during that time or of their requirement for ongoing support or intervention. The Trust agreed to facilitate and fund specialist support if this was required.

Initial HSIB contact was made during the week of 21 November by HSIB staff. The purpose of the initial HSIB woman or family contact was to:

- Introduce the HSIB review
- Explain the purpose of the thematic safety review and that it is separate to any previous/current individual HSIB investigation
- Describe the terms of reference and arrange for those to be sent following the telephone call
- Request agreement to include each woman's or family's experience after permission to access medical records and speak to them or other family members in more depth about their experience if not previously spoken to
- Explain that there may be some press interest that the review is taking place and what is being shared by HSIB
- Discuss the timelines for the review that will culminate in a report that will be shared with women and/or families in January 2023
- Discuss how women or families would like to be kept informed about the review and agree an ongoing communication plan with them, which included methods of contact and any additional requirements to assist with that contact
- Following these initial telephone calls, the terms of reference for the review, a consent form and guidance information about the consent was sent to all women or families

All women or families consented to HSIB accessing their medical records.

Due to the strict parameters of this review a point of contact for women or families within the Trust was requested to ensure ongoing communication could be established and maintained for questions that sat outside of the scope of the review.

Following the review planning meetings and the identification of initial themes, further updates to the women and/or families were provided. To ensure these updates were

communicated in the most appropriate way possible, a communication plan relevant to each individual woman or family was developed.

2.4.1 Women or family interviews

Understanding the perspective of patients and families following a patient safety event is fundamental to a thorough and balanced patient safety investigation. All women that had experienced a maternal collapse (the non HSIB maternal death investigations) were asked if they would be willing to discuss their experience with members of the review team; the families from the HSIB maternal death investigations had already been interviewed as part of their HSIB investigation.

Crucial to this request was understanding the practical, physical, or psychological adjustments that individual women required to ensure they felt supported and enabled to take part in these conversations. Options for the best method and any required support or actions to aid the process was discussed with all women or families and agreed.

2.4.2 Sharing of the review

The draft report was shared with the ICB for oversight and with the Trust for a review to ensure processes, procedures and services had been accurately reflected. The Trust was asked to respond within five working days, before the report was finalised.

The specific sections of the report relating to individual events were shared with the relevant women and/or families to ensure the summaries of their care and their comments were an accurate reflection of the discussions held with the review team.

2.5 Engaging with staff

Members of staff from all maternity staff groups, anaesthetics, the emergency department, and theatres were informed of the review team's visit and invited to meet/speak to a member of the review to discuss, in confidence, their experiences of working at the Trust. The review was mindful of the capacity and acuity of the unit and offered a variety of methods of contact including email, Microsoft Teams (virtual call), telephone, face to face and drop-in sessions both on and off site. The effect on staff involved in the events subject to this review was considered and a central point of contact within the Trust was established in case any additional support was required.

The review learned during the site visit that many of the staff were unaware of HSIB attending the Trust, and this had caused some nervousness amongst staff. This was exacerbated as a site visit was also being undertaken at the same time by another external team. The review learned that the communications office had informed staff that HSIB was undertaking the review on these particular days. It is not known why the messaging had not filtered down to staff effectively.

During the Trust visit, the review was able to meet and talk to:

- Obstetricians
- Anaesthetists
- Interim Head of Midwifery
- Clinical Director
- Junior and senior midwives
- Emergency department staff
- Theatre staff
- Pharmacy staff
- Chief Nurse
- Blood Bank Manager

In addition, the team observed an elective maternity theatre list and was able to observe the medication preparation for some of the theatre list.

2.6 The Trust – University Hospitals of Derby & Burton NHS Foundation Trust

The University Hospitals of Derby & Burton NHS Foundation Trust (UHDB) Trust was formed on the 1 July 2018 following a merger between Burton Hospitals NHS Foundation Trust and Derby Teaching Hospitals NHS Foundation Trust. The Trust was an early adopter site for the Patient Safety Incident Response Framework (PSIRF) launched in August 2022.

The Trust currently has 120 inpatient maternity beds and provides a wide range of maternity services across three sites: the Royal Derby Hospital, Queen's Hospital, Burton and the Samuel Johnson Community Hospital in Lichfield. In addition to the obstetric led labour wards, services include outpatient services, a maternal and fetal

medicine centre, an alongside midwifery led unit and a stand-alone midwifery led unit.

The last Care Quality Commission inspection visit was in early 2019 and was published on the 6 June 2019. Maternity services were rated as good overall.

The number of births across the sites in recent years are;

Year	Number of births	The Royal Derby Hospital	Queen's Hospital, Burton
2019	8887	5674	3213
2020	8429	5562	2867
2021	8813	5889	2924
2022	8616	5850	2766

2.7 The events

During the period January 2021 to May 2022 there were three maternal deaths and four maternal collapses at the Trust. All these events occurred at the Royal Derby Hospital site.

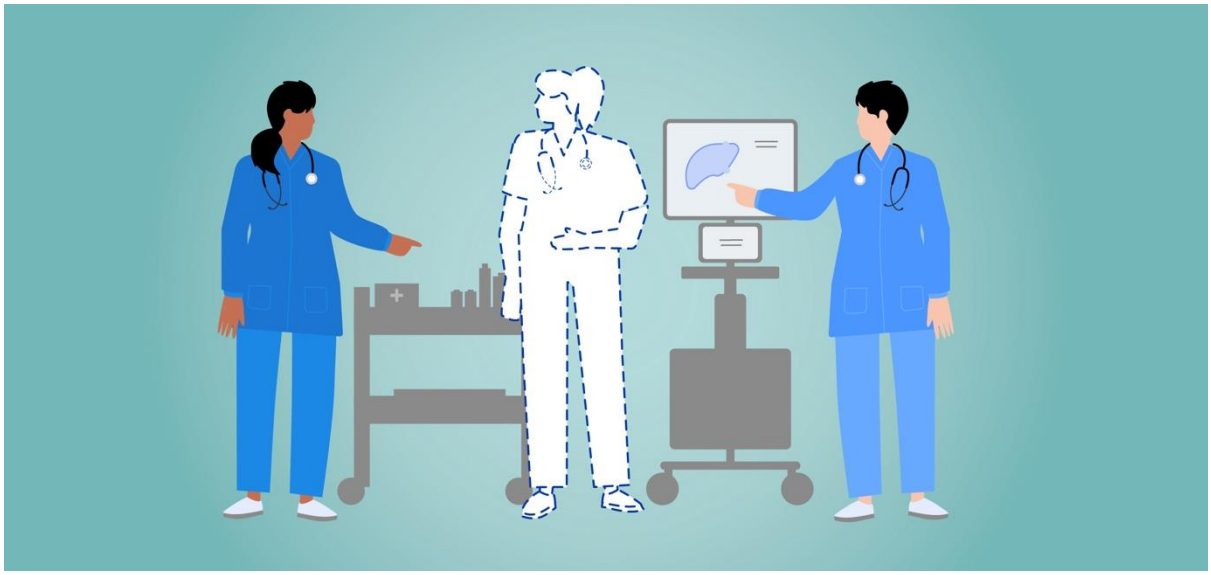
As part of the initial tabletop review, key demographics were explored including deprivation scores, previous medical and social history, ethnicity, and age. In addition, the review examined environmental factors such as days of week, time of birth, the journey of the women and the location of the event. Six of the seven events occurred within a daytime shift pattern (07:00 hours – 22:00 hours) with one event occurring late afternoon on a weekend; six events occurred within the Trust and one event was at home.

The three elective caesarean birth events occurred in the same operating theatre environment, theatre 4, in the gynaecology theatre complex. Three of the emergency caesarean births were in the labour ward theatres and one was performed in the home environment prior to transfer to the emergency department.

Section 3 - Analysis

During the two-day tabletop exercise the review identified eight themes that required additional exploration; a theme was considered for inclusion if it was present in two or more of the events being reviewed. Each of these themes are explored in the subsections below.

3.1 Staffing and leadership



3.1.1 Staffing

During the initial tabletop exercise an in-depth analysis around staffing for the seven events was undertaken. This included the midwifery, obstetric, anaesthetic and theatre staffing. The review explored which staff were present at each event, their role at the time of the emergency, whether their shift was a rostered or an extra shift and the planned versus actual staffing for that shift.

The review found that staffing within maternity service at the Trust was and remains challenging; the review learned the reasons for this were multiple and included short and long-term sickness, the retention of staff, and difficulties in recruiting new staff members.

The issues with the key staff groups are further explored below. As the review was focussed on the care of women rather than their babies, it did not explore neonatal services or staffing at the Trust.

3.1.1.1 Midwifery staffing

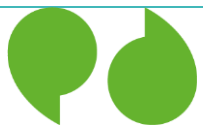
As with many trusts across England, the review found there are significant staffing gaps within the midwifery workforce at the Trust, and this is having a detrimental effect on the operational running of the service. The Trust's safe staffing requirement for the midwifery workforce is 379.19 whole time equivalent (WTE) midwives; at the time of the review visit there was a midwifery vacancy rate of 45.12 WTE midwives.

The review found no evidence that the reduction in the midwifery workforce directly impacted on the outcome of the seven events under review; there was evidence that it impacted on the experience of the women and/or families involved. The review found that staffing levels indirectly impacted on the ability of staff to communicate effectively with women and/or families; one woman commented:

"they kept telling us someone would see us to review my plan, but it was often hours before anyone came".

The review learned that several initiatives to optimise midwifery staffing are being undertaken to maintain the safety of the service. These include an enhanced bank rate payment, the use of registered nurses and midwifery support workers in certain clinical areas (high dependency unit), the opportunity of international recruitment and the use of NHSE support frameworks for retention.

During the review, multiple staff raised their concerns that staffing issues are having an impact on their ability to deliver safe care. Staff commented that:



"the labour ward co-ordinator is rarely supernumerary, and this affects the leadership and oversight of the labour ward … it is not unusual to come out of your room and not be able to find the co-ordinator".

The investigation learned that on the postnatal ward one midwife may be looking after eight or nine women and their babies. Staff expressed that they knew that

midwifery staffing is a national issue and not limited to their trust; the effect for the staff on the front line “felt relentless” and many were “very tired” concerned about “burnout”.

Some staff described “hostility” from women who experienced delays in their care as a result of staffing; staff reported feeling blamed for a national problem.

3.1.1.2 Obstetric staffing

The review heard that two new substantive obstetric consultant posts had recently been funded, which were viewed as much needed and welcomed additions to the team. From a number of different sources, the review heard about staffing challenges within the non-consultant doctor level of the obstetric rota. Recent funding had been secured for a third registrar level doctor to support the provision of obstetric and gynaecology acute care; shifts were not always filled and so not all shifts benefitted from this additional level of support. Staff reported that when the shifts were unfilled other members of the on-call team were required to take on the duties of the third registrar in addition to their own.

3.1.1.3 Anaesthetic staffing

The anaesthetic department provides staffing for the labour ward 24/7, elective caesarean birth lists and obstetric anaesthetic antenatal clinics.

Labour ward and the obstetric high dependency unit

The anaesthetic support for the labour ward consists of resident specialty doctor presence; this is a combination of experienced specialty doctors and obstetric-competent specialist trainees. There are designated consultant anaesthetic clinical sessions covering the labour ward from 08:00 hours Monday to Friday. These sessions were previously until 18:00 hours; they have been increased recently to ensure cover until 20:00 hours in response to the current increased workload. The review was informed that the anaesthetic workload was increasing within the maternity service over the last couple of years seeing more women with complex obstetric conditions along with women with medical co-morbidities.

Out-of-hours consultant anaesthetic cover for the labour ward is provided by the general consultant anaesthetic on-call rota, which consists of 42 consultants in total to cover the nights rota. There is a resident on call junior/middle grade anaesthetist

in the labour suite, and two other resident junior/middle grade anaesthetists in the hospital who will support the obstetric unit if they are available. These are supported by two on call non-resident Consultant Anaesthetists. There is no dedicated obstetric anaesthetic consultant on the on-call rota at present for this hospital site, which has 6,500 births per year and is a receiving hospital for mothers with placenta accreta. The out-of-hours consultant anaesthetist response may not be provided by a consultant with current exposure to regular obstetric anaesthetic sessions within their job plan.

The anaesthetic team provides medical support for the obstetric high dependency unit (HDU) on the labour ward, which consists of four beds; this area was an important resource for pregnant and postnatal women during the COVID-19 pandemic. The HDU team can require significant input from the resident obstetric anaesthetist depending on the complexity of the women being cared for. The HDU is staffed by midwives as well as critical care nurses, who had supported the area during the COVID-19 pandemic.

The current lead obstetric anaesthetist has recognised the risk around the increasing anaesthetic workload on the labour ward and a business case has been developed to provide an additional anaesthetist at specialty doctor grade to provide support as part of the anaesthetic workforce 24 hours per day; this is due to ‘go live’ in August 2023.

Elective caesarean birth list

The review learned that the presence of two experienced specialty doctors working together during an elective caesarean birth list, was a recent change to support both the delivery of safe care and the efficiency of the list to reduce potential delays. This approach also facilitates the anaesthetic team to be able to take breaks during the session.

It was described to the review that there had been “a shift in the culture of the [anaesthetic] department to support health and wellbeing”. The review acknowledges the Trust has recognised the impact of fatigue on performance at work and has demonstrated it is aware of the ‘Wellbeing and Support’ guidance from the Association of Anaesthetists (2022) to actively support staff and of the need to take ‘time out to refresh’.

The review learned that there are vacancies at consultant level within the anaesthetic department and this, coupled with the increased demands on the department for staff to add additional operating lists to support the COVID-19 elective recovery plan, the ability to staff additional theatre lists is challenging.

There are plans to increase the number of elective caesarean birth lists to seven half-day sessions, including Saturday sessions. The safety of these additional sessions, on Saturday in the gynaecology theatre complex (a remote area on the second floor, distant from the labour ward) has been raised. Currently there are identified escalation pathways to get assistance when required, as observed by the review during the normal working week, when the other three operating theatres on the floor are staffed; this may not be the case with Saturday sessions.

3.1.2 Leadership

The review found there had been a prolonged period of fragmented leadership since the Trust's merger, with many changes in the leadership structure, particularly in the midwifery leadership. As part of the merger a cross site Divisional Director post was created within the Women and Children Division. The original post holder remained in post until retirement in May 2020 when a new post holder was appointed. The changes in leadership did not directly impact on the seven events under review, the review did find indirect influences on accountability and the acceptance of poor behaviours, this is explored further within section 3.7.

There is evidence that a strong, adaptive, and responsible leadership team plays a significant role in in the delivery of high quality and safe care. Previous independent reviews have highlighted that effective leadership delivers better outcomes for women and their families (Kirkup, 2015; Ockenden, 2022).

3.1.2.1 Midwifery leadership team

The midwifery leadership team has experienced numerous structure changes, vacancies, and absences since the Trust's merger in 2018. There have been six changes within the director of midwifery (DoM) and head of midwifery (HoM) roles and the governance team has experienced significant gaps in its leadership over the 4-year period. The matron team has also seen considerable turnover including a major reconfiguration during 2019/2020 (See Appendix 2).

The review learned that the constant change within the midwifery leadership had been “unsettling and inconsistent”, and some considered this led to a “lack of ownership and accountability” for patient safety and governance within the maternity service. Many staff commented that the structure “now seemed more stable” and there was a widespread, positive feeling that the midwifery leadership had improved in recent months, this was primarily attributable to the support, stability, and vision of the interim HoM; this was echoed by a high number of staff. The review learned from interviews with the leadership team that “planning is being undertaken around midwifery leadership in preparation for the new director of midwifery starting in January 2023”.

3.1.2.2 Obstetric leadership team

The obstetric team has experienced a period of stable leadership, over many years, from the Trust wide clinical director (CD), who is supported by an assistant clinical director (ACD) on each of the two main sites providing maternity care. In addition, both sites have a labour lead and an obstetric fetal monitoring lead. The members of the obstetric team that the review spoke with during the site visit reported that the obstetric leadership team structure worked well, and there was more trust-wide collaborative working within the obstetric team planned.

3.1.2.3 Anaesthetic leadership team

The review heard that the leadership of the anaesthetic team had been through a period of uncertainty, with the lead role being vacant for a period of time. A senior obstetric anaesthetist has recently agreed to take on the role, with allocated time agreed by their clinical director.

The review learned that behaviours (the perception of blame being attributed to individuals) displayed within the multi-disciplinary maternity senior team had led to limited engagement of anaesthetists in the safety and governance aspects of the maternity service. One of the outcomes of these behaviours was demonstrated by the difficulty in appointing a new lead obstetric anaesthetist, after the previous lead stepped down; it was described to the review as “a poisoned chalice”. The involvement of the new lead obstetric anaesthetist in the maternity safety and governance team has been recognised by the anaesthetic team as a positive intervention.

3.1.3 Staffing and leadership summary

The review found no evidence that staffing levels or service leadership had a direct impact on the outcome for the women who received care during the seven events included in this thematic review.

The review heard that staff were passionate about providing a high-quality service for women and most of them pulled together to support one another. Staff are keen to develop and improve the maternity service at the Trust.

The review considers that staffing and leadership has had indirect impact on care provision in the Trust. Many staff shared concerns about staffing levels not feeling safe and concerns that specialities work in silos, particularly within the obstetric and anaesthetic teams. The review learned this was starting to improve, contributed to by having a new lead obstetric anaesthetist in post.

Safety prompts for the Trust

Staff need to feel their leadership teams are kind, compassionate and lead by example. Staff benefit from feeling the wider multi-professional team is pulling in the same direction.

What leadership training, coaching and support is the Trust providing for their leadership teams? Is there an opportunity to improve/increase the multi-professional learning to allow teams to develop their relationships? Are multi-professional teams encouraged to plan service provision together, rather than working in silos?

3.2 Major obstetric haemorrhage and emergency calls

3.2.1 Emergency call numbers

Three of the seven events were massive obstetric haemorrhages (MOH). The review learned the Trust currently has two different emergency numbers (2222 – adult cardiac arrest only and 3333 – all other emergency calls) and that there is confusion amongst staff, around which emergency number should be used when there is an MOH.

It is unclear from the information available to the review whether the local dedicated emergency call number of 3333 was used to alert staff during any of the MOH events. The National Patient Safety Agency (NPSA) advised and reinforced that all hospitals in England should use one number for emergencies (2222); this is being standardised across Europe. It is unclear why this standard number is not used at the Trust for obstetric emergencies including MOH. The Trust guidance states that 2222 is used for adult cardiac arrest only and there was evidence this had been used to summon the adult cardiac arrest team.

At the time of the site visit the review learned there was no method of the switchboard team cascading an MOH emergency call to a specific, pre-defined group of staff. This meant there are delays in ensuring the required staff are present to undertake the specific tasks needed (e.g. collecting blood) to safely manage an MOH emergency.

The review learned that switchboard received a call stating ‘obstetric emergency’ in one woman’s care, a fast bleep was requested in another’s. The MOH team was not requested in two of the events and in the third event there was confusion as to whether the MOH call had been put out; the call happened over 30 minutes after the blood bank was alerted separately. This confusion was evident in a previous maternal death investigation for the Woman from event 5.

The Woman from event 2

A 36-year-old mother booked for obstetric led care in her second pregnancy. It was identified at an ultrasound scan at 17+1 weeks that she had placenta praevia. The Mother was booked for an elective caesarean birth at 38 weeks. When she was 37+3 weeks, she experienced a large vaginal bleed at home. Emergency services were called, and she was transferred by ambulance to the Trust. The Mother was transferred to the labour ward where she was seen by an obstetrician and an anaesthetist.

Further bleeding was identified, and she was transferred into the operating theatre for a category 1 caesarean birth. Following the birth of the Baby and the placenta, the Mother’s condition deteriorated, there was continued blood loss and she had a cardiac arrest. An anaesthetic emergency was called; the resident, senior

anaesthetist on call and ITU anaesthetists were ‘fast bleeped’. The first unit of blood was given at 57 minutes after the Mother’s admission.
There were differing accounts from staff of when the MOH call was put out and this led to a delay in the administration of required blood products.

3.2.2 MOH guidance

The review learned there is no separate Trust MOH guidance; there is a flow chart as an appendix in the post-partum haemorrhage (PPH) guidance which includes a hyperlink to the Trust wide general massive haemorrhage guideline. Though some staff knew that the local emergency number for an MOH is 3333, local guidance (PPH and the Trust wide general massive haemorrhage) does not advise the use of this number during an MOH. The review understands that there is currently separate MOH guidance being written.

The use of prompt cards for time-critical clinical events are in common use in healthcare as reference guides for staff. The review learned that in theatre 4 in the gynaecology theatre complex, there are two different major haemorrhage prompt cards on display; one behind the anaesthetic machine entitled ‘Transfusion management of severe haemorrhage. Action cards 5/6’ and one in the drug preparation area which is entitled ‘Massive Haemorrhage Action card’. The review learned these are not specific prompt cards for maternity patients. In addition, the prompt cards were not aligned in content, with one being out of date. One prompt card did have a section about MOH; it did not state how to call the emergency team in the event of an MOH.

3.2.3 MOH team

The local flow chart for MOH (mentioned above) states that a call for help is to include a senior midwife and obstetric and anaesthetic registrars; it does not stipulate the use of an MOH emergency call to activate a cascade alert to the whole clinical team that is required.

The Royal College of Obstetricians and Gynaecologists (RCOG), ‘Prevention and Management of Postpartum Haemorrhage’ (2017:119) states ‘early involvement of appropriate senior staff (including the anaesthetic team and laboratory specialists) is

fundamental to the management of PPH'. The RCOG guidance goes on to recommend:

> 'the following members of staff should be called and summoned to attend:
>
> - an experienced midwife (in addition to the midwife in charge).
> - the obstetric middle grade.
> - the anaesthetic middle grade.
> - the on-call clinical haematologist with experience in major haemorrhage.
> - porters for delivery of specimens/blood.
>
> Furthermore, the consultant obstetrician and consultant anaesthetist should be alerted, and the blood transfusion laboratory should be informed'.

The review learned that an adaptation is often used during an emergency due to no clearly agreed, standardised process being known by all staff members; staff call for individuals rather than using a dedicated number to cascade an alert to the required emergency team. Staff explained that this adaptation is more commonly used when an emergency is in a theatre location, as it is perceived that most of the team members that are needed are already present. The review also learned that the number to call for obstetric emergencies was not familiar to staff in other areas of the Trust.

The Woman from event 1

A 28-year-old mother was booked for obstetric care in her first pregnancy. When the Mother was 31 weeks, she had a cardiac arrest in the community setting. The Baby was born at home by resuscitative hysterotomy and died at two days of age. The Mother was transferred to hospital where resuscitation continued. There was no obstetric emergency call put out as emergency department staff were not familiar with the process to make an obstetric emergency call. This led to a delay in an urgent senior obstetric review of the Mother.

3.2.4 Blood bank

The review learned that the blood bank is not included in the MOH flow chart – a separate bleep must be made to alert the blood bank that there is an emergency. There is guidance in the Trust's postpartum haemorrhage guideline that a designated staff member should be nominated to collect blood; there is no dedicated porter/runner included in the MOH flow chart. The review learned that a member of staff present at the emergency is allocated to collect blood from the blood bank, which is on a different floor and can take up to 20 minutes for a round trip.

The review learned that until recently there has been no access to O Rhesus negative blood on the labour ward or in the gynaecology theatre complex. There is no blood fridge on the labour ward; it broke some time ago and has not been replaced. The review understands there are now two units of emergency O Rhesus negative blood available in the gynaecology theatre complex, which is approximately a two-minute walk from the labour ward theatres.

3.2.5 Documentation during an MOH

An MOH proforma is required to be completed as per local guidance; for two of the events the review has not been supplied with the MOH proforma. In the third MOH event, there is evidence of a scribe during the emergency and there are emergency notes written, though not on an MOH proforma. This is discussed further in section 3.4.

3.2.6 Recent improvement work

The review learned of a "back to basics" approach to PPH/MOH which has started recently. There is now a PPH QI team, and the Trust has engaged with the regional maternity team around similar projects. Staff informed the review that "it is difficult to do improvement when the challenge is so difficult with staffing levels".

The review learned the Trust has secured funding for extra maternity support workers to start weighing blood loss more accurately as it recognised this process was "sporadic and inconsistent". The Trust is now at full complement for maternity support workers and is confident there will be consistent and significant improvement of this process. The Trust is planning new faculty planning meetings around multi-professional working to support the management of haemorrhage.

3.2.7 MOH and emergency calls summary

The review found there were significant opportunities for the Trust to optimise process elements of the management of an MOH. Workarounds were often employed as the current processes were either not clear to all staff or did not support the rapid activation of an alert to summon all the required staff to an emergency.

The review found that these process elements are unlikely to have directly impacted on the outcomes for the women included in this review; the review does consider that optimising these processes would allow clinicians to have more headspace when managing an acute emergency situation.

HSIB safety recommendation

The Trust to ensure there is a clear process for declaring a massive obstetric haemorrhage, and that following an emergency call a cascade notification alerts the pre-defined group of staff, as defined in RCOG guidance, to support the safe and timely provision of care.

HSIB safety recommendation

The Trust to follow national guidance in the use of a universal 2222 call for all emergency calls.

Safety prompts for the Trust

The review learned there is now a blood fridge in the gynaecology theatre complex; is there a barrier to having one located on labour ward?

What work is being undertaken to support learning in view of previous HSIB MOH safety recommendations?

3.3 Medication

The review learned that there is a clear structure in the pharmacy department at the Trust, with an experienced medication safety officer that reports directly to the chief pharmacist leading on medication safety and policy. The clinical pharmacists appear to be well integrated into clinical specialities including obstetrics and the operating theatres.

3.3.1 Medication preparation

The review learned that medication is, on occasions, batch prepared prior to use in the operating theatre. This is performed with the intention of reducing delays during an operating list.

During the observation day, the review observed the preparation of oxytocin for both intravenous bolus administration and intravenous infusion for two women. In addition, suxamethonium was prepared in a syringe and stored in the fridge in case it was needed; the Trust no longer has pre-prepared syringes of suxamethonium which it previously used.

The review learned that advance medication preparation and multi-dosing as observed is not part of the Trust's medicines policy and not supported. HSIB acknowledges whilst this does not comply with either local or national guidance and standards, HSIB is aware this practice occurs within other hospitals. HSIB has highlighted this issue in the ongoing maternal death report.

Extract from investigation report regarding the Woman's care in event 3

The investigation learned that all the medication was drawn up, labelled using pre-printed labels and placed in a tray.

The Royal College of Anaesthetists (RCOA, 2016) further states that all infusions and syringes containing medicines must be clearly labelled. If medicines are drawn up and labelled in a theatre setting ideally the preparation should be done by the person who will administer them. Adequate uncluttered surface space and trays, clean for each patient, are required for the drawing up, arranging and holding the syringes and medication for each procedure. HSIB considers the process of drawing up of the medication for use in the elective CS procedures on the day of the Mother's care was reasonable.

Local guidance on medicines management states that prepared medication must never be left unattended. The investigation learned that the three trays with the prepared medication were left in the 'prep room'. The investigation learned this room is within the operating theatre. The investigation learned the required tray would be collected by the consultant anaesthetist prior to each procedure. The tray with the prepared medication would be placed by the anaesthetic machine within easy reach of the anaesthetist. HSIB notes there is no local or national guidance to support the advance preparation of the medication for a procedure. HSIB acknowledges that the local guideline states that practices involving the prescribing and administration of medicines in an operating theatre may differ substantially from those on a hospital ward.

3.3.2 Documentation

Within the anaesthetic documentation, rates of administration of intravenous infusions were recorded, for example phenylephrine in millilitres (ml) per hour; no detail around the concentration of these infusion in milligram (mg) per ml was stated. The intravenous infusions were administered using intravenous infusion pumps with specific profiles for each medication for safe delivery within specified infusion rates.

The review attempted to review the standard local guidance for obstetric anaesthesia with respect to commonly used drugs. It was informed that this is incorporated into labour suite guidelines; the review has been unable to access these guidelines,

either paper-based or in electronic format. This raises the question of whether staff are able to locate the guidance.

The use of ‘Synto/Syntometrine’ in the local guideline is contrary to the United Kingdom Clinical Pharmacy Association (2019) guidance which states to avoid the use of brand names due to look alike and sound alike selection errors with other medication with a similar name – e.g. Synacthen.

3.3.3 Medication summary

The review found that the preparation and administration of medication did not directly impact on the outcome of the women who received care during the seven events.

The review learned relationships and cohesive working was evident both within the Pharmacy department and across the specialities.

There was some learning identified around the preparation of medication before elective procedures and around the documentation of the administration of medications. In the seven events reviewed, it was noted that the documentation did not support all aspects of the administration of medicines.

The review encountered difficulties in navigating local guidance and this may impact on staffs’ ability to provide care or medication in line with local and national guidance.

Safety prompts for the Trust

The review learned it was difficult to navigate local guidelines and that there were different maternity guidelines between sites.

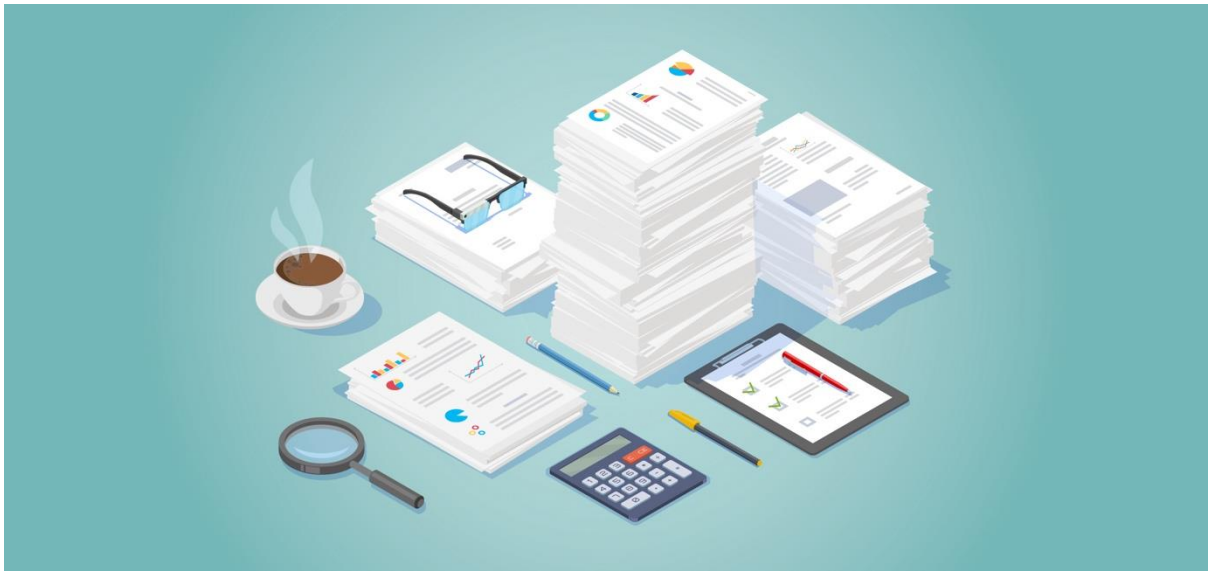
How do the staff navigate the guidelines? Are they easy to find? What are the barriers to formulating Trust wide guidance?

Safety prompts for the Trust

The review learned pre-preparation of medication was common within the elective theatre environment.

Has consideration been given to providing the theatre team with pharmacy pre-prepared syringes?

3.4 Documentation and record keeping



The review learned that documentation and record keeping did not impact on the outcome of the women who received care during the seven events. The review found areas of documentation were not completed in full or were missing altogether. A common theme was no designated scribe for the emergency, this meant key areas of care were not clearly identifiable; this can affect the recollection of those present and the ability to identify learning after an event. These areas are further explored below.

3.4.1 MOH proforma

As described in section 3.2.5, the review found that two of the three MOH events did not have a proforma completed. In the other event there was evidence that a scribe had completed documentation during the emergency without the use of the proforma. The review was unable to locate a blank MOH proforma, though it is referred to in the PPH local guidance. If staff are not aware of where to find the MOH proforma or do not have easy access this may be a reason why it is not routinely used.

3.4.2 World Health Organisation (WHO) safer surgery checklist

In some of the events, the WHO checklist had not been completed at the ‘sign out’ stage; the review was unable to establish the reasons for this.

3.4.3 Documentation during emergency care

There was variability in the standard of the documentation of medication administered during resuscitation events, for example, some medication had no dose documented, and the route was rarely stated.

The review has not been able to ascertain whether there was a dedicated scribe for all of the emergency events; there did not appear to be limited staffing in the theatre at the time of the emergencies.

It was difficult to define from the paper anaesthetic charts the actual time of medication administration and the anaesthetic charts gave no indication of the rate of administration for bolus doses. The review attempted to look at the process for recording medication administration during an emergency/resuscitation situation. An appendix to the local medication policy contains some information; the review was unable to establish the Electronic Prescribing and Medicines Administration (ePMA) process for emergency documentation either in their local policy or during observation.

3.4.4 Documentation of leadership during emergency care

The review was unable to clarify in six of the events whether there was any one member of staff with a ‘helicopter view’ of the emergency, who would be able to designate a scribe and ensure events were recorded contemporaneously. During a previous, maternal death investigation, HSIB made a safety recommendation that the Trust ‘should ensure that in emergency situations, senior members of the team are involved and that a shared mental model is developed that recognises the evolving clinical picture with maintenance of a helicopter view’. The review learned through interview that staff thought the emergency situations in the theatre were at times ‘chaotic’ and there was confusion on whether protocols were activated, and which member of staff was allocated to certain tasks.

3.4.5 Electronic patient record documentation

The maternity department was one of the first implementers of the Lorenzo electronic patient record (EPR) modules in 2016. The review learned that this system has now reached a plateau stage, where the focus is on the wider Lorenzo user; maternity elements are effectively like an appendix to the main system and the system no longer meets the needs of the maternity unit. Examples given were:

"staff may not have a full overview of all a patient's care" and there is "lots of duplication and we remain paper heavy".

The review learned that there have been some challenges historically with getting this issue and the needs of the maternity unit accepted and understood by the Trust digital team; very recently a business case has been accepted for a new maternity electronic patient records (EPR) system.

3.4.6 Guidelines

Although staff have proactively looked at guidelines from the opposite maternity site, the review learned that the Trust wide maternity team could not agree on merged guidelines; the review learned the approach taken in other parts of the Trust was that both site guidelines had already been merged and listed alphabetically for ease of access. Staff commented there was resistance from both sites to agree and align maternity guidance as both sites felt theirs was more reasonable. This has led to both sets of guidelines being available to staff. The review has experienced considerable challenges in finding guidelines and proformas to inform their findings.

3.4.7 Documentation and record keeping summary

Effective record keeping and documentation are essential components of patient care and fundamental to ensuring patient safety. The Trust has a responsibility to provide their staff with easy to find, robust guidance to support their contemporaneous documentation of events, particularly in an emergency situation.

This theme did not directly impact on the outcome of the women who received care during the seven events included in the review; the review found learning opportunities to further support staff within the maternity service and improve safety for women and their families.

Safety prompts for the Trust

The review learned it was difficult to navigate local guidelines and that there were different maternity guidelines between sites.

How do the staff navigate the guidelines? Are they easy to find? What are the barriers to formulating Trust wide guidance?

Safety prompts for the Trust

The review learned that during six of the seven events, it was not clear who was maintaining a helicopter view of the emergency.

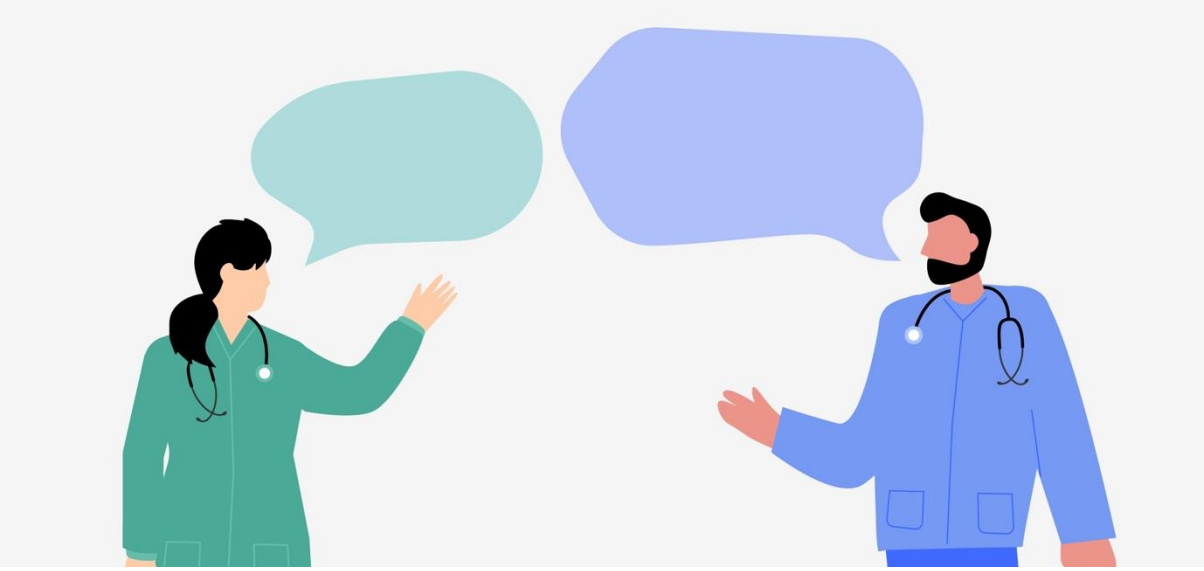
What is taught on obstetric emergency study days? What are the barriers to accurate, contemporaneous scribing? Is there a process in place to call for additional consultant level support during an emergency?

Safety prompts for the Trust

The review learned there was inconsistency in completing MOH proformas.

How do the staff find the proforma? Is it easy to find? What are the barriers to accessing or completing the proforma?

3.5 Communication



The review heard some examples from families of “kind and supportive” communication, particularly from their community midwife and theatre teams.

The family of the Woman from event 3 commented:

“Overall, the relaxed attitude of the staff put [the Woman] at ease and she was very relaxed”.

Overall, the review repeatedly heard from the families that, at times, communication with staff affected the confidence in their care. The review found examples of communication which led to non-engagement with and an unwillingness to involve the women and their families in decisions about their care. There was limited evidence of follow up care for the women or their families once they left the hospital.

The review learned that staff faced barriers to effective communication primarily due to a perception of hierarchy amongst the disciplines involved in maternity care. This meant care planning and communication was not always effective within the multi-professional team.

3.5.1 Within the Trust

The review learned that there were significant communication issues between different clinical teams within the Trust with evidence of isolated working. There was a perception of obstetric hierarchy with some obstetricians appearing dominant over other specialities such as the anaesthetic team. The review learned that communication was impaired as:

“staff did not feel psychologically safe and the way we treat each other is not great”.

“We are trying to improve this as we [the leadership team] need to role-model and develop insight”.

There was also evidence of unkind words, demeaning behaviours and bullying treatment of colleagues particularly from within the obstetric body towards predominately the midwifery workforce and other disciplines (e.g. anaesthetics).

Many national reports evidence the fundamental importance of kind, effective, inclusive and open communication.

‘Effective communication is key to all clinical care, particularly in the maternity services, where there may be multiple handovers of care. Communication is effective only if the relevant information is actually made available to, and understood by, those who need to act on it’ (The King’s Fund, 2008).

The review further learned there was a hierarchical process within the labour ward:

“You cannot just speak to a [obstetric] consultant for advice or support – you have to go through certain people [the labour ward co-ordinator or middle grade doctors], there is certainly an element of ‘gatekeeping’”.

There have been previous recommendations from the Trust’s HSIB maternal death reports relating to communication:

‘The Trust to ensure that the multidisciplinary team explores and implements mechanisms to improve working relationships and

communication during changes to planned care. This should include consideration of human factors training and multidisciplinary skill drills'.

Members of the leadership team acknowledged there had been historic behaviours that led to a breakdown in collaborative working and the review learned this was appearing to improve slightly. This is further explored below in section 3.7.

The review further learned that there was a perception that communication to and from the Trust's executive board "was not strong". Some of the leadership team within the service commented there had "been little exec support" surrounding the maternal death events or around the subsequent escalation of the four maternal collapses. On reviewing the timeline of changes within the executive team the review observed there had been significant changes in the past year. The review learned the changes have contributed to more insight and collaborative working at board level and that relationships and communication channels between the service and board level were improving.

3.5.2 With women and/or families

The review heard some examples of positive communication; some stated that communication during their pregnancy care had been satisfactory with many of the women and/or families stating their community midwifery care was "excellent". Most of the women and/or families also commended the communication within the theatre, intensive care unit (ICU) and the high dependency unit (HDU) stating that staff were particularly "kind, calming and compassionate".

The family of the Woman from event 3 recalled during a meeting with the obstetric team:

"50 percent of this story is this little guy. Thanks for safely bringing him to me and [the Woman] and everybody really. He is a very happy healthy baby".

A number of the women and/or families commented their obstetric appointments felt "very much 'standalone' due to their short nature". Women and/or families stated that

the appointments seemed to focus only on that moment in time rather than considering their pregnancy as a whole.

The family of the Woman from event 1 found their obstetric appointments “frustrating”. The family further commented:

> “She [the Woman] didn’t feel listened to … she used to come away from her appointments feeling like she didn’t matter ... They just seemed to focus on the baby and not her”.

The review learned that once the women and/or families had been discharged from the hospital the communication was “unbelievably poor”.

Woman from event 5

A 42-year-old mother booked for obstetric led care in her second pregnancy.
An elective caesarean birth was arranged for 39+1 weeks due to the Baby’s breech presentation. During the caesarean, it was noted to be a difficult birth of the Baby and at this time the Mother’s heart rate significantly slowed. This resolved with medication, the caesarean was completed, and the Mother was transferred to the recovery area.
In the recovery area the Mother experienced significant blood loss. Her condition deteriorated and an MOH was called. Treatment as per the MOH flowchart was given and the Mother was subsequently transferred to the intensive care unit. She was discharged home on day 5 after the birth.

On returning home, the Woman from event 5 described how she and her family did not hear anything from the Trust for “four months”; they were then offered a debrief with an obstetric consultant. The Woman and her family recalled that they did not find this useful as they were unable to understand why the event had happened. The Woman and her family were not informed of any internal investigation and did not receive any information from the Trust until they were informed of the HSIB thematic review.

The Woman’s partner recalls:

"During the resuscitation, I was placed in a room with our baby and did not hear from anyone for five hours. When I was eventually updated, I was advised to return home with the baby. This was so distressing, as I felt my wife had gone and there was no reason to stay at the hospital".

"Once home, I remember the community midwife asking me … and how are you? I froze, because it was only then I realised nobody had ever asked ME that. I just broke down".

The Woman from event 4

A 31-year-old mother booked for obstetric led care in her second pregnancy. The Mother was booked for an induction of labour for post maturity. Following an unsuccessful induction process over three days, a category 3 emergency caesarean birth was planned.

Following the birth of the Baby, the Mother experienced an unexplained cardiac arrest and cardiopulmonary resuscitation was performed.

The Mother was then transferred to the intensive care unit for ongoing support and underwent a number of investigations to find a cause for her collapse.

She remained in hospital for seven days before being discharged home with outpatient follow up. The Mother continues to experience significant health issues and has access to specialist care at the hospital.

The Woman from event 4 has no recollection of her time in hospital and was supported intensely by her mother in the initial postnatal period. The family commended the initial care following the birth and stated the staff were "brilliant". Once home, the family recollected that the midwifery team visiting them had no information about the severity of the Woman's care episode and they kept having to repeat it; this caused more trauma. The Woman and her family did not receive any

offer of a debrief and did not know this was an option for them until weeks after the event. They were advised there would be an internal investigation; they did not hear anything until they were contacted about the HSIB thematic review. At the time of the interview, the Woman and her family had not heard about the outcome of the internal investigation.

"I was 32 and my heart had stopped, I am so scared to even walk down the road in case it stops again, I have no idea why this happened and the support from the Trust has been awful … I feel the Trust could have offered so much more support following such a traumatic incident".

The Ockenden report (2022) states that an absence of communication, transparency and openness with families is 'most concerning'.

The Woman from event 6

A 29-year-old mother was booked for obstetric led maternity care in her sixth pregnancy. At 36+0 weeks the Mother's waters broke spontaneously and she started contracting shortly after admission to the Trust. At 36+1 weeks, during augmentation of labour there were concerns around the Baby's heart rate, following this the Mother collapsed and experienced seizures. Following treatment to reduce the seizures, the Baby was born by emergency caesarean birth.
The Mother was cared for in the intensive care unit (ICU) for 13 days experiencing neurological complications and was also treated for infection. Following discharge from the ICU, the Mother remained in hospital for 27 days. After discharge home, she received on going neurological outpatient appointments and rehabilitation.

"I was just sent home with no idea what happened to me ... I still can't remember what happened".

"It's really bad ... how can they just send you home and not tell you anything".

"My [family member] keeps having to remind me of things and I have to have a whiteboard to remind me to do really basic things ... What if this happens for the rest of my life?".

The Woman from event 7

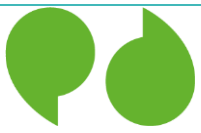
A 37-year-old mother was booked for shared obstetric and midwifery care in her second pregnancy.

The Mother's had a medical history of psoriatic arthropathy treated with certolizumab. A plan was made for an elective caesarean birth. During the pregnancy the Mother developed gestational diabetes which was managed by medication.

At 39+1 weeks the Baby was born by elective caesarean birth, the Mother was COVID-19 positive at this time. The Mother experienced a cardiac arrest during the birth and sustained extensive internal trauma during the cardio-pulmonary resuscitation that required additional surgery at a major trauma hospital.

The Mother remained in the intensive care unit and as an hospital inpatient for three weeks. She was discharged home with continuing community care and outpatient follow up from the trauma centre.

The Woman from event 7 provided examples of kind and compassionate care immediately following an event:



"[my partner] felt that the midwives immediately after the event were very kind and compassionate and provided him with support during the

uncertainties. They kept him updated with how I was and the treatment I was receiving. [Our baby] was brought to [my partner] quickly and when it was appropriate, they were given their own room".

Once discharged home, this woman's reflections echo those of the others in that:

"Some confusion regarding feedback of the review has left us feeling less supported. We appreciate not attending in person makes communication harder, but we have explained why I am unable to attend the hospital in person to voice my concerns … no alternatives were given. We feel that alternatives should be as standard - especially as we will not be the only family who undergo a review of care that experience longer term psychological/physical issues".

During an interview with the family of the Woman from event 2, they commented that the staff and been "kind, supportive and visibly upset" at the time of the event. They further commented that once returning home:

"we heard nothing from Derby at all, any minimal information was given to us by the [different] hospital providing care for [the Baby] … I was so unsure of what I needed to do, did I have to sign anything about my wife's death? … it was terrible".

The review heard reflections of emotional trauma, vulnerability and distress from the women and/or families involved in this review.

The review spoke with the newly formed, local maternity voices partnership (MVP) and learned encouraging information on how the Trust plans to listen, build, support and maintain kind and effective relationships with women and their families within the

region. They heard examples of well attended forums by the matron and senior team held by the MVP to capture the hopes and vision of the women. The review considers this a positive step in ensuring women's voices are central to the development of the maternity service.

3.5.3 Communication summary

The review found that communication did not directly impact on the outcome of the women who received care during the seven events included in the review. The review found that communication with women and/or families after the event did not support them to understand the events, they had experienced, and found that they felt "abandoned" by the Trust in the postnatal period.

The review found that the local MVP is strengthening the relationship between women, families and the Trust.

HSIB considers meeting with women and/or families and understanding their needs and concerns post critical event is vital to inform learning within maternity services.

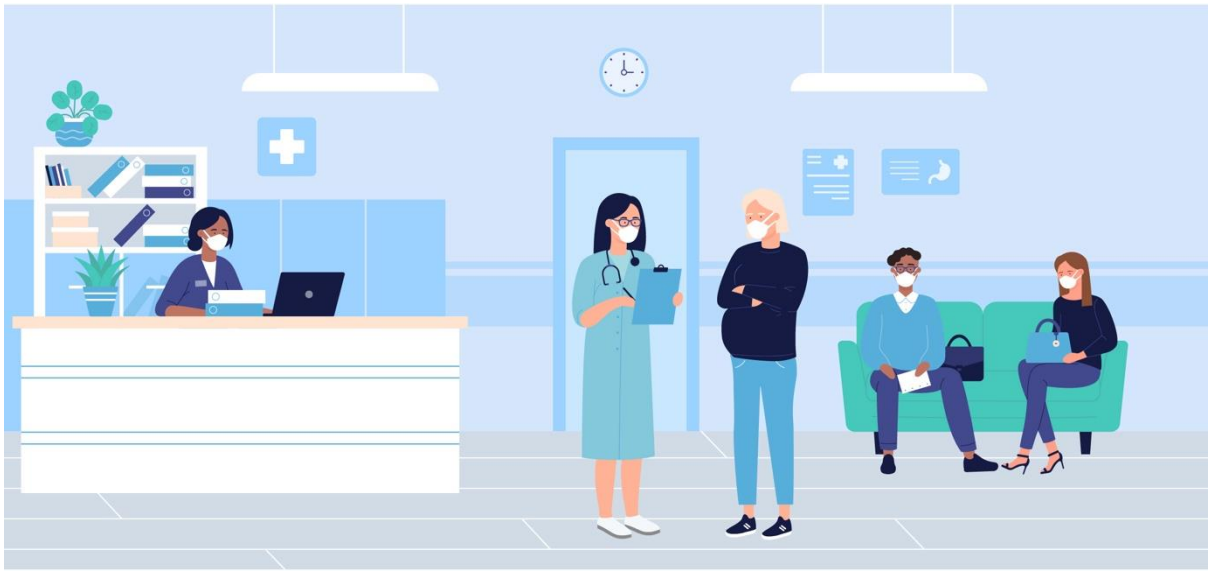
HSIB safety recommendation

The Trust to ensure that communication and support, with women and/or families who have experienced a significant event around the time of birth, continues in the postnatal period to ensure women receive the required holistic care

HSIB safety recommendation

The Trust to ensure that communication and support, with women and/or families who have experienced a significant event around the time of birth, continues in the postnatal period to inform immediate and ongoing learning.

3.6 Environment



At the Royal Derby Hospital there are two maternity theatres on the labour ward for emergency caesarean births. The elective caesarean birth operating list is performed within the gynaecology theatre complex on a different floor within the women's health part of the hospital.

Six of the seven events took place in either the obstetric (labour ward) or the elective (gynaecology) theatre. The remaining event was initially in the community setting and then in the Trust's emergency department.

3.6.1 Theatre clocks

Inconsistent timings can mean that accurate timings may not be reflected in documentation, especially during an emergency when timings can be critical.

The review identified that at the time of the observational visit there were ongoing discrepancies between the clocks in the elective operating theatre – this was a finding in one of the HSIB maternal death investigations and had previously been shared with the Trust.

The Woman from Event 3

A 30-year-old mother in her first pregnancy was initially booked for low-risk care. She received growth ultrasound scans initially for reduced fetal movements. These identified the Baby to be large for dates and following a discussion, the Mother was booked for an elective caesarean birth at 39 weeks. Immediately following the

birth of the Baby, the Mother had a cardiac arrest. Resuscitation was commenced and was unsuccessful.
During the investigation it was noted that the clocks within equipment in the theatre were not synchronised to the main electronic clock. This meant that the timings of critical elements of the resuscitation differed within the documentation.

The review found that the discrepancies in the theatre clock times did not have a direct impact on the care the women included in this review received; it did impact on the ability of the review to fully understand the timing of events and interventions during their care.

3.6.2 Elective caesarean birth

Of the seven events reviewed, three women were booked for an elective caesarean birth. The review learned the elective caesarean birth lists are currently provided in one of the elective operating theatres, assigned to gynaecology. There is provision for five half-day sessions during the week with the aim to undertake, dependent on case complexity, three caesarean births in a morning session and two caesarean births in an afternoon session. Local guidance stipulates which staff should be present at an elective caesarean birth and the review found that these staff members were present in the events reviewed.

The review observed a morning caesarean birth list staffed with two experienced specialty anaesthetic doctors, with three caesarean births booked; the afternoon session was staffed by a consultant anaesthetist with two caesarean births booked. One of the morning caesarean births was a woman whose caesarean birth had been postponed from the previous day due to the workload on that day; the review was aware of an additional woman requiring a category 3 caesarean birth on the day of observation, this operation was likely to undertaken in one of the maternity theatres on labour ward, rather than in the elective theatre. The review found no evidence of delays in any of the three elective caesarean births included in this thematic review.

The review learned that the presence of two experienced specialty anaesthetic doctors working together was a recent change to support both the delivery of safe care and the efficiency of the elective caesarean birth lists to reduce potential delays. This contrasted with information given to the review from theatre staff who reported that having two anaesthetic doctors in an elective caesarean birth list was unusual.

The observed staffing levels facilitated the anaesthetic team to be able to take breaks during the session; it was described to the review that there had been a shift in the culture of the anaesthetic department to support health and wellbeing. The impact of fatigue on performance at work has been highlighted by the Association of Anaesthetics, Wellbeing, and support (2022) and the need to take ‘time out to refresh’ is actively supported.

3.6.3 Weekend operating in the elective gynaecology theatre complex

The review learned there are plans to increase the number of elective caesarean birth lists to seven half-day sessions, including a Saturday session. The review heard from staff there was a “nervousness” around elective caesarean births taking place on a weekend as these would be performed in the gynaecology theatre which is not co-located on the labour ward.

Currently there are identified pathways for escalation and assistance if required, as observed by the review during the normal working week when the other three operating theatres on the floor are staffed; this may not be the case with Saturday sessions. The staff had been reassured these would be for “lower risk women”; the staff were keen to highlight that some of the women included in this review did not have “high risk factors”.

3.6.4 Emergency blood

As mentioned in section 3.24 the review learned that there is now a blood fridge with emergency blood located approximately two minutes’ walk from the elective theatre.

3.6.5 Environment summary

The review did not find evidence that the environment impacted on the outcome of the women who experienced care during the seven events.

The review was informed by the women and/or families that during elective procedures staff were “calm and personable”. The review was able to identify that for these events the required staff were present in the theatre, as per local guidance.

The review found both the emergency and elective theatre environments to be calm, spacious and modern environments. The review heard that anaesthetic cover and wellbeing was being addressed and this was improving.

Safety prompts for the Trust

The time on the theatre clocks and equipment in theatre differ.

Are there any barriers to ensuring the times are synchronised? Is there a checklist at the start of each procedure to acknowledge any discrepancies within the clocks within an operating theatre?

Safety prompts for the Trust

There is a “nervousness” amongst staff at the implementation of a Saturday elective caesarean birth list within the gynaecology theatres within the Trust

Is the Trust aware of the feelings amongst staff? What plans are being undertaken to mitigate the risks of being remote from the labour ward on a weekend? Is there an opportunity for some elective caesarean births for women booked at the Derby site to occur at the Burton site during the working week? Is there an opportunity for elective caesarean births that are required to be done at the weekend to use one of the labour theatres?

3.7 Culture

The review found there was primarily a kind and compassionate culture amongst front-line staff; the review heard many examples of colleagues covering extra shifts and staying longer to support each other. The review also found that there were

areas of considerable concern in relation to compassion, kindness, teamworking and a vision of common purpose amongst the maternity team.

The review learned that staff felt a kind and compassionate culture was not universally reflected in all of the senior team, particularly from some of the obstetric team. The review heard evidence of intimidation, bullying, incivility, poor behaviours, and poor role modelling. This topic was a significant theme for almost all who were interviewed or who contacted the review directly and it is on that basis that this has been included in this report.

Staff commented poor behaviours were often displayed during meetings and handovers, examples of “being shouted at” and “being made to feel small and that your input was not welcomed or useful”. This was often witnessed by front line staff. A number of staff commented that the obstetric consultant body did not always meet the required standards of professional behaviour.

These behaviours in maternity services, and their direct link to patient safety, have been widely publicised since the Morecambe Bay report in 2015. The recent ‘Maternity and neonatal services in East Kent: 'Reading the signals' report’ by Bill Kirkup (2022:159) highlights ‘unprofessional conduct is disrespectful to colleagues and endangers effective and safe working’.

The review heard many different examples from staff:

“There is a tier of obstetricians that are very experienced, knowledgeable and have been here a long time but some of their practice is out of date and we still have to call them by formal titles, it is so archaic ... This is a barrier to escalating”.

“Incivility is the biggest issue this service has got”.

The review also heard there was a low appreciation for resilience and mental health considerations:

“they just need to get on with it”.

“once people go off, it is hard to get them back to work”.

It is widely accepted that poor behaviours have an obvious, detrimental effect on colleagues and ‘a failure to treat each other with civility and compassion will directly affect those receiving care, ultimately affecting patient safety’ (NHS – People Plan for 20/21, 2021:57).

The review heard multiple examples of attempts to escalate poor behaviours and to support colleagues to be aware of the impact of their behaviour; the review heard that this had been met with more hostility and incivility and has led to behaviours becoming the “norm” over time and that these were now “tolerated”. Staff commented “we do not have a safe space, and we don’t know who we can trust”. The review further learned that when there was evidence of escalation and attempts at whistleblowing, this had led to comments such as “I hope you are in a union?”, that were perceived as “threatening” with discouragement to escalate further.

Many staff also commented on limited visibility of the “senior maternity team on the shop floor”, though did comment that this had improved over the past couple of months.

The involvement and engagement of anaesthetists in the strategic and operational delivery of the maternity service has been impacted by these behaviours. The review was informed about the difficulty in recruiting to the role of lead obstetric anaesthetist despite allocated time to undertake this role and a group of consultant obstetric anaesthetists delivering clinical sessions within the maternity service. The role was described as a “poisoned chalice”; the current lead stepped into the role to ensure

that anaesthesia can improve on the care it delivers to mothers by working with all disciplines. The development of additional tiers of medical cover in both obstetrics and anaesthesia were undertaken as separate business cases within each specialty silo rather than as a collaborative approach to strategic developments in medical workforce planning for the maternity service.

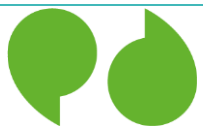
The review learned that there was an awareness of the culture and behaviours within the unit and work was being undertaken to address this. There was acknowledgement of a “a small shift in a more reflective culture”, with some staff members showing more insight into the impact of their behaviours.

3.7.1 Culture summary

The review acknowledges that addressing culture and behaviours is not easy nor straightforward, especially when these have become embedded in an organisation.

The review found that the cultural elements described above did not have a direct impact on the outcome of the women who received care during the seven events included in the review.

HSIB notes it is known from several national reports (Francis, 2013; Kirkup, 2015; Ockenden 2021; Kirkup, 2022) that there is a direct correlation between culture, behaviours, and patient safety, and as such these findings are important to share with the Trust.



‘unless these difficult areas are tackled, we will surely see the same failures arise somewhere else, sooner rather than later. This Report must be a catalyst for tackling these embedded, deep-rooted problems' (Kirkup, 2022).

Safety prompts for the Trust

Staff felt a kind and compassionate culture was not universally reflected in all of the senior team, particularly from some of the obstetric team.

Is the Trust’s executive board aware of the culture and behaviours within the unit?

Are there any plans to hold insight or civility training within the Trust? How are staff empowered to raise concerns in psychologically safe environment?

3.8 Training, governance and learning

3.8.1 Training

The review learned that midwifery training requirements were 100% compliant. This figure was based on staff being booked to attend the training; it was explained that there was no system in place to monitor which staff had attended the training they had been booked on. It was indicated that it was the individual responsibility of staff members to ensure that their training was up to date. Both medical and midwifery staff told the review that their training was out of date due to being taken off training days to undertake clinical duties.

The review learned that the Trust will not be reporting 100% compliance as part of the NHS Resolution maternity incentive scheme CNST requirements as the 100% training compliance figure was inaccurate.

The review found no evidence that absence of training or out of date training impacted on the care provided to the women in the seven events reviewed. The review did not identify concerns about the competency of anaesthetic, obstetric or midwifery staff involved in the events.

3.8.2 Governance

The review learned that until the summer of 2022 the maternity safety review process was a “closed process, inconsistent and held erratically”, “they [the obstetric team] certainly weren’t open to other specialities, assumptions were made on their behalf” and only since the summer of 2022 have the people who provided the care been invited to attend reviews.

Disagreements occurred between individuals in the same or different professional groups about women’s care, this led to “inconsistent grading of incidents and in some cases not grading at all”

Staff shared concerns about their limited confidence in incident reporting and questioned if all safety incidents in the unit were reported. The review learned that there had been significant improvement in the maternity unit’s governance process;

staff acknowledged “they still had a long way to go”. The review learned there is now an open maternity safety forum with designated staff attending from many specialities.

Generally, the review found there was evidence of sound pharmacy governance with a clear reporting structure. There were some gaps identified with regards to medications in anaesthetic governance. This has been discussed in section 3.3.

HSIB raised with the Trust at the start of the thematic review that their 72-hour reports were variable and, in some cases, not fit for purpose. The reports did not follow a template, in some instances there was only a chronology available. No immediate learning or actions were identified and there was no evidence of the 72-hour reports being shared. There was no evidence that family engagement or involvement informed the reports. The review is aware that there has been significant change in senior leadership roles and notes this may have had an impact on the way that 72-hour reports were discussed and written.

The review learned that, in recent months, there has been a new approach to governance, and this has been welcomed by all specialities. There is a conscious effort to move away from blame and concentrate on a systems approach to safety investigations at the Trust.

3.8.3 Learning

The review heard several examples of inadequate learning during the review process. Evidence given stated that there was “poor sharing of learning opportunities … [and] no sharing of themes for review”, there was a “slow response to incidents and complaints and [a] lack of respect” for external reviews and HSIB maternity investigation reports.

The review noted that findings relating to an HSIB maternity investigation from 2021 have not been acted upon, the issue related to staff confusion about making emergency calls using either 3333 or 2222 as discussed in section 3.2.1. Further evidence gathered stated that:

"nothing much has been put in place in relation to learning from HSIB reports".

3.8.4 Training, governance and learning summary

The review found learning from previous HSIB safety recommendations had not been fully implemented and it is unknown if these had been progressed what impact this would have had on the outcome of the seven women who received care during the events included in this review.

The review found some staff training was out of date due to staff being redeployed to cover clinical duties. This meant that the Trust will not be reporting full training compliance for their CNST data.

The review found the governance processes within the Trust were not robust and there was limited evidence historically of multi-professional review. This has led to low quality rapid review reports and a low assurance of robust incident reporting. The review acknowledges the maternity service is aware of these issues and understands significant improvements are currently being made to the governance process.

HSIB safety recommendation

The Trust to ensure that following a patient safety event, a robust rapid review takes place, involving the woman and family involved wherever possible, to identify opportunities for learning in a timely way.

Safety prompts for the Trust

Staff shared they had little confidence in the maternity governance process at the Trust.

How is the Trust executive board assured they have a full understanding of patient safety events within the maternity service? How do the executive and non-

executive board level maternity safety champions make themselves available to hear from all members of the maternity multi-professional team?

Section 4. Previous HSIB safety recommendations

Eighty-two HSIB safety recommendations have made to the Trust between April 2019 and November 2022 in HSIB maternity investigation reports.

The review acknowledges many of the previous recommendations do not relate to the seven events under review. Upon analysis of previous recommendations there were some that were pertinent to the events included in this review. These are detailed below:

The review considers that robust action planning and prompt addressing of the learning from these previous recommendations, may have had an impact on the outcome for the women who received care during the seven events included in this thematic review.

Section 5. Conclusion

This thematic review of three maternal deaths and four maternal collapse events between January 2021 and May 2022 has provided a number of key findings and safety recommendations that need action, along with safety prompts that require further exploration by the Trust.

The review team acknowledges that elements of this report are not easy to read. The review's intention was to undertake a fair and balanced approach, as well as to ensure kind, sensitive and empathetic engagement with the women, families and staff involved in this thematic review.

The primary aim of this report was to identify key learning within the Trust's systems and processes that will improve the safety of the women that access their maternity services.

In accordance with the terms of reference (ToR) following the tabletop review, HSIB shared with the ICB and the Trust an immediate concern in relation to the quality of the rapid reviews (72-hour reports) the Trust had undertaken following a patient safety event. The review did not identify from the evidence provided or as part of the observational visit any information outside the scope of the review that required escalation to other relevant authorities.

The review found that since the merger in 2018, policies, processes, guidelines and leadership have remained inconsistent and fragmented. The Trust has and continues to experience significant staffing issues within its maternity service; there was no evidence this had a direct impact on the events within this report.

The review found a high level of comradeship amongst front-line staff within the midwifery and theatre teams. There was a palpable message of wanting to support each other to provide the best care possible for women and their families. The review found the comradeship was not universally replicated within the senior and leadership teams, with substantial evidence of poor behaviours, bullying and a hierarchical culture, especially within the obstetric team. This did not directly impact on the seven women whose care was being explored in this thematic review; there are significant issues that the Trust needs to address, particularly around governance and leadership.

The review found two crucial areas of safety improvement that require prompt action. The first was the optimisation of process elements within the management of major obstetric haemorrhage (MOH) including the process for calling for help and which staff should be present. The review acknowledges the Trust is currently working to improve this process.

Secondly, whilst there was evidence of kind and compassionate care whilst the women were in hospital, the review learned that once the women and/or families had been discharged from the hospital the communication was “unbelievably poor”. The review repeatedly heard examples of communication which led to non-engagement and an unwillingness to involve the women and/or their families in decisions about their care. There was limited evidence of follow up care for the women or their families once they left the hospital and many of the women and/or families felt “abandoned” by the Trust in the postnatal period. Safety recommendations have been made for the Trust to ensure women and families are actively invited to share their experience to inform safety investigations and to ensure they receive the required holistic postnatal care.

The review found that at the point the seven women experienced their collapse or cardiac arrest, there were no identified common themes that directly impacted on all outcomes. Safety recommendations have been made where the findings identified during the exploration of the themes were considered to be contributory to one or more events. The review found that it is not possible to know if a different approach to safety investigation and implementation of learning, or a different safety culture within the maternity unit could have influenced a different pathway of care prior to the critical events.

The review team is confident that the findings, safety recommendations and safety prompts made throughout this report will support the University Hospitals of Derby and Burton NHS Foundation Trust on its safety journey.

Appendix 1. Terms of reference

- Provide a thematic system focused safety review identifying opportunities for implementing learning without apportioning blame or liability.
- Engage widely, openly, and transparently with all relevant parties identified to participate in the review process.
- Ensure engagement and communication with women and/or families is individualised in accordance with their preferences and choice.
- Ensure the Trust multidisciplinary team is informed and supported to engage and participate with the review.
- Be respectful when dealing with individuals who have been impacted by the incidents being investigated.
- In the event of any serious safety concerns being identified immediate escalation will be made to Trust/ICB to ensure they can undertake a rapid response.
- Adopt an evidence-based system focused approach to the review, this would include incorporation of both the clinical and safety science perspectives.
- Apply relevant local/national policy/guidance and best practice in relation to midwifery, maternity, obstetric and anaesthetic care in place at the time of each event.
- Handle data and information with care and in accordance with good information management practice and legislation.
- Consider at all times referral and escalation to other relevant authorities if information is identified that is outside the scope of a safety investigation. This would lead to the review being immediately paused to allow consultation with the relevant authority and consider if further progression can be undertaken. In this situation a report will not be completed.

Appendix 2. Midwifery leadership changes

2018

Month	Position	Comment
July	Chief Nurse (CN)	In post
July	Director of Midwifery / Divisional Nurse Director (DoM / DND)	In post
July	Deputy Medical Director (DMD)	In post
July	General Manager (GM)	In post
July	Head of Midwifery (HoM)	Long term absence Nov 2018 onwards
July	Matron, acute services Queens Hospital Burton (QHB) & Samuel Johnson Hospital (SJH)	Single site role
July	Matron, Royal Derby Hospital (RDH) acute services	In post
July	Matron, community midwifery (Cross site)	Retired
July	Matron, antenatal services (Cross site)	In post
July	Transformation matron (Gynaecology)	In post
July	Clinical governance facilitator (Maternity, gynaecology & genitourinary medicine (GUM))	Retired October 2018
October	Deputy general manager	In post
October / November	Clinical governance facilitator	In post

2019

Month	Position	Comment
February	HoM resigned	Vacant position
April	Deputy HoM 6 months secondment position	HoM post remained vacant

August / September	Matron, acute - seconded Matron, antenatal services – resigned Matron cross site - retired	Matron team reconfiguration
June - September	Re-organisation of matron team. • One cross site intrapartum matron (Labour ward RDH & QHB) • One cross site community midwifery matron (Derby & Burton community midwifery teams and SJH) • One cross site antenatal services matron (QHB antenatal clinic (ANC), maternity assessment unit (MAU) & RDH ANC & pregnancy assessment unit (PAU)) • One cross site inpatient matron (ward 314 RDH, ward 11 QHB) • Gynaecology matron (new position)	
October	Cross site intrapartum matron (labour ward RDH & QHB)	12-month secondment
October	Cross site community midwifery matron (Derby & Burton community midwifery teams and SJH)	
October	Cross site antenatal services matron (QHB ANC, MAU & RDH ANC & PAU)	
October	Cross site inpatient (ward 314 RDH, ward 11 QHB)	Out to advert in September 2019. Interview November 2019.
November	Inpatient matron interviewed & appointed to (external)	
December	Substantive HoM post appointed to	
December	Gynaecology matron appointed	

2020

Month	Position	Comment
April	Inpatient matron commenced	
September	New DoM commenced	Previous DOM retired from post
October	Inpatient matron post substantive position	

2021

Month	Position	Comment
May / June	Clinical governance facilitator position - long term absence	Gaps in governance team. Deputy HoM position created to support HoM to cover governance.
June	Deputy HoM post interviewed & appointed	Change to matron structure
September	Continuity of carer (CoC) lead midwife	Lead CoC matron role also supporting operational on calls and some additional projects.
September	Clinical governance facilitator – retired	
September	Agency cover for clinical governance facilitator position	
October	New post Deputy HoM and lead for risk & governance agreed in division and advertised	December 2021 -Interviewed and appointed to post
December	HoM returned from long term absence (Aug – Dec 2020)	

2022

Month	Position	Comment
March	Deputy HoM (operational – retired & returned)	Agreed for 12 months – 3 days per week
March	HoM retired – substantive post out to advert	HoM post out twice. Not appointed to – job share between two retirees
April	Deputy HoM risk & governance commenced	
June	New Chief Nurse	
September	HoM position secondment commenced	Left 14 October
October	DoM resigned / left	
October – Dec 2022	Current interim arrangement:	Deputy HoM and previously retired DoM covering HoM post in addition to Deputy HoM risk & Governance, CNST & SBL lead role previously retired HoM covering two days Deputy HoM Risk & Governance. Deputy Operation HoM long term absence from October.

2023

Month	Position	Comment
January	New DoM in post	

Appendix 3. Reference list

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Appendix 4. Explanations and definitions of specific terms used in this report

Augmentation of labour	To increase the speed of labour.
Governance	Governance in healthcare is a system in which hospitals are accountable for continuously improving the quality of their services and achieving and maintaining a high standard of care.
Integrated Care Board	The role of an ICB is to allocate money from the government and commission services for their local population.
Intravenous bolus	Intravenous means directly into the vein. Bolus is a single dose of a drug or other substance given over a very short period of time.
Intravenous infusion	Intravenous means directly into the vein. An infusion is a drug or other substance given over a longer period of time.
Patient Safety Incident Response Framework (PSIRF)	The is the NHS approach to responding to patient safety incidents. Its main aim is to involved patients, families and staff in learning and improving safety.
Rostered shift	A shift where a member of staff has been pre-planned to work, often with more than four weeks' notice.
Supernumerary	An extra staff member in addition to the number usually needed.
Thematic	This is one of the most common forms of analysis. It looks at recognising and interpreting patterns.
Working in silos	Working in silos is when different teams or team members in the same trust do not share valuable information with other members of the wider team.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 101

Report Title	Audit & Governance Committee Assurance Report – February 2023							
Author	Sue Sunderland, Non-Executive Member (Audit & Governance)							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Sue Sunderland, Non-Executive Member (Audit & Governance)							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report Signed off by Chair	Sue Sunderland, Non-Executive Member for Audit & Governance							
Which committee has the subject matter been through?	Audit & Governance Committee, 9th February 2023							

Recommendations
The ICB Board are recommended to **NOTE** the Audit & Governance Committee Assurance Report.
Items to escalate to the ICB Board
No matters of concern or key risks to escalate.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Audit & Governance Committee on the 9th February 2023.
Background
The Audit & Governance Committee ensures that the ICB complies with the principles of good governance whilst effectively delivering the statutory functions of the ICB.
Report Summary
The ICB Audit & Governance Committee's Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate; • decisions made; • major actions commissioned or work underway; • positive assurances received; and • comments on the effectiveness of the meeting.

Identification of Key Risks
Any risks highlighted and assigned to the Audit & Governance Committee will be linked to the ICB's Board Assurance Framework and Risk Register.
Has this report considered the financial impact on the ICB or wider Integrated Care System?

Yes ☐	No☐	N/A☒
Details/Findings		**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision making process?
No conflicts of interest were raised.
Project Dependencies
Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable to this report.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable to this report.					

Board Assurance Report

Audit and Governance Committee on 9 February 2023

Matters of concern or key risks to escalate	Decisions made
No matters of concern or key risks to escalate.	1. The following policies were approved: • Risk management policy • Patient and public involvement payment policy • Close personal relationships policy • Flexible working policy • Disclosure & barring policy • Pay progression policy • Probationary policy • Menopause policy (jointly developed across they system) 2. Approved a change to the 2022/23 Internal Audit plan to defer the review of public partnership arrangements and use the resources to support completion of the Transformation & Efficiency review and risk management input 3. Approved the 2022/23 accounting policies 4. Approved changes in risk score (R5) and new risk description (R16) 5. Approved the adverse weather plan for 2023/24
Major actions commissioned or work underway	**Positive assurances received**
1. The process of the development, future monitoring, and reporting arrangements of the Board Assurance Framework (BAF) is ongoing but progressing well. Further work is needed by Committees around the articulation of the controls and sources of assurance. The draft BAF will be reported to the ICB Public Board in March. 2. The procurement highlight report only reports on procurements that are in progress and so does not highlight contracts which are coming towards their end point where procurement has not been started. This gives the Audit Committee an incomplete picture as it fails to highlight those	1. Continued progression of the ICB draft 2022/23 Board assurance framework & risk registers 2. Reviewed and discussed reports which provided assurance that these areas where being appropriately controlled: • Aged receivables, payable credit notes, write offs and losses and special payments • Month 9 quarterly accruals • Single tender waivers • ICB month 9 financial position • Complaints • Freedom of Information

contracts where it is likely that extensions will be needed because re-procurement has not commenced in time. A more complete picture is needed. 3. ICB committee meeting log to be reviewed to clarify it's purpose and whether the level of detail contained enables the Audit & Governance Committee to take any assurances from it.	• Digital and Cyber Security • EPRR and business continuity 3. The development of governance arrangements linked to the joint commissioning of pharmacy, optometry and dental services provided some assurance re progress to date although some elements have yet to be confirmed by NHSE.

Comments on the effectiveness of the meeting

The meetings are well focused and participants are engaged and contribute effectively.

Although this committee does not include any partner non-executives due to the nature of the committee's business. I chair a bi-monthly meeting with the other audit committee chairs to foster relationships and share relevant information and discuss common concerns.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 102

Report Title	Derbyshire Public Partnership Committee Assurance Report – January and February 2023							
Author	Sean Thornton, Deputy Director Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Julian Corner, Non-Executive Member (Population Health and Strategic Commissioning)							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Julian Corner, Non-Executive Member (Population Health and Strategic Commissioning)							
Which committee has the subject matter been through?	Public Partnership Committee, 24th January 2023 and 28th February 2023							

Recommendations
The ICB Board are recommended to **NOTE** the Public Partnership Committee Assurance Report.
Items to escalate to the ICB Board
No matters of concern or key risks to escalate.
Purpose
This report provides the ICB Board with highlights from the formal business meeting of the Public Partnership Committee on the 24th January 2023, and a brief summary of discussions held at the committee's development workshop on 28th February 2023. This report provides a summary of the items transacted for assurance.
Background
The Public Partnership Committee ensures that the ICB effectively delivers the statutory functions of the ICB in relation to patient and public involvement. The committee also seeks, through its terms of reference, to drive citizen engagement in all aspects of the ICB's work to ensure that local people are central to planning and decision-making processes.
Report Summary
The Derbyshire Public Partnership Committee Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate;

- decisions made;
- major actions commissioned or work underway;
- positive assurances received; and
- comments on the effectiveness of the meeting.

Identification of Key Risks
Any risks highlighted and assigned to the Public Partnership Committee will be linked to the ICB's Board Assurance Framework and Risk Register.

Has this report considered the financial impact on the ICB or wider Integrated Care System?		
Yes ☐	No☐	N/A☒
Details/Findings		**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision-making process?
No conflicts of interest were raised.

Project Dependencies

Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☐	Improved patient access and experience	☒
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
None raised as a result of the items reviewed at these meetings. The committee supported the process for the ICB and broader system approach to the Equality & Diversity System, which is a crucial evidence gathering process to demonstrate compliance with the Equality Act and Public Sector Equality Duty.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable to this report.					

Board Assurance Report

Derbyshire Public Partnership Committee on 24th January and 28th February 2023

Matters of concern or key risks to escalate	Decisions made
No matters of concern or key risks to escalate.	Equality & Delivery System The Committee was presented with the proposed self-assessment approach, which was a collective approach across all ICB NHS organisations in Derby and Derbyshire and would provide system wide evidence on EDS Domain 1 – Patients and the Public, with domains 2 and 3 applying to staff. A stakeholder scoring event would take place in March to peer review the self-assessment. The committee felt good progress was being made and supported the approach.
Major actions commissioned or work underway	**Positive assurances received**
Primary Care Legal Duties – clarity had been sought on the specific public engagement legal duties in relation to General Practice. Statutory law does not apply to general practice only NHS Trusts and large statutory hospitals but as commissioners we have a statutory duty to ensure we inform, involve, or consult on any service change, including General Practice. Further Developing the Role of the Public Partnership Committee – the Committee discussed and agreed the: • sub-structure of groups that will support the development of public engagement approaches for assurance at committee level; • business that will come through the committee for decision, assurance and information when the committee is operating at optimum levels and with complete membership; and • role of committee members, given the desire to run with a lay majority.	Risk Management and Board Assurance Framework – 360 Assurance presentation which included a brief focus on some of the Committee's risk management responsibilities, risk tolerances, targets and capacity followed by a feedback discussion on the BAF format. Further discussion took place at the February development session with assurance that existing actions in place against the Board Assurance Framework were sufficient to manage the identified threats. Public Involvement Assessment Forms – the Committee continues to routinely review PPI forms completed at the earliest stages of project development to understand the required and desired level of public involvement. This is a key step in ensuring compliance with legal and moral duties of involvement. Previously known as S14Z2 forms (the reference to the previous section in legislation), the forms are now renamed as the Public Involvement Assessment Form. The log of forms is also shared with our two Health Overview and Scrutiny Committees for transparency and to inform future and mutual agenda setting.
Comments on the effectiveness of the meeting	
The meetings are well focused and participants are engaged and contribute effectively.	

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 103

Report Title	People & Culture Committee Assurance Report – March 2023							
Author	Amanda Rawlings, Chief People Officer							
Sponsor (Executive Director)	Amanda Rawlings, Chief People Officer							
Presenter	Margaret Gildea, Non-Executive Member (People and Culture)							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Margaret Gildea, Non-Executive Member (People and Culture)							
Which committee has the subject matter been through?	People & Culture Committee, 8th March 2023							

Recommendations
The ICB Board are recommended to **NOTE** the People & Culture Committee Assurance Report.
Items to escalate to the ICB Board
At the 8th March 2023 meeting, Committee members discussed the strategic risks for the ICB Board Assurance Framework for People and Culture. Initial risks have been agreed with further work required to refine the mitigations. The Committee reviewed the first stage return on the annual system workforce plan and the challenges to get the final draft triangulated with the activity and finance plans. The Committee welcomed the development of the One Workforce Strategy to commence in Quarter 1 of 2023/24. The Committee received a briefing the Project Derbyshire Digital Work Programme.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the People & Culture Committee on the 8th March 2023.
Background
The People & Culture Committee ensures the effective delivery of the statutory functions of the ICB.

Report Summary
The People & Culture Committee's Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate; • decisions made; • major actions commissioned or work underway; • positive assurances received; and • comments on the effectiveness of the meeting.
Identification of Key Risks
The Committee discussed and agreed the draft Board Assurance Framework risk for People and Culture.
Has this report considered the financial impact on the ICB or wider Integrated Care System?

Yes ☐	No☐	N/A☒
Details/Findings		**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision-making process?
No conflicts of interest were raised.
Project Dependencies
Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?					
Equality, Diversity and Inclusion is a key work programme for the NHS Trusts collaborative work programme with focused targets and actions.					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable to this report.					

Board Assurance Report

People & Culture Committee – 8th March 2023

Matters of concern or key risks to escalate	Decisions made
Development of the annual plan has been and continues to be challenging to pull together. Further work is required to refine the data and position on substantive to temporary staff requirements during 2023/24.	Board Assurance Risks for People and Culture were discussed and agreed with work required on refinement of the mitigations.
Major actions commissioned or work underway	**Positive assurances received**
• System wide Workforce Conference was held on 28th February 2023 bringing together all parts of the Derbyshire system to discuss workforce models and ways of working. Further workshops are planned for the future. • During Quarter 1 of 2023/24, work will commence to develop the ICS One Workforce Strategy. • Launch of the Project Derbyshire - People Services Digital Programme	People Services 7 x 5 work programmes have been populated into the ePMO system that Derbyshire is utilising to support the transformation programmes to capture and monitor progress which will support improved reporting to People and Culture going forward.
Comments on the effectiveness of the meeting	
This report covers the 8th March 2023 People and Culture Meeting. The Committee is now formed and starting to focus on the key people and culture issues across the Integrated Care System for Health and Social Care.	

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 104

Report Title	Quality & Performance Committee Assurance Report – January and February 2023							
Author	Jo Hunter, Director of Quality							
Sponsor (Executive Director)	Brigid Stacey, Chief Nurse Officer and Deputy Chief Executive Officer							
Presenter	Margaret Gildea, Interim Chair of Quality and Performance Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report signed off by	Brigid Stacey, Chief Nurse Officer and Deputy Chief Executive Officer							
Which committee has the subject matter been through?	Quality and Performance Committee, 26th January and 23rd February 2023							

Recommendations
The ICB Board are recommended to **NOTE** the Quality & Performance Committee Assurance Report.
Items to escalate to the ICB Board
1. Following the deep dive in to discharge there was a recommendation from the Committee that Chief Executives discussed the cultural and leadership behaviours, the lessons learnt and accountability. 2. The ICB is currently not compliant with any statutory operational targets relating to the urgent care, planned care and cancer programme.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Quality & Performance Committee on the 26th January and 23rd February 2023.
Background
The Quality & Performance Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
The Quality & Performance Committee's Assurance Report (Appendix 1) highlights to the ICB Board any:

- matters of concern or key risks to escalate;
- decisions made;
- major actions commissioned or work underway;
- positive assurances received; and
- comments on the effectiveness of the meeting.

Identification of Key Risks
Any risks highlighted and assigned to Committee will be linked to the ICB's Board Assurance Framework and Risk Register. The Committee discussed the revised Board Assurance Framework and agreed the additional detail provided in this version at the February meeting.

Has this report considered the financial impact on the ICB or wider Integrated Care System?		
Yes ☐	No☐	N/A☒
Details/Findings		**Has this been signed off by a finance team member?** Not applicable to this report.

Have any conflicts of interest been identified throughout the decision-making process?
No conflicts of interest were raised.

Project Dependencies

Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☐	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
None identified.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?

Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable to this report.					

Board Assurance Report

Quality & Performance Committee – 26th January and 23rd February 2023

Matters of concern or key risks to escalate	Decisions made
1. Following the deep dive in to discharge there was a recommendation from the Committee that Chief Executives discussed the cultural and leadership behaviours, the lessons learnt and accountability. 2. The ICB is currently not compliant with any statutory operational targets relating to the urgent care and planned care & cancer programme. The 2023/24 NHS Operational Plan developed by the Derby and Derbyshire System addresses these issues of underperformance and will be presented to an extraordinary ICB Quality Committee 20/03/23, extraordinary ICB Board 29/03/23 prior to submission on 30/03/23.	The following items were approved by the Group: • Healthcare Safety Investigation Branch, UHDB – to delegate oversight and assurance on the timely and effective delivery of the UHDB improvement plan to LMNS Board on behalf of the Committee; and • Board Assurance Framework (BAF) – revised risks and format agreed in January, with further amendments and approval gained in February.
Major actions commissioned or work underway	**Positive assurances received**
The Committee requested Remedial Action Plans (RAP) for the following: • 31 /62 /128-day cancer waits • CYP Eating Disorders • 78 week waits for electives	• Integrated Quality & Performance Report • Industrial Action Update Report • Healthcare Safety Investigation Branch, UHDB • Deep Dive – Discharge and Outflow • Development of the BAF and Strategic Risk Management • Risk Stratification and Harm Review Update • System Quality Group Assurance Reports
Comments on the effectiveness of the meeting	
Those present agreed that the meetings had been effective, with sufficient opportunity for discussion and that the papers presented were appropriate.	

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 105

Report Title	Population Health & Strategic Commissioning Committee Assurance Report – February and March 2023							
Author	Julian Corner, (Chair) Non-Executive Member (Population Health and Strategic Commissioning and Public Partnerships)							
Sponsor (Executive Director)	Zara Jones, Executive Director of Strategy & Planning							
Presenter	Julian Corner, (Chair) Non-Executive Member (Population Health and Strategic Commissioning and Public Partnerships)							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Julian Corner, (Chair) Non-Executive Member (Population Health and Strategic Commissioning and Public Partnerships)							
Which committee has the subject matter been through?	Population Health & Strategic Commissioning Committee – 9th February 2023 and 9th March 2023							

Recommendations
The ICB Board are recommended to **NOTE** the Population Health & Strategic Commissioning Committee Assurance Report.
Items to escalate to the ICB Board
As detailed within the report.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Population Health & Strategic Commissioning Committee on 9th February 2023 and 9th March 2023.
Background
The Population Health & Strategic Commissioning Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
The Population Health & Strategic Commissioning Committee Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate; • decisions made;

- major actions commissioned or work underway;
- positive assurances received; and
- comments on the effectiveness of the meeting.

Identification of Key Risks

Any risks highlighted and assigned to the Population Health & Strategic Commissioning Committee will be linked to the ICB's Board Assurance Framework and Risk Register.

Has this report considered the financial impact on the ICB or wider Integrated Care System?

Yes ☐	No☐	N/A☒
Details/Findings		**Has this been signed off by a finance team member?** Not applicable to this report.

Have any conflicts of interest been identified throughout the decision-making process?

None identified.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:

Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?

Not applicable to this report.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable to this report.

Board Assurance Report

Population Health & Strategic Commissioning Committee – 9th February and 9th March 2023

Matters of concern or key risks to escalate	Decisions made
Any matters of concern or key risks are to be escalated confidentially.	All decisions made were confidential.
Major actions commissioned or work underway	**Positive assurances received**
None to report	1. Risk Register Reports. 2. Board Assurance Framework. 3. Primary Care Sub-Group Highlight Report. 4. The following items were received for information: • Derbyshire Prescribing Group report/minutes • Clinical & Professional Leadership Group minutes • Derbyshire Joint Area Prescribing Committee Bulletin • CPAG Bulletin
Comments on the effectiveness of the meeting	
The sharing of differing views was welcomed as a positive contribution to ensuring robust discussion and decision making.	

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 106

Report Title	Board Assurance Framework Quarter 4 2022/23							
Author	Helen Dillistone, Executive Director of Corporate Affairs Chrissy Tucker, Director of Corporate Delivery Suzanne Pickering, Head of Governance							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Helen Dillistone, Executive Director of Corporate Affairs							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Quarter 4 2022/23 Board Assurance Framework							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	ICB Committees - February 2023 ICB Board - 19 January 2023							

Recommendations
The ICB Board is asked to: • **APROVE** the Quarter 4 2022/23 Board Assurance Framework; • **AGREE** and sign up to the ICB Board's Risk Appetite Statement contained in the ICB's Risk Management Policy; and • **CONSIDER** if the risk appetite scores are realistic in relation to the ICB being at the beginning of a five-year plan; and that mitigations may be slow to show progress and achievement.
Purpose
The purpose of this report is to present to the Board the Quarter 4 2022/23 Board Assurance Framework.
Background
A fundamental aspect of the ICB's governance structure is the establishment and implementation of sound risk management arrangements. The effective design and embedment of these arrangements will ensure that the Board is kept informed of the key risks facing the ICB and the wider system and is assured that robust processes are in place to manage and mitigate them. At its inaugural meeting on the 1st July 2022, the Board agreed the ICB's opening Board Assurance Framework (BAF). Since then, the Board has held various workshops to develop and define the ICB's strategic risks, in order to develop and populate the full Board Assurance

Framework. The Board approved the strategic risks on the 17th November 2022; these strategic risks were used as the basis for developing the full 2022/23 Board Assurance Framework.

Report Summary

Further to the Board's agreement of the ICB's proposed strategic risks, work has been underway to develop the BAF template design initially, and then with the Executive Officer risk owners and relevant Committees to populate the templates to support the draft Board Assurance Framework (BAF). This has also involved engaging with key system leads and system groups who will have an important role to play to support the management of the strategic risks.

The Derby and Derbyshire ICB Risk Management Policy was approved by Audit and Governance Committee at the meeting held on 9th February 2023. The policy includes the ICB Board Risk Appetite Statement which the ICB Board is asked to agree and sign up to:

NHS Derby and Derbyshire ICB Board Risk Appetite Statement

The Board of NHS Derby and Derbyshire Integrated Care Board (ICB) recognises that long-term sustainability and the ability to improve quality and health outcomes for our population, depends on the achievement of our strategic objectives and that this will involve a willingness to take and accept risks. It may also involve taking risks with our strategic partners in order to ensure successful integration and better health services for the people of Derby and Derbyshire.

The ICB will strive to adopt a ***mature***[1] approach to risk-taking where the long-term benefits could outweigh any short-term losses, particularly when working with strategic partners across the Derby and Derbyshire system. Such risks will be considered in the context of the current environment in line with the ICB's risk tolerance and where assurance is provided that appropriate controls are in place and these are robust and defensible.

The ICB will seek to ***minimise***[2] risks that could impact negatively on the health outcomes and safety of patients or in meeting the legal requirements and statutory obligations of the ICB. We will also seek to ***minimise*** any undue risk of adverse publicity, risk of damage to the ICB's reputation and any risks that may impact on our ability to demonstrate high standards of probity and accountability.

In view of the changing landscape, the ICB's risk appetite will not necessarily remain static. The ICB Board will have the freedom to vary the amount of risk it is prepared to take, depending on the circumstances at the time. It is expected that the levels of risk the ICB is willing to accept are subject to regular review.

Board Assurance Framework Further Development

Following the agreement of the draft Board Assurance Framework at the ICB Board on the 19th January 2023, further work has been undertaken with the Committee Chairs, responsible Executive Officers and Directors to strengthen and finalise the Quarter 4 BAF.

For each strategic risk, a corresponding BAF template has been further developed and finalised. This can be explained as follows:

[1] Good Governance Institute Risk Appetite for NHS Organisations – definition of 'mature' is confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.
[2] Good Governance Institute Risk Appetite for NHS Organisations – definition of 'minimise' is preference for ultra-safe delivery options that have a low degree of inherent risk.

- The committee has agreed an overall assurance level against that risk, highlighted at the top of the template. This is broken down in the actions to treat threats section at the bottom of the template to give a level of assurance relating to the mitigating actions for each threat.
- ICB responsible leads and committee chairs are identified, together with system leads and system groups that will contribute to the assurance and management of the risk.
- Each committee has agreed an initial score and a target score which will remain the same. At each refresh the current score will be updated, reflecting the progress on actions to mitigate the risk. A graph is provided which will provide a visual representation of the movement of the scores over time.
- At the February/March Committee meetings, the committees agreed a risk appetite score, which is the highest score that can be tolerated, which may be higher than, or at the same level as, the target score. The Board are asked to consider if the risk appetite scores are realistic in relation to the ICB being at the beginning of a five year plan; and that mitigations may be slow to show progress and achievement.
- For each threat, the existing controls and sources of assurance are considered, together with any gaps in control and assurance. Quarter 4 final position provides consistency across the strategic risks in relation to the level of detail explanation in the system controls, gaps in control, and system assurances.
- The bottom section of the template provides an action plan to treat any gaps in controls, together with delivery dates. These actions will be updated/renewed during the course of the year.

As a significant amount of detailed information is provided in the strategic risk templates, a summary sheet has been provided at page 1 of Appendix 1 to enable an overview of the current position in terms of the risk scores and owners.

Each responsible Committee reviewed and approved their final quarter 4 strategic risks at the Committee meetings in February and March prior to this report being presented to the ICB Board.

Identification of Key Risks

The strategic risks are defined in the BAF.

Has this report considered the financial impact on the ICB or wider Integrated Care System?

Yes ☒	No☐	N/A☐

Details/Findings	**Has this been signed off by a finance team member?**
The proposed strategic risks describe the system's financial risk: *There is a risk that the NHS in Derby and Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move to a sustainable financial position and achieve best value from the £2.9billion available funding.*	Keith Griffiths, Executive Director of Finance

Have any conflicts of interest been identified throughout the decision-making process?

No conflicts of interest have been identified.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?

There are no implications or risks which affect the ICB's obligations under the Public Sector Equality Duty.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings

The ICB Risk register defines the risk to the achievement of Net Zero Targets and the delivery of the Derbyshire ICS Green Plan.

The key elements of the BAF are:

- A description of each Strategic Risk, that forms the basis of the ICB's risk framework
- Risk ratings – initial, current (residual), tolerable and target levels
- Clear identification of strategic threats and opportunities that are considered likely to increase or reduce the Strategic Risk
- Key elements of the risk treatment strategy identified for each threat and opportunity, each assigned to an executive lead and individually rated by the lead committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate the three lines of defence: (1) **Management** (those responsible for the area reported on); (2) **Risk and compliance** functions (internal but independent of the area reported on); and (3) **Independent assurance** (Internal audit and other external assurance providers)
- Clearly identified gaps in the control framework, with details of planned responses each assigned to a member of the Senior Leadership Team (SLT) with agreed timescales

Key to lead committee assurance ratings:

Green = Assured: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity

- no gaps in assurance or control AND current exposure risk rating = target OR
- gaps in control and assurance are being addressed

Amber = Partially assured: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy

Red = Not assured: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each Strategic Risk and also to identify any further action required to improve the management of those

Risk scoring = Probability x Impact (P x I)

Impact		Probability				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
5	Catastrophic	5	10	15	20	25
4	Major	4	8	12	16	20
3	Moderate	3	6	9	12	15
2	Minor	2	4	6	8	10
1	Negligible	1	2	3	4	5

This BAF includes the following Strategic Risks to the ICB's strategic priorities:

Reference	Strategic risk	Responsible committee	Executive lead	Initial date of assessment	Last reviewed	Target risk score	Previous risk score	Current risk score	Risk appetite risk score	Overall Assurance rating
SR1	There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to delivery consistently safe services with appropriate levels of care,	Quality & Performance	Brigid Stacey	17.11.2022	23.02.2023	10	20	20	12	Partially assured
SR2	There is a risk that short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	Quality & Performance	Brigid Stacey	17.11.2022	23.02.2023	10	20	20	12	Partially assured
SR3	There is a risk that the population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	Public Partnerships Committee	Helen Dillistone	17.11.2022	28.02.2023	9	16	16	12	Partially assured

Reference	Strategic risk	Responsible committee	Executive lead	Initial date of assessment	Last reviewed	Target risk score	Previous risk score	Current risk score	Risk appetite risk score	Overall Assurance rating
SR4	There is a risk that the NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £2.9bn available funding.	Finance & Estates Committee	Keith Griffiths	17.11.2022	02.03.2023	9	16	16	12	Partially assured
SR5	There is a risk that the system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	People & Culture Committee	Amanda Rawlings	17.11.2022	01.03.2023	16	20	20	16	Partially assured
SR6	There is a risk that the system does not create and enable One Workforce to facilitate integrated care.	People & Culture Committee	Amanda Rawlings	17.11.2022	01.03.2023	9	12	12	9	Partially assured
SR7	There is a risk that decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	Population Health & Strategic Commissioning Committee	Zara Jones	17.11.2022	01.03.2023	9	12	12	9	Partially assured
SR8	There is a risk that the system does not: A . establish intelligence and analytical solutions to support effective decision making. B. deliver digital transformation.	Finance & Estates Committee	Jim Austin	17.11.2022	28.02.2023	8	12	12	12	Partially assured
SR9	There is a risk that the gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	Population Health & Strategic Commissioning Committee	Zara Jones	17.11.2022	01.03.2023	12	16	16	12	Partially assured

Strategic Risk SR1 – Quality and Performance Committee

Strategic Aim - To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.	**Committee overall assurance level**	Partially assured	
	ICB Lead: Brigid Stacey, Chief Nurse Officer **ICB Chair** :Margaret Gildea, Interim Chair of Quality & Performance Committee	**System lead:** Brigid Stacey, Chief Nurse Officer, Dr Robyn Dewis **System forum:** System Quality Group	**Date of identification: 17.11.2022** **Date of last review: 23.02.2023**

Strategic risk (what could prevent us achieving this strategic objective)	There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and both upper tier Councils to deliver consistently safe services with appropriate standards of care.	**Risk appetite: target, tolerance and current score**		**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee		**20**	**20**	**10**
		12				

Strategic threats (what might cause this risk to materialise)	**Strategic threats**	**Impact** (what are the impacts of each of the strategic threats)
	1. Lack of timely data to improve healthcare intervention 2. Lack of system ownership and capacity by the Integrated Care Partnership (ICP) and County and City Councils 3. Ineffective Commissioning of services across Derby and Derbyshire	1. No intelligence and data to support the improvement healthcare intervention 2. Lack of clarity of direction and expectations, with all parts of the system identifying their own role in achieving the objectives 3. Inability to deliver safe services and appropriate standards of care across Derbyshire

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – **management, risk and compliance, external)**	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1	• Derbyshire ICS Integrated Quality and Performance Report has been refined and is reported and managed by the System Quality and Performance Committee monthly. These will highlight areas of significant concern. • System Deep Dives provide further assurance at the Quality and Performance Committee. Deep dives are identified where there is lack of performance. • The Integrated Assurance and Performance Report has been developed and is reported to public ICB Board bimonthly. Specific section focuses on Quality. • Health inequalities programme of work supported by the strategic intent function of the ICS, the anchor institution and the plans for data and digital management. This reports to the PHSCC. • Agreed ICB Quality Risk Escalation Policy. • Risk Escalations from System Quality Group to Quality and Performance Committee.	• Intelligence and evidence are required to understand health inequalities, make decisions and review ICS progress. • Plan for data and digital need to be developed further. • Lack of real time data collections. • Requirement for streamlining Data and Digital needs of all Partners (Including LA's). • Finalised and implemented System BAF.	• Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • System Quality Group assurance to the Quality and Performance Committee and ICB Board. • System Quality Group assurance on System risks and ICB Risks. • Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • Agreed ICB Quality Risk escalation Policy. • Risk Escalations from SQG to Q&P. • Quality and Safety Forum provides assurance into the System Quality Group and meets bi-monthly. This provides the detailed sense check of reporting.	• The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. • Consistent escalation reporting across the system to be agreed.

	• Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023. • ICB and ICS Exec Teams in place.			
Threat 2	• Agreed System Quality infrastructure in place across Derbyshire • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023. • Agreed System Quality and Performance Dashboard to include inequality measures • Agreed NHSE Core20PLUS5 Improvement approach to support the reduction of health inequalities. • ICB Board and Derbyshire Trusts approved and committed to the delivery of the Derbyshire ICS Green Plan. • Agreed Derby and Derby City Air Quality Strategy.	• Derbyshire ICS Health Inequalities Strategy has been developed and requires approval form the ICP and ICB Board. • Integrated Care Strategy is currently in development	• Dr Robyn Dewis, Director of Public Health Derby City is the Chair of Health Inequalities Group across the System • Approved Integrated Care Partnership (ICP) Terms of Reference by the ICP and ICB Board. • ICP is now formally meeting in Public from February 2023. • County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Agreed Core20PLUS5 approach across Derbyshire.	• Derbyshire ICS Health Inequalities Strategy has been developed and requires approval from the ICP and ICB Board.
Threat 3	• Derbyshire Cost Improvement Programme (CIP) in progress and Service Benefit Reviews challenge process is in place to support efficiencies. • Agreed Prioritisation tool is in place. • Population Health Strategic Commissioning Committee providing clinical oversight of commissioning and decommissioning decisions. • Robust system QEIA process for commissioning/ decommissioning schemes • Agreed targeted Engagement Strategy – to implement engagement element of Comms & Engagement strategy. • Robust Citizen engagement across Derbyshire and reported through Public Partnerships Committee	• Commissioning to focus on patient cohorts, with measures around services to be put in place to support reduction of inequalities. • Increase Patient Experience feedback and engagement. • CIP programme requires further development. • Integrated Care Strategy is currently in development	• Agreed ICS 5 Year Strategy in place • Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • Population Health Strategic Commissioning Committee assurance to the ICB Board via the Assurance Report. • System Quality Group assurance to the Quality and Performance Committee and ICB Board. • System Quality Group assurance on System risks and ICB Risks • Public Partnerships Committee Public assurance to ICB Board. • NHSE Assurance Reviews and Assurance Letters provide evidence of compliance and any areas of concern.	• Draft 2023/24 Operational Plan in development • Draft Integrated Care Strategy in development with the ICB Board and ICP. • Development of Draft Joint Forward Plan

Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)		
				Has work started?	Committee/ Sub Group assurance	Committee level of assurance
Threat 1 -	• Development of Intelligence and dashboard to evidence Core20PLUS5 principles	Dr Robyn Dewis	Quarter 1 2023/24	Commenced	Population Health and Strategic Commissioning Committee	Partially assured
	• Development of Integrated Care Strategy	Zara Jones	Quarter 1 2023/24	Commenced	ICB Board/ ICP/ PHSCC	Partially assured
Threat 2 -	• Development of a system Health Inequalities strategy as part of the wider Integrated Care Partnership strategy	Dr Robyn Dewis	Quarter 1 2023/24	Commenced	Population Health and Strategic Commissioning Committee	Partially assured
Threat 3 –	• Development of Patient Experience Plan	Letitia Harris	30/06/2023	Commenced	System Quality Group	Partially assured
	• Development of Operational Plan • Development of Joint Forward Plan	Executive Team	Quarter 1 2023/24	Commenced	ICB Board	Partially assured

Strategic Risk SR2 – Quality and Performance Committee

Strategic Aim - To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.	**Committee overall assurance level**	Partially assured	
	ICB Lead: Brigid Stacey, Chief Nurse Officer **ICB Chair:** Margaret Gildea, Interim Chair of Quality & Performance Committee	**System lead:** Brigid Stacey, Chief Nurse Officer, Dr Robyn Dewis **System forum:** System Quality Group	**Date of identification:** 17.11.2022 **Date of last review:** 23.02.2023

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.**	**Risk appetite: target, tolerance and current score**	**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee **12**	**20**	**20**	**10**

Strategic threats (what might cause this risk to materialise)	**Strategic threats**	**Impact** (what are the impacts of each of the strategic threats)
	1. Lack of system ownership and collaboration 2. The ICS short term needs are not clearly determined 3. Lack of coordination across Derbyshire results in health outcomes and life expectancy improvements not being achieved.	1. No intelligence and data to support the improvement healthcare intervention 2. Lack of clarity of direction and expectations, with all parts of the system identifying their own role in achieving the objectives 3. Inability to deliver safe services and appropriate standards of care across Derbyshire

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – **management, risk and compliance, external)**	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1	• ICB and ICS Exec Teams in place • Agreed System Quality infrastructure in place across Derbyshire • System Committees are in place and established since July 2022. • Integrated Care Partnership (ICP) was established in shadow form and met in formally Public from February 2023. • JUCD Transformation Co-ordinating Group in place with responsibility for delivery of transformation plans across system. • Provider Collaborative Leadership Board in place overseeing Delivery Boards and other delivery groups. • System Delivery Boards in place - providing a mechanism to share decisions and challenge actions enhancing transparency and shared understanding of impact. • Agreed System Quality and Performance Dashboard to include inequality measures.	• Intelligence and evidence to understand health inequalities, make decisions and review ICS progress. • In some cases, the 'scope' of System Delivery Board focus is not sufficiently broad enough to tackle the root cause of problems and thus there is an issue that system partners are crowded out from influencing the business of the Board. • Level of maturity of Delivery Boards and PCLB • Level of maturity of the ICP	• Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • System Quality Group assurance to the Quality and Performance Committee and ICB Board. • System Quality Group assurance on System risks and ICB Risks. • Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE • Consistent management reporting across the system to be agreed • NHS Executive Team in place • NHSE Assurance Reviews and Assurance Letters provide evidence of compliance and any areas of concern.	• The Integrated Assurance and Performance Report is in place but will developed further as reported to ICB Board.

Threat 2	• Agreed ICS 5 Year Strategy sets out the short-term priorities • Agreed ICB Strategic Objectives • Draft Integrated Care Strategy in development with the ICB Board and ICP. • Integrated Care Partnership (ICP) was established in shadow form and met in formally Public from February 2023. • System planning & co-ordination group managing overall approach to planning • Agreed Commissioning Intentions in place	• Commissioning to focus on patient cohorts, with measures around services to be put in place to support reduction of inequalities. • Increase Patient Experience feedback and engagement.	• The ICB Board Development Sessions provide dedicated time to agree ICB/ ICS Priorities. • ICB Board agreement of Strategic Objectives	• The draft Integrated Care Strategy in development with the ICB Board and ICP.
Threat 3	• Agreed NHSE Core20PLUS5 Improvement approach to support the reduction of health inequalities • Agreed System Quality & Performance dashboard to include inequality measures • County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Integrated Care Partnership (ICP) was established in shadow form and met in formally Public from February 2023. • Robust Citizen engagement across Derbyshire and reported through Public Partnerships Committee	• Derbyshire ICS Health Inequalities Strategy has been developed and requires approval form the ICP and ICB Board. • Ensuring prevention is embedded in all Care pathways • Alignment between the ICS and the City and County Health and Wellbeing Boards	• County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Public Partnerships Committee Public assurance to ICB Board.	• Derbyshire ICS Health Inequalities Strategy has been developed and requires approval from the ICP and ICB Board.

Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)		
				Has work started?	Committee/ Sub Group assurance	Committee level of assurance
Threat 1 -	Develop the Intelligence and evidence to understand health inequalities	Dr Robyn Dewis	Quarter 1 2023/24	Commenced	Population Health and Strategic Commissioning Committee	Partially assured
Threat 2 -	Develop Patient Experience Plan	Letitia Harris	30/06/2023	Commenced	System Quality Group	Partially assured
Threat 3 –	Development of a system Health Inequalities strategy as part of the wider Integrated Care Partnership strategy	Dr Robyn Dewis	Quarter 1 2023/24	Commenced	Population Health and Strategic Commissioning Committee	Partially assured

Strategic Risk SR3 – Public Partnerships Committee

Strategic Aim - To improve overall health outcomes including life expectancy and healthy life expectancy rates for people (adults and children) living in Derby and Derbyshire.	**Committee overall assurance level**	Partially assured			
	ICB Lead: Helen Dillistone, Executive Director of Corporate Affairs **ICB Chair:** Julian Corner, Chair of Public Partnerships Committee	**System lead: Helen Dillistone,** Executive Director of Corporate Affairs **System forum:** Public Partnerships Committee	**Date of identification: 17.11.2022** **Date of last review: 28.02.2023**		
Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.**	**Risk appetite: target, tolerance and current score**		**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee **12**		**16**	**16**	**9**

Strategic threats (what might cause this risk to materialise)	**Strategic threats**	**Impact** (what are the impacts of each of the strategic threats)
	1. The public are not being engaged and included in the strategy development and early planning stage of service development therefore the system will not be able to suitably reflect the public's view and benefit from their experience in its planning and prioritisation. 2. Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised. 3. The complexity of change required, and the speed of transformation required leads to patients and public being engaged too late in the planning stage, or not at all leading to legal challenge where due process is not being appropriately followed. 4. The communications and engagement team are not sufficiently resourced to be able to engage with the public and local communities in a meaningful way.	1. Potential legal challenge through variance/lack of process. 2. Failure to secure stakeholder support for proposals. 3. inability to deliver the volume of engagement work required; risk of transformation delay due to legal challenge; reputational damage and subsequent loss of trust among key stakeholders. 4. Services do not meet the needs of patients, preventing them from being value for money and effective.

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – **management, risk and compliance, external)**	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1	• Agreed system Communications & Engagement Strategy. • Agreed targeted Engagement Strategy – to implement engagement element of C&E strategy. • Agreed Guide to Public Involvement, now being rolled out to ICB and then broader system. • Public Partnership Committee now established and identifying role in assurance of softer community and stakeholder engagement. • Communications and Engagement Team leaders are linked with the emerging system	• Analysis of insight in relation to stated system priorities required, to inform further targeted engagement work. • Require engagement team involvement in NHS planning development. • All aspects of the Engagement Strategy need to be developed and implemented. This includes the Insight Framework, Co-production Framework and Evaluation Framework. The Governance Framework also needs further development. • Once Insight Framework proof of concept work is up and running, establish how we make better use of insight in the system. Collect it, collate it, analyse and interpret it, and put it in a format that the	• Senior managers have membership of IC Strategy Working Group to influence • Comprehensive legal duties training programme for engagement professionals • Public Partnership Committee assurance to ICB Board • Public Partnership Committee Assurance to ICB Board on identified risks • ePMO gateway structure ensures compliance with PPI process • NOF evidence, self-assessment and submission (tbc) • Benchmarking against comparator ICS approaches.	• Analysis of insight in relation to stated system priorities required, to inform further targeted engagement work. • Further work is needed with providers to embed the guide to PPI, especially around system transformation programmes. • Assurance on skills relating to cultural engagement and communication across all JUCD partners

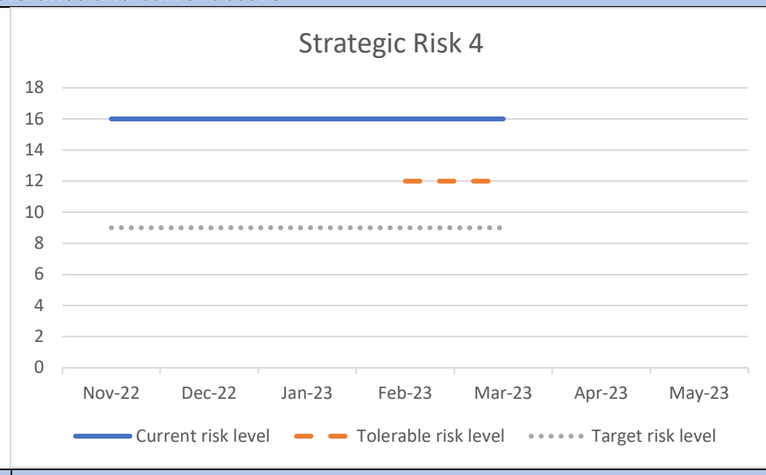
Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – **management, risk and compliance, external)**	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
	strategic approach, including the development of place alliances. • Insight summarisation is informing the priorities within the strategy. • Insight Framework has been developed and its implementation will ensure that we have insight around what matters to people to feed into future strategic priorities. Proof of Concept Project starting in New Year. • Agreed gateway for PPI form on the ePMO system.	system can use to ensure public participation is informing decision making. • Further work is needed with providers to embed the guide to PPI, especially around system transformation programmes. • Assurance on skills relating to cultural engagement and communication across all JUCD partners		
Threat 2	• Agreed system Communications & Engagement Strategy, with ambitions on stakeholder relationship management. • Membership of key strategic groups, including Executive Team, Delivery Board, Senior Leadership Team and others to ensure detailed understanding of progression. • Functional and well-established system communications and engagement group	• Development of system stakeholder communication methodologies understand and maintain/improve relationships and maximise reach • Systematic change programme approach to system development and transformation not yet articulated/live. • Staff awareness of work of ICS and ICB programme, to enable to recruitment of advocates for the work • Behaviour change approach requires development to support health management and service navigation. Proposal required for UECC Delivery Board and other areas to develop this, requiring resource.	• NHS/ICS ET membership and ability/requirement to provide updates • ePMO progression • Public Partnership Committee Assurance to ICB Board on identified risks • ePMO gateway structure ensures compliance with PPI process • Benchmarking against comparator ICS approaches	• NOF evidence, self-assessment and submission (tbc)
Threat 2	• Agreed system Communications & Engagement Strategy. • Agreed Guide to Public Involvement, now being rolled out to ICB and then broader system. • Public Partnership Committee now established and identifying role in • assurance of softer community and stakeholder engagement. • ePMO gateway process includes engagement assessment check • Training programme underway with managers on PPI governance requirements and process	• Clear roll out timescale for transformation programmes	• Comprehensive legal duties training programme for engagement professionals • PPI Governance Guide training for project/programme managers • Public Partnership Committee assurance to ICB Board • ePMO progression • Public Partnership Committee Assurance to ICB Board on identified risks • ePMO gateway structure ensures compliance with PPI process	• NOF evidence, self-assessment and submission (tbc)
Threat 4	• Detailed work programme for the engagement team • Clearly allocated portfolio leads across team to share programmes • Distributed leadership across system communications professionals supports workload identification and delivery.	• Clear roll out timescale for transformation programmes to enable resource assessment • Quantification of required capacity challenging • Delivery of Communications & Engagement Strategy infrastructure work requires completion and is competing factor	• Wrike Planning Tool • Risk/threat monitored by Public Partnership Committee	• Benchmarking against comparator ICS approaches

Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)		
				Has work started?	Committee/ Sub Group assurance	Committee level of assurance
Threat 1	• Secure attendance in NHS Joint Forward Plan development group. • Ongoing implementation of Engagement Strategy frameworks • Ongoing implementation of Insight Framework approach • Programme of work to roll out PPI Guide with system partners, including general practice • Assess current team skills in cultural engagement and communications, including channel assessment, and devise action plan to close gaps/implement training and development.	Sean Thornton Karen Lloyd Karen Lloyd Karen Lloyd Sean Thornton	31 Jmarch 2023 31 March 2023+ 31 March 2023+ 31 March 2023+ 31 March 2023	Commenced Commenced Commenced Commenced Commenced	JFP Development Group PPC PPC PPC Communications and Engagement Team	Partially assured Partially assured Partially assured Partially assured Partially assured
Threat 2	• Delivery of Communications and Engagement Strategy Stakeholder chapter to scope processes on relationship managing and stakeholder perceptions, resulting in business case. • Meet with ePMO colleagues to understand change model approach to system transformation, including financial context for 23/24. • Delivery of Communications and Engagement Strategy Internal Communications chapter to create platform for engagement with ICB and system staff, building on existing mechanisms. • Develop proposal and business case for UEC behaviour/insight programme following social marketing principles.	Andy Kemp Sean Thornton David Lilley-Brown Donna Broughton	31 March 2023 31 March 2023 31 March 2023 31 March 2023	Commenced Commenced Commenced Commenced	PPC Communications and Engagement Team Communications and Engagement Team Communications and Engagement Team	Partially assured Partially assured Partially assured Partially assured
Threat 3	• Allied to ePMO programme review, implement scoping exercise across system/ICB delivery boards and other groups to establish baseline of work • Programme of work to roll out PPI Guide with system partners, including general practice	Sean Thornton Karen Lloyd	31 March 2023 31 March 2023+	Commenced Commenced	Communications and Engagement Team PPC	Partially assured
Threat 4	• Allied to ePMO programme review, implement scoping exercise across system/ICB delivery boards and other groups to establish baseline of work • Confer with regional ICB leads on appetite for potential benchmarking approach to understand approaches, team roles, capacity. • Implement remaining elements of Communications and Engagement Strategy chapters	Sean Thornton Sean Thornton Sean Thornton & team	31 March 2023 31 March 2023 31 March 2023	Commenced Commenced Commenced	Communications and Engagement Team Communications and Engagement Team PPC	Partially assured Partially assured Partially assured

Strategic Risk SR4 – Finance and Estates Committee

Strategic Aim - To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	Partial Assurance	
	ICB Lead: Keith Griffiths, Chief Finance Officer **ICB Chair:** Richard Wright, Finance and Estates Committee Chair	**System lead:** Keith Griffiths, Chief Finance Officer **System forum:** Finance and Estates Committee	**Date of identification: 17.11.22** **Date of last review: 02.03.2023**

Strategic risk (What could prevent us achieving this strategic objective)	**There is a risk that the NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £2.9bn available funding.**	**Risk appetite: target, tolerance and current score**	**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee **12**	**16**	**16**	**9**



Strategic threats (What might cause this risk to materialise)	**Strategic threats**	**Impact** (what are the impacts of each of the strategic threats)
	1. Rising activity needs, capacity issues, and availability and cost of workforce 2. Shortage of out of hospital provision across health and care impacts on productivity levels 3. The scale of the challenge means break even can only be achieved by structural change and real transformation. failure to deliver against plan and/or to transform services 4. National funding model does not reflect clinical demand and operational / workforce pressures	1. Unable to meet financial plan / return to sustainable financial position. Severe cash flow issues and additional cost of borrowing 2. Increasing bed occupancy to above safe levels and poor flow in/out of hospital 3. Provider performance levels drop and costs increase 4. Any material shortfall in funding means even with efficiency and transformation and structural change there could still be a gap to breakeven, whilst also preventing any investment in reducing health inequalities and improving population health

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – **management, risk and compliance, external)**
Threat 1	• Given the scale of the challenge there is no single control that can be put in place to totally mitigate this risk now. • Detailed triangulation of activity, workforce and finances in place • Provider Collaborative overseeing 'performance' and transformation programmes to deliver improvement in productivity	• New Workforce and Clinical Models Plan. • Triangulated activity, workforce, and financial plan. • Do not understand the low productivity to address the clinical workforce modelling. • Benchmark against pre Covid data and activity as a starting point to get to sustainable levels. • Do not have the management processes in place to deliver the plans and level of productivity / efficiency required. • The integrated assurance and performance report needs to be developed further to triangulate areas of activity, workforce, and finance.	• Financial data and information is trusted but needs further work to translate into a sustainable plan. Workforce planning is in its infancy and improving but is not yet robust enough to be fully triangulated with demand, capacity, and financial plans. • Five-year financial plan has been prepared to accelerate and influence change. • Operational Plan and strategic plan being agreed at Board level. • Integrated Assurance and Performance Report.
Threat 2	• Not aware of effective controls now, and the solution requires integrated changes across social care and the NHS • Collaborative escalation arrangements in place across health and care to ensure maximum cover out of hospital and flow in hospital is improved. • Programme delivery boards for urgent and elective care review	• National shortage in supply of out of hospital beds and services for medically fit for discharge patients prevents full mitigation. • New Workforce strategy and Clinical Model required, alongside clear priorities for improving population health. • Triangulated activity, workforce, and financial plan.	• Integrated assurance and performance report and tactical responses agreed at Board level. Assurances for permanent, long-term resolution not available. • National productivity assessment tool now available to assist all systems across the country, which will be used to influence 23/24 planning and delivery.

		• Do not fully understand the low productivity levels and the opportunities to improve via the clinical workforce. • Benchmark against pre Covid data and activity as a starting point to get to sustainable levels.	
Threat 3	• The CIP and Transformation Programme is not owned by leads, managed, implemented, and reported on for Finance to build into the system financial plan. • EPMO system has been established and is led by Transformation Director. • EPMO has list of efficiency projects only that are not developed to a level where the financial impact can be assured. • Long term national funding levels are insufficient and uncertain, meaning despite radical improvements in efficiency and structural, transformational change, a financial gap to breakeven will remain.	• Need to embed and cascade ICB savings target / CIP plan – staff at all levels to understand imperative and role in identification of savings / innovation. • Ownership of system resources held appropriately. • The EPMO System is not fully developed, owned, and managed to make the savings required. • Programme delivery boards need to refocus on delivering cash savings as well as pathway change. • The provider collaborative needs to drive speed and scope through the programme delivery boards	• Reconciliation of financial ledger to EPMO System. • SLT monthly finance updates provided – including recalibration of programme in response to emerging issues. • Finance and Estates Committee oversight. • Weekly system wide FD meetings focussed on long term financial stability, with real evidence of effective distributive leadership and collegiate decision making.
Threat 4	• National political uncertainty alongside national economic and cost of living crisis means long term, stable and adequate financial allocations are unlikely to emerge in the short to medium term.	• No assurance can be given	• All opportunities to secure resources are being maximised, alongside which a strong track record of delivery within existing envelopes is being maintained. This should give assurance regionally and nationally. • Executive and non-executive influencing of regional and national colleagues needs to strengthen, and a positive, inspiring culture maintained across the local health and care system.

Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (e.g., assured, partially assured, not assured)
Threat 1 -	• Development of Triangulated Demand, Workforce and Financial plan • Benchmark exercise and Report against pre covid levels of activity • Develop management processes to deliver plans and level of productivity required • Further development of integrated assurance and performance report	Zara Jones, Amanda Rawlings, Keith Griffiths Executive Team Executive Team	Awaiting national guidance Estimated 31/03/2023	Partial assurance given the transparency and debate at Board level, recognising the socio-economic environment the health and care sectors are currently navigating and the scale of the tasks that lie ahead – both operationally and culturally
Threat 2 -	• Development of new Workforce and Clinical Models Plan • Development of Triangulated Demand, Workforce and Financial plan • Benchmark exercise and report against pre covid levels of activity	Amanda Rawlings/ Chris Weiner Executive Team Executive Team	End Quarter 3 2023/24	Partial assurance given the transparency and debate at board level, recognising the socio-economic environment the health and care sectors are currently navigating and the scale of the tasks that lie ahead – both operationally and culturally
Threat 3 –	• Develop and embed EPMO System • CIP Engagement Plan being implemented	Tamsin Hooton	End April 2023	Partial assurance through evidence of improving reporting and accountability, although real delivery is yet to be seen
Threat 4 -	• National Allocations unclear	Executive Directors / NEMs	On Going	Not Assured

Strategic Risk SR5 – People and Culture Committee

Strategic Aim - To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	Partially assured	
	ICB Lead: Amanda Rawlings, Chief People Officer **ICB Chair:** Margaret Gildea, Chair of People and Culture Committee	**System lead:** Amanda Rawlings, Chief People Officer **System forum:** People and Culture Committee	**Date of identification:** 17.11.2022 **Date of last review:** 01.03.2023

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.**	**Risk appetite: target, tolerance and current score**	**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee **16**	**20**	**20**	**16**

Strategic threats (what might cause this risk to materialise)	**Strategic threats**	**Impact** (what are the impacts of each of the strategic threats)
	1. Lack of system alignment between activity, people and financial plans 2. Staff resilience and wellbeing is negatively impacted by environmental factors eg the industrial relations climate and the financial challenges in the system 3. Employers in the care sector cannot attract and retain sufficient numbers of staff to enable optimal flow of service users through the pathways and the scale of vacancies across health and care and some specific professions	1. There is an under supply of people to meet the activity planned and the funding available 2. Increased sickness absence, deterioration in relationships and higher turnover particularly people retiring early leading to gaps in the staffing required to deliver services 3. People are going to better paid jobs in other sectors which means that patients cannot be discharged from hospital due to lack of care packages causing long waiting times in the Emergency pathways, poorer quality of care

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – **management, risk and compliance, external)**	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1	• An Integrated planning approach has been agreed across the system covering finance activity and workforce. • Agreed System level SRO for Workforce Planning supported by Workforce Strategy and Planning Assistant Director • The System People and Culture Committee provides oversight of workforce across the system • The Workforce Advisory Group brings together all component part to discuss workforce and planning and system engagement of the plan. • People Services Collaborative Delivery Board has oversight of operational issues	• There is not an agreed integrated planning tool or system across all partners due to affordability. • The Primary Care workforce plans are not aligned with other system plans.	• Monthly monitoring of workforce numbers and temporary staffing spend vs budget and agency spend. • Approved System One Workforce Strategy and Workforce plan • Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • The Workforce Advisory Group brings together all component part to discuss workforce and planning and system engagement of the plan. • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce.	• The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. • Consistent escalation reporting across the system to be agreed.
Threat 2	• A Comprehensive staff wellbeing offer is in place and available to Derbyshire ICS Employees • Engagement and Annual staff opinion surveys are undertaken across the Derbyshire Providers and ICB • The System People and Culture Committee provides oversight of workforce across the system	• Funding for wellbeing offer is not recurrent • Staff opinion surveys are not carried out across the Primary Care sector. • The Leadership Development offer is not yet fully embedded in each organisation.	• Monthly monitoring of absence and turnover • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce. • System Wellbeing Group provides performance information to the People Services Collaborative Delivery Board.	• The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. • Despite measures being in place the situation is deteriorating in terms of staff health and being due to a range of factors.

	• The Workforce Advisory Group brings together all component part to discuss workforce and planning and system engagement of the plan • People Services Collaborative Delivery Board has oversight of operational issues • Enhanced Leadership Development offer to support Managers and promoting Health and Wellbeing.					
Threat 3	• Promotion of social care roles as part of Joined Up careers programme • The System People and Culture Committee provides oversight of workforce across the system • Integrated Care Partnership (ICP) was established in shadow form and now meets in Public from February 2023 onwards	• More work required to understand how the NHS can provide more support to care sector employers • Lack of Workforce representation on the ICP. • Insufficient connection with People and Culture and the ICP		• Monthly monitoring of vacancies via Skills for Care data • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce. • Approved Integrated Care Partnership (ICP) Terms of Reference by the ICP and ICB Board. • County and City Health and Wellbeing Boards support the delivery of the Health Inequalities Strategy and Plan. • Better Care funding supports the Joined Up Careers team to work in partnership with Health and Social Care.	• The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. • Insufficient connection with People and Culture and the ICP	
Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)		
				Has work started?	Committee/ Sub Group assurance	Committee level of assurance
Threat 1	Refresh of 22/23 workforce plan Design approach for 23/24 plan, agree common assumptions and ensure plan is workforce and activity lead.	Sukhi Mahil	Quarter 1 2023/24	Commenced	TBC 8.3.23	TBC 8.3.23
Threat 2	Continue to spread and embed well-being offer Review Occupational Health Services to ensure they are focused on promoting health and wellbeing	Nicola Bullen	Review 31.03.23 Quarter 1 2023/24	Commenced	TBC 8.3.23	TBC 8.3.23
Threat 3	Continue to develop system wide recruitment campaigns to meet demand for health and care across Derbyshire	Susan Spray	System Recruitment campaigns planned until 31.12.23	Commenced	TBC 8.3.23	TBC 8.3.23

Strategic Risk SR6 – People and Culture Committee

Strategic Aim - To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	Partially assured	
	ICB Lead: Amanda Rawlings, Chief People Officer **ICB Chair:** Margaret Gildea, Chair of People and Culture Committee	**System lead: :** Amanda Rawlings, Chief People Officer **System forum:** People and Culture Committee	**Date of identification: 17.11.2022** **Date of last review:** 01.03.2023

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the system does not create and enable One Workforce to facilitate integrated care.**	**Risk appetite: target, tolerance and current score**	**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee **9**	**12**	**12**	**9**

Strategic threats (what might cause this risk to materialise)	**Strategic threats**	**Impact** (what are the impacts of each of the strategic threats)
	1. There is not an agreed definition of what "One Workforce" means 2. There is insufficient funding to undertake skills and cultural development needed to support integration 3. Lack of system ownership and commitment to 'One Workforce'	1. System partners are not aligned in workforce development and integration 2. It is more challenging to transition from current ways of working to a more integrated approach 3. The system is not integrated on the Workforce Strategy and workforce development

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – **management, risk and compliance, external)**	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1	• Work is underway to develop a One Workforce Strategy and plan aligned to a developing Integrated Care Strategy involving all system partners • The Draft Integrated Care Strategy is in development by the ICB Board and ICP • The System People and Culture Committee provides oversight of workforce across the system • The Workforce Advisory Group brings together all component part to discuss workforce and planning and system engagement of the plan. • People Services Collaborative Delivery Board has oversight of operational issues • Agreed People Services Collaborative Programme	• Development and implementation of the One Workforce Strategy will be overseen by the HRD's Delivery Group and assurance given to the PCC	• Monthly monitoring of workforce numbers and temporary staffing spend vs budget and agency spend. • Approved System Workforce Strategy and implementation plan • Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • The Workforce Advisory Group provides assurance to the System People and Culture Committee • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce. • The Workforce Advisory Group brings together all component part to discuss workforce and planning and system engagement of the plan.	• The Draft Integrated Care Strategy is in development by the ICB Board and ICP • The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board.
Threat 2	• A system wide training needs analysis is to be carried out so that learning and development needs can be identified and prioritised for investment	• Agreement needed that any education and training funding will be invested in accordance with the priorities identified.	• The outcome of the training needs analysis and decisions on investment of education and training funding will be overseen by the HRD's Delivery Group.	• The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. • Consistent escalation reporting across the system to be agreed.

	• The System People and Culture Committee provides oversight of workforce triangulation across the system • The Workforce Advisory Group provides the operational issues across the system • People Services Collaborative Delivery Board has oversight of operational issues • The System People and Culture Committee provides oversight of workforce triangulation across the system • The Workforce Advisory Group provides the operational issues across the system		• Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • The Workforce Advisory Group brings together all component part to discuss workforce and planning and system engagement of the plan. • People and Culture Committee assurance to the Board via the ICB Board Assurance Report and Integrated Assurance and Performance Report which includes workforce.	
Threat 3	• The Workforce Advisory Group provides the operational issues across the system • The Workforce Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board • Work is underway to develop a One Workforce Strategy and plan aligned to a developing Integrated Care Strategy involving all system partners	• Development and implementation of the One Workforce Strategy will be overseen by the HRD's Delivery Group and assurance given to the PCC	• Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE. • The Workforce Advisory Group provides assurance to the System People and Culture Committee • People and Culture Committee assurance to the Board via the ICB Board Integrated Assurance Report and Integrated Assurance and Performance Report which includes workforce.	• Work is underway to develop a One Workforce Strategy and plan aligned to a developing Integrated Care Strategy involving all system partners • The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. • Consistent escalation reporting across the system to be agreed.

Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)		
				Has work started?	Committee/ Sub Group assurance	Committee level of assurance
Threat 1 -	Develop One Workforce Strategy	Sukhi Mahil	Initial draft by 30.4.23	Commenced	TBC 8.3.23	TBC 8.3.23
Threat 2 -	System Wide TNA process to be developed and implemented	Faith Sango	Quarter 1 2023/24	Commenced	TBC 8.3.23	TBC 8.3.23
Threat 3 –	Develop One Workforce Strategy	Sukhi Mahil	Initial draft by 31.03.23	Commenced	TBC 8.3.23	TBC 8.3.23

Strategic Risk SR7 – Population Health and Strategic Commissioning Committee

Strategic Aim - To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	Partially assured	
	ICB Lead: Zara Jones, Executive Director of Strategy and Planning **ICB Chair:** Julian Corner, Chair of PHSCC	**System lead:** Zara Jones, Executive Director of Strategy and Planning **System forum:** Population Health and Strategic Commissioning Committee	**Date of identification:** 17.11.2022 **Date of last review:** 01.03.2023

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.**	**Risk appetite: target, tolerance and current score**	**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee **9**	**12**	**12**	**9**

Strategic threats (what might cause this risk to materialise)	**Strategic threats**	**Impact** (what are the impacts of each of the strategic threats)
	1. Lack of joint understanding of strategic aims and requirements of all system partners. 2. Demand on organisations due to system pressures/restoration may impact ability to focus on strategic aims. 3. Time for system to move more significantly into "system think". 4. Statutory requirements on individual organisations may conflict with system aims.	1. System partners interpret aims differently resulting in reduced focus or lack of co-ordination. 2. System partners may be required to prioritise their own organisational response ahead of strategic aims. 3. If the system does not think and act as one system, support is less likely to be there to achieve strategic aims. 4. Individual boards to take decisions which are against system aims.

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – **management, risk and compliance, external)**	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1	• Strategic objectives agreed at ICB Board; dissemination will occur via Board members who represent system partners. • ICB and ICS Exec Teams in place • JUCD Transformation Co-ordinating Group in place with responsibility for delivery of transformation plans across system. • System Delivery Boards in place - providing a mechanism to share decisions and challenge actions enhancing transparency and shared understanding of impact • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis • Delivery Boards engagement with JUCD Transformation Board. • Provider Collaborative Leadership Board in place overseeing Delivery Boards and other delivery groups. • System planning & co-ordination group managing overall approach to planning	• Lack of a systematic approach/framework to guide the prioritisation of allocating resources to advance population health. • In some cases, the 'scope' of System Delivery Board focus is not sufficiently broad enough to tackle the root cause of problems and thus there is an issue that system partners are crowded out from influencing the business of the Board. • Level of maturity of Delivery Boards • Values based approach to creating shared vision and strong relationships across partners in line with population needs • Potential lack of clarity until the roles and responsibilities of new structures fully embed. • Potential gap from 01/04/23: the GP Provider Board is only funded until 31/03/23. Without the GPPB there would be a gap in the development, dissemination and co-ordination of response to strategic objectives. • Potential structural gap in that General Practice largely works to a nationally set contract which may not always totally align with locally set strategy	• Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE • PHSCC assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • Audit and Governance committee oversight and scrutiny • BAFs • Internal and external audit of plans • HOSC • ICB Strategic objectives and strategic risks • System Delivery Board agendas and minutes • Provider Collaborative Leadership Board minutes • Health and Well Being Board minutes • ICB Scheme of Reservation and Delegation • Agreed process for establishing and monitoring financial and operational benefits • GPPB proposal for future operating model and funding planned for ICB Board discussion in April 23.	• The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. • Consistent management reporting across the system to be agreed • Implement routine mechanism for shared reporting of risks and risk management across the system • Draft 2023/24 Operational Plan in development • Draft Integrated Care Strategy in development with the ICB Board and ICP. • Development of Draft Joint Forward Plan

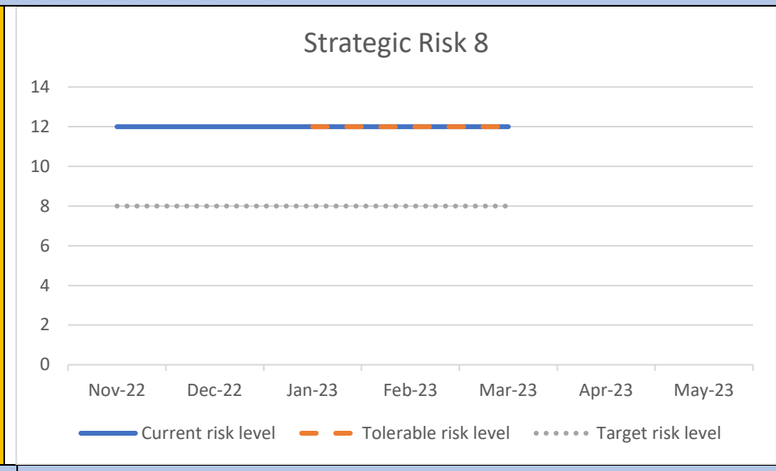
	• Formal risk sharing arrangements in place across organisations (via Section 75s/ Pooled Budgets) • HOSCs/ Health and Wellbeing Boards are in place with an active scrutinising role • Dispute resolution protocols jointly agreed in key areas e.g. CYP joint funded packages – reducing disputes • Currently the system part funds the GP Provider Board (GPPB) which provides a collective voice for GP practices in the system at a strategic and operational level • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023.	• No agreed process to measure system understanding and implementation of strategic aims. • Process to ensure consistent approach is adopted to share outputs from ICS and ICB Exec team meetings. • Lack of process to measure impact of agreed actions across the system. • System PMO not in place. • Scoping, baselining, strategic overview, and solution choice to be carried out to ensure right solution is adopted to fit the business problem • Understand impact of changes, how they support operational models, how best value can be delivered, and prioritised. • Further development of the strategy to bring greater efficiencies to staff and patients • Establish a robust governance structure to programme, agree and prioritise change with operational leadership		
Threat 2	• **As above and:** • System performance reports received at Quality & Performance Committee will highlight areas of concern. • ICB involvement in NOF process and oversight arrangements with NHSE. • As above – GPPB and LMC both provide some resourced 'headspace' giving GP leaders time and opportunity to focus on strategic aims. • PCN funding gives GP Clinical Directors some time to focus on the development of their Primary Care Networks • System Planning and Co-ordination Group ensuring strategic focus alongside operational planning	• Prolonged operational pressures ahead of winter and expected pressures to continue / increase. • Individual GP practices have little time or incentive to participate in delivering the strategic aims of the system unless they are aligned with the national contract or are specifically locally commissioned. • Inconsistent planning and performance management systems in place across the system • Implement routine mechanism for shared reporting of risks and risk management across the system • Level of maturity of Delivery Boards	• NHSEI oversight and reporting • Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • System Quality Group assurance to the Quality and Performance Committee and ICB Board. • System Quality and Performance Report • Monthly reports provided to ICB/ ICS Executive Team/ ICB Board and NHSE • Measurement of relationship in the system: embedding culture of partnership across partners • Coproduction • Workforce resilience • Demand in the system • Audit and Governance Committee oversight and scrutiny • BAFs	• The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. • Consistent management reporting across the system to be agreed • Draft 2023/24 Operational Plan in development • Draft Integrated Care Strategy in development with the ICB Board and ICP. • Development of Draft Joint Forward Plan
Threat 3	• SOC/ICC processes – ICCs supporting ICB to collate and submit information • As above – GPPB and LMC both provide some resourced 'headspace' giving GP leaders time to focus on system working • Development and delivery of Integrated Care System Strategy • Embedded Place Based approaches that focus partners together around community / population aims not sovereign priorities	• As above, extent of operational pressures and time required to focus on reactive management. • Individual practices may not see system working as a priority unless it delivers the requirements of their national contract • Routine reporting not yet in place that is recognised by the system to enact real time change management. • Recruitment of workforce not complete – lack of resilience. • Lack of real time data collection. • Embed reporting • Complete recruitment of staff for posts	• Daily reporting of performance and breach analysis – identification of learning or areas for improvement • Measurement of relationship in the system: embedding culture of partnership across partners • Resilience of OCC in operational delivery including clinical leadership • Coproduction • Workforce resilience • Demand in the system • NHSE oversight and daily reporting	• The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. • Draft 2023/24 Operational Plan in development • Draft Integrated Care Strategy in development with the ICB Board and ICP. • Development of Draft Joint Forward Plan

Threat 4	• Strategic objectives agreed at ICB Board; dissemination will occur via Board members who represent system partners. • ICB and ICS Exec Teams in place • JUCD Transformation Co-ordinating Group in place with responsibility for delivery of transformation plans across system. • System Delivery Boards in place - providing a mechanism to share decisions and challenge actions enhancing transparency and shared understanding of impact • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis • Delivery Boards engagement with JUCD Transformation Board. • Provider Collaborative Leadership Board in place overseeing Delivery Boards and other delivery groups. • GPPB and LMC both provide some resourced 'headspace' giving GP leaders time and opportunity to focus on strategic aims. • PCN funding gives GP Clinical Directors some time to focus on the development of their Primary Care Networks • System Planning and Co-ordination Group ensuring strategic focus alongside operational planning	• Process to ensure consistent approach is adopted to share outputs from ICS and ICB Exec team meetings. • Lack of process to measure impact of agreed actions across the system. • Prolonged operational pressures ahead of winter and expected pressures to continue / increase. • Individual GP practices have little time or incentive to participate in delivering the strategic aims of the system unless they are aligned with the national contract or are specifically locally commissioned. • Inconsistent planning and performance management systems in place across the system. • Level of maturity of Delivery Boards • System Oversight of Individual boards decisions which may be against system aims.	• Monthly reporting provided to ICB/ ICS Executive Team/ ICB Board and NHSE • Audit and Governance committee oversight and scrutiny • ICB Strategic objectives and strategic risks • System Delivery Board agendas and minutes • Provider Collaborative Leadership Board minutes • Health and Well Being Board minutes • Measurement of relationship in the system: embedding culture of partnership across partners • Coproduction • Draft Integrated Care Strategy • JUCD Operational Plan	• Draft 2023/24 Operational Plan in development • Draft Integrated Care Strategy in development with the ICB Board and ICP. • Development of Draft Joint Forward Plan		

Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)		
				Has work started?	Committee/ Sub Group assurance	Committee level of assurance
Threat 1	Agree long term plan for resourcing GPPB Produce and embed the use of a universal prioritisation framework to guide resource allocation decisions. Complete 23/24 planning round and deliver robust system plan	GPPB/ CN ZJ ZJ	Quarter 1 2023/24 Quarter 1 2023/24 Quarter 1 2023/24	Commenced Commenced Commenced	Primary Care Sub Group/GPPB PHSCC PHSCC	Partially assured Partially assured Partially assured
Threat 2	Surge planning process established / all year-round planning approach – this does not prevent operational pressures but helps to predict and plan better the response	UECC Board / UECC SRO / ZJ	End Q1 2023/24	Commenced	UECC Board	Partially assured
Threat 3	Prioritisation process agreed in the system to better manage our time and use of resource	ICB / ICP	Quarter 1 2023/24	Commenced	PHSCC	Partially assured
Threat 4	Development of log System Board decisions Establishment System ICB Board Meetings	HD HD	Quarter 1 2023/24 Quarter 1 2023/24	Commenced Commenced	ICB Board ICB Board	Partially assured Partially assured

Strategic Risk SR8 – Finance and Estates Committee

Strategic Aim - To improve health and care gaps currently experienced in the population and engineer best value, improve productivity, and ensure financial sustainability of health and care services across Derby and Derbyshire.	**Committee overall assurance level**	Partially assured	
	ICB Lead: Jim Austin, Chief Transformation Officer **ICB Chair:** Richard Wright, Chair of Finance and Estates Committee	**System lead:** Keith Griffiths, Chief Finance Officer **System forum:** Finance and Estates Committee Data and Digital Board	**Date of identification: 17.11.2022** **Date of last review: 28.02.2023**

Strategic risk (what could prevent us achieving this strategic objective)	There is a risk that the system does not: **A. establish intelligence and analytical solutions to support effective decision making and** **B. deliver digital transformation.**	**Risk appetite: target, tolerance and current score** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee** **12**		**Initial** **12**	**Current** **12**	**Target** **8**

Strategic threats (what might cause this risk to materialise)	**Strategic threats**	**Impact** (what are the impacts of each of the strategic threats)
	1. Agreement across the ICB on prioritisation of analytical and BI activity is not realised and therefore funding and associated resources are not identified to deliver the analytical capacity 2. Agreement across the ICB on prioritisation of digital and technology activity may not be realised and therefore budget allocation and reconciliation process across ICB for digital and technology are not agreed. 3. Digital improvements and substitutions to clinical pathways are not delivered through either a lack of citizen engagement and/or clinical engagement	Threat 1 As a result of incomplete and non-timely data provision/analysis, the ICB will be hampered in the making optimal strategic commissioning decisions and it will require complex and inefficient people structures to ensure system oversight of daily operations. This will result in: • A reduced ability to effectively support strategic commissioning and service improvement work • A failure to meet national requirements on population health management, • A reduced ability to analyse how effectively resources are being used within the ICB • A failure to deliver the required contribution to regional research initiatives • A continued paucity of analytical talent development and recruitment resulting in inflated costs Threats 2 and 3 • Failure to secure patient, workforce and financial benefits from digitally enabled care and implementation of alternative care pathways highlighted in ICB plan; eg limited adoption of alternative (digital) clinical solutions (eg PIFU, Virtual Ward, self-serve on line) • Failure to meet the national Digital and Data strategy key priorities (eg attain HIMMS level 5; cyber resilience)

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – **management, risk and compliance, external)**

Threat 1	• Agreed and publicly published Digital and Data Strategy
	• Digital and Data Board (D3B) in place. This provides board support and governance for the delivery of the agreed Digital and Data strategy.
	• D3B responsible for reporting assurance to ICB Finance and Estates Committee and assurance and direction from the Provider Collaborative Leadership Board.
	• Strategic Intelligence Group established with oversight of system wide data and intelligence capability and driving organisational improvement to optimise available workforce and ways of working
		• Prioritisation and investment decision making process is required to fully implement the data and intelligence priorities
		• Permanent, funded structure for analytical team demonstrating
		  ○ Recruitment of a permanent Chief Data Analyst;
		  ○ Allocation of analytical resource from within current workforce;
		  ○ Development of analytical workforce in line with investment plan
		• Strategic Intelligence Group needs formalising and structured reporting through to D3B and direct link to ICB Strategic Intent function and ICB planning cell.
		• JUCD Information Governance Group needs formalisation and work required on using data for planning purposes
			• Data and Digital Strategy
			• CMO and CDIO from ICB executive team are vice chairs of the D3B.
			• Regional NHSE and AHSN representation at D3B provide independent input.
			• D3B minutes demonstrating challenge and assurance levels
			• Provider Collaborative Leadership Board Minutes demonstrating challenge and assurance levels
			• Monthly Reporting to Finance and Estates Committee, ICB Board, NHSE and NHS Executive Team
			• Evidence of compliance with the ICB Scheme of Reservation and Delegation

	• Analytics and business intelligence identified as a key system enabler and priority for strategic planning and operationally delivery in the Digital and Data strategy • NHSE priorities and operational planning guidance 23/24 requires the right data architecture in place for population health management • Digital and Data identified as a key enabler in the Integrated Care Partnership strategy		• A staffed, budgeted establishment for ICB analytics (workforce BAF link required) • Data Sharing Agreements in place across all NHS providers, ICB, hospices and local authorities for direct care purposes.
Threat 2	• Agreed and publicly published Digital and Data Strategy • Digital and Data Board (D3B) in place. This provides board support and governance for the delivery of the agreed Digital and Data strategy. • D3B responsible for reporting assurance to ICB Finance and Estates Committee and assurance and direction from the Provider Collaborative Leadership Board. • Representation from Clinical Professional Leadership Group on D3B • Digital programme team leading and supporting key work in collaboration with system wide Delivery Boards e.g., Urgent and Emergency Care, Elective to embed digital enablement in care delivery • Digital and Data identified as a key enabler in the Integrated Care Partnership strategy • NHSE priorities and operational planning guidance 23/24 requires the right data architecture in place for population health management	• ICB prioritisation and investment decision making process is required to fully implement the digital and data strategy priorities • Digital literacy programme to support staff build confidence and competency in using technology to deliver care • Clear prioritisation of clinical pathway transformation opportunities needs formalising through Provider Collaborative and ICB 5 year plan • Stronger links / formalisation required to link the GP IT governance and activity to the wider ICB digital and technology strategy	• Data and Digital Strategy approved by ICB and NHSE • CMO and CDIO from ICB executive team are vice chairs of the D3B. • Regional NHSE and AHSN representation at D3B provide independent input. • D3B minutes demonstrating challenge and assurance levels • Provider Collaborative Leadership Board Minutes demonstrating challenge and assurance levels • Clinical Professional Leadership Board Minutes demonstrating challenge and assurance levels • Evidence of compliance with the ICB Scheme of Reservation and Delegation • exploitation of Derbyshire Shared Care Record capabilities; demonstrated through usage data • Acceptance and adoption of digital improvements by operational teams (COO, primary care and comms support needed – links to digital people plan and Delivery Board outcomes) • A staffed, budgeted establishment for ICB digital and technology (workforce BAF link required)
Threat 3	• Digital and Data Board (D3B) enabling delivery board and support governance established and responsible for the delivery of the agreed Digital and Data strategy • D3B responsible for reporting assurance to ICB Finance and Estates Committee and assurance and direction from the Provider Collaborative Leadership Board • Citizen's Engagement forums have a digital and data element • ICB and provider communications team engaged with messaging (eg Derbyshire Shared Care Record)	• Data and Digital communication and engagement strategy required to increase awareness of digital technology and solutions available to support care delivery • Development of a ‘use case’ library to help promote the benefits of digitally enabled care • Improved information and understanding of Citizen and Community forums that could be accessed to discuss digitally enabled care delivery • Increased collaboration with the Voluntary Sector across Derby and Derbyshire to harness capacity and expertise - Links to Rural Action Derbyshire (ICS lead on digital engagement) need strengthening	• ICB and provider communications plans with evidence of delivery • Staff surveys showing ability to adopt and influence change • Patient surveys and D7F results • D3B minutes demonstrating challenge and assurance levels • Provider Collaborative Leadership Board Minutes demonstrating challenge and assurance levels • Clinical Professional Leadership Board Minutes demonstrating challenge and assurance levels • Evidence of compliance with the ICB Scheme of Reservation and Delegation • Data and Digital Strategy adoption reviewed through Internal Audit • ICB Board Finance and Estates Committee Assurance Report to escalate concerns and issues. • Public Partnerships Committee minutes demonstrating challenge and assurance levels

Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)
Threat 1	• Secure agreement on data resource funding • Agree structure of ICB analytics team and role of Chief Data Analyst • Recruitment of analytics team • Formalisation of Strategic Intelligence Group governance • Execution of planned investment in analytical skills development in line with ICB plan • Formalise JUCD IG group and draft data sharing agreements for using data for purposes other than direct care	Jim Austin / Darran Green Chris Weiner Chris Weiner Chris Weiner (CDA once appointed) Chris Weiner (CDA once appointed) Chris Weiner (CDA once appointed)/ Chrissy Tucker	By April 2023 June 2023 September 2023 June 2023 April 2024 June 2023	Partially assured Partially assured Partially assured Partially assured Partially assured Partially assured
Threat 2	• Secure agreement on digital and technology resource funding • Develop and roll out staff digital literacy programme • Adopt ICB prioritisation tool to enable correct resource allocation • Formally incorporate Primary Care digital and technology governance within D3B	Jim Austin / Darran Green Jim Austin / Workforce lead/AR Jim Austin / Zara Jones Jim Austin / Chrissy Tucker	31 March 2023 October 2023 TBC – requires prioritisation tool June 2023	Partially assured Partially assured Partially assured Partially assured
Threat 3	• Formalise link to Public Partnership Committee • Work with ICB communications team and Provider communications teams to integrate digital strategy messaging into current engagement programme • Deliver digital (and data) messaging through ICB communications plan	Jim Austin /Sean Thornton Jim Austin /Sean Thornton Jim Austin /Sean Thornton	31 March 2023 June 2023 June 2023+	Partially assured Partially assured Partially assured

Strategic Risk SR9 – Population Health and Strategic Commissioning Committee

Strategic Aim - Reduce inequalities in health and be an active partner in addressing the wider determinants of health.	**Committee overall assurance level**	Partially Assured	
	ICB Lead: Zara Jones, Executive Director of Strategy and Planning **ICB Chair:** Julian Corner, Chair of PHSCC	**System lead:** Dr Robyn Dewis **System forum:** Population Health and Strategic Commissioning Committee	**Date of identification:** 17.11.2022 **Date of last review:** 01.03.2023

Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.**	**Risk appetite: target, tolerance and current score**	**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee **12**	**16**	**16**	**12**

Strategic threats (what might cause this risk to materialise)	**Strategic threats**	**Impact** (what are the impacts of each of the strategic threats)
	1. Resource required for restoration of services post-Covid impacts progress of health inequalities programme. 2. The cost of living crisis worsens health inequalities. 3. The population may not engage with prevention programmes. 4. The ICS aim to achieve too much in too many areas with limited resources	1. Delay or non-delivery of the health inequalities programme. 2. Fuel/food poverty exacerbates or accelerates health conditions or diverts individuals from activities to support their health. 3. The population are not able to access support to improve health. 4. The ICS fails to make any impact rather than focusing on a small number of priority areas where the ICS can make an impact

Threat status	System Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	System Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	System Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective – **management, risk and compliance, external)**	System Gaps in Assurance (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)
Threat 1	• Integrated Care Partnership Board in place with Terms of Reference agreed and work programme in place. • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023. • NHS and ICS Executive teams in place. • Core 20 Plus 5 work programme. • Delivery Boards remit to ensure work programme supports HI. • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis inclusive of access and inequality considerations • System-wide EQIA process supports identification of equalities risks and mitigations and reduces risk of projects/ programmes operating in isolation – and specifically decommissioning decisions • Ambulance handover action plan developed – improvement trajectory agreed with NHSI – monthly improvement trajectories monitored at Boards	• Financial position and requirement to break-even / lack of funds to invest or double-run whilst transforming. • Clear ICP work programme • The national formula for funding GP practices (Carr-Hill) probably provides insufficient weighting for deprivation • Development of system needs assessment • Infection Rates – impact on recovery • Limited capital - impact on recovery • Under performance against key national targets and standards • Single integrated improvement plans being developed with regular monitoring • Relationships between various operating tiers of the ICS, in particular what a delegation and governance arrangements might be across the ICS (e.g. provider collaborative) in relation to place based delegation and governance arrangements.	• Measurement of relationship in the system: embedding culture of partnership across partners • PHSCC assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • System Delivery Board agendas and minutes • Provider Collaborative Leadership Board minutes • Health and Well Being Board minutes • ICP Agenda and minutes • Coproduction • Workforce resilience • Demand in the system • Audit and Governance Committee oversight and scrutiny • HOSC • EDI Committee reporting • Derbyshire ICS Greener Delivery Group and minutes	• The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. • Draft 2023/24 Operational Plan in development • Draft Integrated Care Strategy in development with the ICB Board and ICP. • Development of Draft Joint Forward Plan

	• Derbyshire ICS Green Plan and action plan approved by Derbyshire Trusts and adopted by the ICB Board July 2022	• Development of clear narrative for provider collaborative, and participation in ICS and place-based discussions • Establish a robust governance structure to programme, agree and prioritise change with operational leadership • Further development of the strategy to bring greater efficiencies to staff and patients • Consistent management reporting across the system to be agreed • Implement routine mechanism for shared reporting of risks and risk management across the system		
Threat 2	• The 22/23 winter plan includes additional funding for practices serving the most deprived populations in DDICB	• Scale of the challenge and areas we cannot directly influence which impact on health, • Place Based Plans not in place • Development of system needs assessment • No impact analysis • System governance arrangements that describe approach to delivery of the system transformation programme • Variation across the ICS of patient and wider involvement in the planning and delivery of services • Patient experience data collated at Trust wide level • Wider population input into service development and population health developments	• PHSCC assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • ICB Board Development sessions • 2022/23 Winter Plan • Alignment between the ICS and the City and County Health and Wellbeing Boards • NHSEI oversight and reporting	• Derbyshire ICS Health Inequalities Strategy has been developed and requires approval from the ICP and ICB Board. • The Integrated Assurance and Performance Report is in place and will be developed further as reported to ICB Board. • Development of Draft Joint Forward Plan
Threat 3	• Prevention work - winter plan and evidence base of where impact can be delivered • General Practice is still trusted by the vast majority of people and has a proven track record of helping people engage with prevention programmes • Integrated Care Partnership (ICP) was established in shadow form and met in Public for the first time February 2023 and has approved a draft ICP Strategy which will support improving health outcomes and reducing health inequalities.	• Core 20 plus 5 work - This programme forms a focus of the Health Inequalities requirement for the NHS but does not cover the entire opportunity for the system to tackle Health Inequalities. • Time and resource for meaningful engagement	• Alignment between the ICS and the City and County Health and Wellbeing Boards • Quality and Performance Committee assurance to the ICB Board via the Assurance Report and Integrated Quality Assurance and Performance Report. • Population Health Strategic Commissioning Committee assurance to the ICB Board via the Assurance Report. • ICB Board and minutes • ICP and minutes	• Derbyshire ICS Health Inequalities Strategy has been developed and requires approval from the ICP and ICB Board.
Threat 4	• NHS and ICS Executive teams in place. • Core 20 Plus 5 work programme. • Delivery Boards remit to ensure work programme supports HI. • Programme approach in place in key areas of transformation to support 'system think' via system-wide cost: impact analysis inclusive of access and inequality considerations • System-wide EQIA process supports identification of equalities risks and mitigations and reduces risk of projects/ programmes operating in isolation – and specifically decommissioning decisions. • The 22/23 winter plan includes additional funding for practices serving the most deprived populations in DDICB.	• Financial position and requirement to break-even / lack of funds to invest or double-run whilst transforming. • Clear ICP work programme • The national formula for funding GP practices (Carr-Hill) probably provides insufficient weighting for deprivation • Development of system needs assessment • Variation across the ICS of patient and wider involvement in the planning and delivery of services • Wider population input into service development and population health developments	• Measurement of relationship in the system: embedding culture of partnership across partners • System Delivery Board agendas and minutes • Provider Collaborative Leadership Board minutes • Health and Well Being Board minutes • ICP Agenda and minutes • Coproduction • 2022/23 Winter Plan • Alignment between the ICS and the City and County Health and Wellbeing Boards	• Derbyshire ICS Health Inequalities Strategy has been developed and requires approval from the ICP and ICB Board. • Development of Draft Joint Forward Plan

	• Prevention work - winter plan and evidence base of where impact can be delivered.					
Actions to treat threat	Action (to address gaps in controls)	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)		
				Has work started?	Committee/ Sub Group assurance	Committee level of assurance
Threat 1	• Review alternative funding formula to Carr Hill – scope cost and logistics	GPPB/ CN/ Finance	01/04/2024	Commenced	GPPB	Partially assured
Threat 2	• Development of priorities for the ICP and delivery commences	ICP/ZJ/KB	Quarter 1 2023/24	Commenced	ICP/PHSCC	Partially assured
Threat 3	• Discuss approach with Public Partnerships committee	Julian Corner/ Sean Thornton	30/04/2023	Commenced	Public partnerships Committee	Partially assured
Threat 4	• Development of priorities for the ICB and delivery metrics	ICB/ZJ/CW/CCo	Quarter 1 2023/24	Commenced	ICP/PHSCC	Partially assured

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 107

Report Title	ICB Corporate Risk Register Report – February 2023							
Author	Rosalie Whitehead, Risk Management & Legal Assurance Manager							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Helen Dillistone, Executive Director of Corporate Affairs							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – ICB Risk Register Appendix 2 – Movement in risk summary – January and February 2023							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	ICB Committees – January and February 2023							

Recommendations
The Board are requested to **RECEIVE** and **NOTE:** • the Risk Register Report; • Appendix 1, as a reflection of the risks facing the organisation as at 28th February 2023; and • Appendix 2, which summarises the movement of all risks in January and February 2023.
Purpose
The purpose of the Risk Register report is to appraise the ICB Board of the Risk Register.
Background
The ICB Risk Register is a live management document which enables the organisation to understand its comprehensive risk profile and brings an awareness of the wider risk environment. All risks in the Risk Register are allocated to a committee who review new and existing risks each month and agree the latest position on the risk, advise on any further mitigating actions that might be required, or approve removal of fully mitigated risks.
Report Summary
The report details the ICB's very high operational risks in order to provide assurance that robust management actions are being taken to mitigate them. It also summarises any movement in risk scores, new risks to the organisation and any closed risks.
Identification of Key Risks
As identified in the report.

Has this report considered the financial impact on the ICB or wider Integrated Care System?		
Yes ☐	No☐	N/A☒
Details/Findings Not appliable.		**Has this been signed off by a finance team member?** Not applicable.
Have any conflicts of interest been identified throughout the decision making process?		
None identified.		
Project Dependencies		
Not applicable.		

Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
There are no implications or risks that would affect the ICB's obligations.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Risk 11 is part of the ICB Risk Register relating to the Greener Plan/Net Zero Carbon targets.					

CORPORATE RISK REGISTER REPORT

1. INTRODUCTION

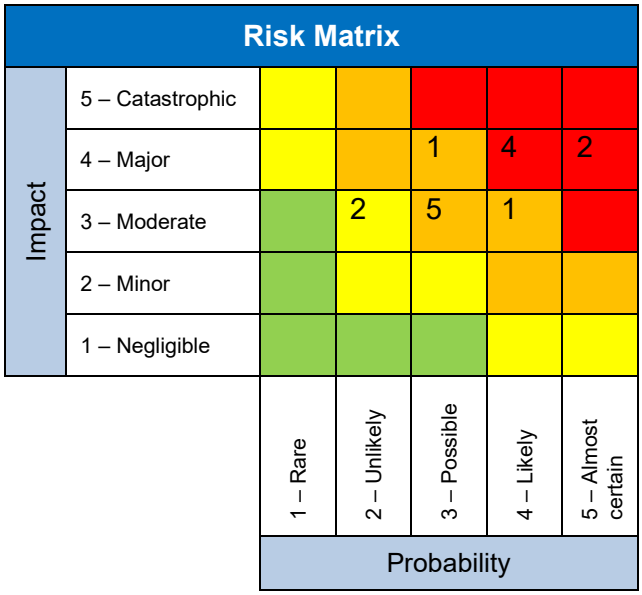
The purpose of this report is to present the ICB Board with the very high (red) operational risks from the ICB's Corporate Risk Register in order to provide assurance that robust management actions are being taken to mitigate them.

2. VERY HIGH OPERATIONAL RISKS

The ICB currently has 6 very high (red) operational risks in its Corporate Risk Register.

The table to the right shows the profile of the current risks scored for **all** operational risks on the Corporate Risk Register. Full details for each risk are described in Appendix 1.

A summary of the latest position regarding these risks is outlined in paragraph 2.1 below.



2.1 Very High (Red) Operational Risks

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
Risk 01	*The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the ICB constitutional standards and quality statutory duties.* **Update:** <u>January 2023 performance:</u> • CRH reported 82.7% (YTD 78.6%) and UHDB reported 61.9% (YTD 61.5%). • CRH: The combined Type 1 and streamed attendances remain high, with an average of 161 Type 1 and 186 streamed attendances per day. • UHDB: The volume of attendances remains high, with Derby seeing an average of 181 Type 1 adult attendances per day, 95 children Type 1s and 120 co-located UTC. At Burton there was an average of 174 Type 1 attendances per day and 19 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average	Overall score 20 **Very High** (5 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	of 11 Resuscitation patients and 170 Major patients per day and Burton seeing 78 Major/Resus patients per day. <u>February 2023 update:</u> • 3 out of the 4 Operational Control Centre (OCC) commanders are in post with the last post in the process of agreeing a start date. Two of the OCC coordinators are now in post. • The recruitment process is in progress for the Hospital Admissions Liaison Officer (HALO) roles.		
Risk 03	*There is a risk to the sustainability of the individual GP practices across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.* **Update:** Opel reporting is now embedded and over 100 GP practices are reporting twice weekly.	Overall score 16 **Very High** (4 x 4)	Population Health and Strategic Commissioning Committee
Risk 06	*Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.* **Update:** • As of 31st January 2023 the system result is a £22.8m deficit. Joined up Care Derbyshire (JUCD) are committed to delivering the deficit of £19.0m for the 2022/23 financial year, as acknowledged by NHSEI. • The roadmap to move the system from the current year to date (YTD) position to the £19.0m forecast out-turn (FOT) position has been developed and therefore there is a high degree of confidence that this is achievable. • There remains a significant challenge going into 2023/24 due to recurrent deficits, but also the level of transformational efficiencies required. • Actions taken for continued improvements: ○ Month on month improvement in year to date position continues to be seen. ○ The System Planning Group is meeting regularly. A timetable has been developed to ensure all partners and disciplines working towards the same timeframe, to ensure triangulation of plans. ○ JUCD Director of Finance's (DOF's) are meeting at least weekly to review and challenge the financial position. ○ System wide meetings are taking place at various levels to drive forward a triangulated 2023/24 plan.	Overall score 16 **Very High** (4 x 4)	Finance and Estates Committee

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	○ An ICB Board Development Session has taken place and NHSE Executives have met to review the Operational Plan process for 2023/24. ○ System DoFs have agreed a series of 'Protocols' to agree how to distribute the allocations received for JUCD. ○ The Initial Plan will be submitted on 23rd February 2023; however, this will be followed by a further review of planning assumptions. ○ A detailed review, possibly to be independently conducted, of baseline expenditure to be carried out to understand how this has grown over recent years.		
Risk 09	*There is a risk to patients on Provider waiting lists due to the continuing delays in treatment resulting in increased clinical harm.* **Update***:* • Quarterly reporting continues. • Standing agenda item at monthly Clinical Quality Reference Group (CQRG).	Overall score 16 **Very High** (4 x 4)	System Quality Group
Risk 19	*Failure to deliver a timely response to patients due to excessive handover delays and transfer of patients to the appropriate care setting from Acute Hospitals. Risk of leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential significant levels of harm.* **Update:** • All required mitigations are in place and these are continuously reviewed by the Discharge Transformation Team. • An escalation process is in place via System Operational Resilience Group (SORG) and Operational Control Centre (OCC).	Overall score 20 **Very High** (5 x 4)	System Quality Group
Risk 20	*Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum Seekers and unaccompanied asylum seekers with undertaking health assessments.* **Update:** • The Home Office and SERCO have made the decision to open another Contingency Hotel adding additional pressure on local services provisions. • There can be no reduction in the risk score this month.	Overall score 16 **Very High** (4 x 4)	System Quality Group

3. RISK MOVEMENT

As risk is reported to the ICB Board on a bi-monthly basis, Appendix 2 details the movement of risk scores during January and February. In summary:

January 2023:

One risk decreased in score:

Risk 05: *If the ICB does not sufficiently resource EPRR and Business Continuity functions and strengthen emergency preparedness policies and processes it will be unable to effectively act as a Category 1 responder which may lead to an ineffective response to local and national pressures.*

This was decreased from a high score of 12 to a high score of 8.

February 2023:

One risk decreased in score:

Risk 05: *If the ICB does not sufficiently resource EPRR and Business Continuity functions and strengthen emergency preparedness policies and processes it will be unable to effectively act as a Category 1 responder which may lead to an ineffective response to local and national pressures.*

This was decreased from a high score of 8 to a moderate score of 6.

4. NEW RISKS

January 2023:

The System Quality Group have approved one new risk:

Risk 20: *Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum Seekers and unaccompanied asylum seekers with undertaking health assessments.*

This risk is scored at a very high score of 16.

5. CONCLUSION

The ICB Board are requested to consider the report and provide any comment they feel appropriate.

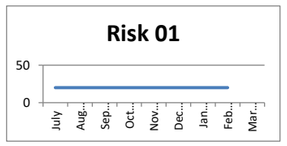
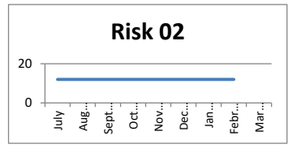
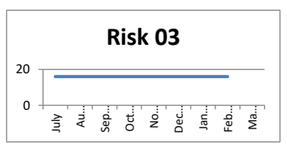
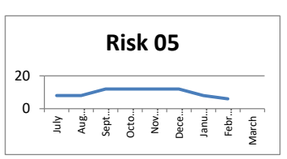
Appendix 1 - Derby and Derbyshire ICB Risk Register - as at February 2023

NHS Derby and Derbyshire Integrated Care Board

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
01	22/23	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the ICB constitutional standards and quality statutory duties.	System Quality Group	Constitutional Standards/ Quality	3	4	12	Governance: - The ICB are active members of the Derbyshire Urgent and Emergency Critical Care Board (UECC) which has oversight and ownership of the operational standards. The performance dashboard is under further development to allow greater scrutiny of performance and any areas of concern to be highlighted and acted upon accordingly. - Providers update the OPEL reporting website daily by 11am and can escalate concerns and requests for support via the ICB urgent care team in hours, or the on-call director out of hours. - Providers across the Derbyshire Health and Social Care System meet weekly as part of the System Operational Resilience Group. The purpose of this silver command level group is to co-ordinate and deliver the actions necessary to respond to significant issues which are affecting, or likely to affect, the functioning of an effective operation at a intra and inter sector level across the Health and Social Care System. This group reports into the System Escalation Group (SEC) which represents Gold Command. - All providers participate in the System Escalation Calls. These meetings are stood up by exception only. - The 22/23 Surge plan is currently being developed to support the times of escalation and extreme pressure for the remainder of the year (this will include plans for both summer and winter). There will be an agreed process in order for this to be monitored and actioned - This will feed into the UECC Board. Nov- Work ongoing to establish a System Control Centre known as the Derbyshire Operational Co-ordination Centre (OCC) as described in the winter letters from NHSE. This was established on 1st of December, operating 7/7 8am- 8pm with on-call cover to support out of hours. System colleagues working collaboratively to design what this looks like for JUCD. Recruitment has commenced. First round of recruitment has been completed. Winter Plan for 22/23 has been approved and initiated. A process has been implemented to monitor this. It is reported and managed through SORG and then reported up into the UECC Board. The Winter initiatives that were put in place for winter 22/23 are being reviewed and discussions taking place regarding a plan for once the funding ends at the end of March 2023 regarding stepping down initiatives or whether we are able to continue you them. It is reported and managed through SORG and then reported up into the UECC Board.	Actions taken: - Review of the Directory of Services to ensure all appropriate patients go to UTCs rather than EDs - Identifying other failed pathway referrals that lead to unnecessary ambulance conveyances, forming a plan to remedy these. Use findings from the Rapid Improvement Fortnight MDT Hub to identify failed pathways and support future development of a Unscheduled Care Coordination Hub (UCCH). Next steps is to re-introduce this for the winter period as a minimum. Awaiting a go live date. - Improving ambulance handover times through increased senior ownership within EDs and applying Releasing Time To Care principles in EMAS. The HALO role has been approved (3 x WTE), recruitment processes have commenced. - Taking a system-wide approach to Same Day Emergency Care working to increase same-day discharges to improve patient flow. - Same day emergency care (SDEC) and urgent treatment centre (UTC) pathways have been developed and continue to increase for EMAS to access, in order to reduce the number of patients directed to ED. - The SORG regularly review the OPEL dashboard to support their operational discussion and to give a full picture on their operational resilience, which supports the system to understand where the pressures are, the impact this has and actions required to support. A workshop is being held on Monday 27th February to review the opel framework and critical incident triggers. - Ambulance handover working group has been established which meets fortnightly which looks at improvements to handovers and alternative pathways. - There are daily regional 10am calls. - Daily system calls at 11:00am. - SORG meetings are weekly at 1:30pm with the option to increase as required. - The Derby and Derbyshire Clinical navigation hub is live and a monitoring and tracking group has been established to monitor and measure the impact. - Business Case approved to expand and enhance the current Derby & Derbyshire Integrated Urgent Care Clinical Assessment Service (IUC CAS) to support flow to the most clinically appropriate setting in order to complete the consult and treat model. This will be known as the Derby & Derbyshire Clinical Navigation Hub (DDCNH) operating 24/7. Go Live date of first element was 1 December 2022. - Review taking place of the new UTC standards.	January 2023 performance CRH reported 82.7% (YTD 78.6%) and UHDB reported 61.9% (YTD 61.5%). CRH: The combined Type 1 & streamed attendances remain high, with an average of 161 Type 1 and 186 streamed attendances per day. UHDB: The volume of attendances remains high, with Derby seeing an average of 181 Type 1 adult attendances per day, 95 children Type 1s and 120 co-located UTC. At Burton there was an average of 174 Type 1 attendances per day and 19 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average of 11 Resuscitation patients & 170 Major patients per day and Burton seeing 78 Major/Resus patients per day. February 2023 Update: • 3 out of the 4 OCC commanders are in post with the last post in the process of agreeing a start date. 2 of the OCC coordinators are now in post. • Recruitment process in progress HALO role (3 x WTE).	5	4	20	5	4	20	3	3	9	On going	No	Feb-23	Mar-23	Zara Jones Executive Director of Strategy and Planning	Catherine Bainbridge, Head of Urgent Care Dan Merrison Senior Performance & Assurance Manager
02	22/23	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the ICB.	System Quality Group	Statutory/ Financial	3	3	9	•The implementation date for Liberty Protection Safeguards (LPS) to replace DoL has been deferred by government, date for implementation not yet confirmed. The new code of practice is currently in draft and is out for public consultation until 07.07.2022 . Midlands and Lancs CSU continue to re-review and identify care packages that potentially meet the 'Acid Test' and the MCA/DoLS staff members are preparing the papers for the CCG to take to the Court of Protection as workload allows. • ICB DoL policy will be updated when the LPS Code of Practice is available. • The ICB is required to submit 100% health funded packages of care that meet the DoL threshold to the Court of Protection (CoP) authorisation, there is an agreement with the LA for the joint funded cases which the LA submit on both our behalves and charge the ICB 50% of the submission fee. There is a reputational risk to the ICB if found guilty of an unauthorised DoL for someone in receipt of CHC funding with associated compensation costs. • Due to the delay in the implementation of LPS the CCG will continue to make applications under the existing Re X process. There is still a backlog of cases that the Court of Protection have not yet processed. • The management oversight of this work is now the responsibility of the MLCSU DoL Lead following agreement between the former CCG and MLCSU. •The Designated Nurse for Safeguarding Adults sits on the CSU Operational Group where any issues in relation to this work are raised.	The Re X DoLS Options Paper was agreed by the December Governing Body meeting and is now being implemented. A further paper was taken Q & P to seek permission for the Safeguarding Adults Team and the CSU MCA/DoLS worker to submit Re X DoLS applications that are 100% funded directly to the CoP. This has been agreed and a framework for this to happen is being developed. This has been agreed and a framework for this to happen is being developed and an account with the COP has been set up.	January update: Awaiting Government response to the consultation and date for implementation. February 2023 No further information available from Government on implementation date. CSU CoP Team to provide monthly trajectory to Ops Group for clearing the backlog ahead of LPS.	3	4	12	3	4	12	3	3	9	April 2023	No	Feb-23	Mar-23	Brigid Stacey - Chief Nursing Officer & Deputy Chief Executive	Bill Nicol, Head of Adult Safeguarding Michelle Grant, Designated Nurse Safeguarding Adults/MCA Lead
03	22/23	There is a risk to the sustainability of the individual GP practices across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.	Population Health & Strategic Commissioning Committee	Primary Care	5	4	20	**Governance processes to enable identification of potential practices requiring support.** Development of Primary Care sub-group to fulfil the ICB delegation requirements in relation to Primary Medical care services. CQC and ICB summit/routine meetings to review and provide assurance re: individual practices who are due to or have had a CQC inspection resulting in a rating of requires improvement or special measures. Quality Assurance programme. Clinical Governance Leads network for sharing best practice. **Primary Care Strategy** Refresh of the former CCG's Primary Care Strategy to take place during 2022/23. The former CCG financially supported the development of the GP Provider Board, who will be the single voice for General Practice, supporting the development of Quality Improvement initiatives relating to access and practice resilience. **Primary Care Networks** The Primary Care Networks will provide a way that practices can support each other in smaller groups and deliver services at scale. Over time this will provide a safe forum for practices to seek help from peers and another route for help for struggling practices. Establishment of Primary Care Assurance and Delivery Board to oversee the delivery of the Primary Care Transformation programme inclusive of estates, IT, workforce - additional roles, access.	Review and refresh of the former Derbyshire wide Primary Care Strategy. Primary Care Quality and Contracting Team to continue to work closely with practices to understand and respond to early warning signs including identification of support/resources available including practice support in discussions around workload transfer from other providers. Establishment of Primary Care sub-group to oversee and ensure compliance with ICB delegation requirements. First meeting to take place on 13th September 2022. October: OPEL dashboard for primary care to be finalised to identify practices at greater risk. Primary Care Hi-light Report draft to be taken to Primary Care sub group for review and agreement of content - to support early identification of practice resilience.	January: • review of Opel reporting by practice including update to definitions and guidance for practices developed by winter team (ICB, LMC, GPPB, DHU) • expansion of winter hub locations and appointments available as part of the winter plan • letter to practices 23/12 and follow up letter 23/1 to provide details of additional support to practices through a winter resilience payment where practices have diverted resources to support the increased urgent demand including during the system period of critical incident status • winter team meeting with practices reporting Opel 4 to undertake review against resilience checklist and support areas identified. No change recommended to risk score. February: Opel reporting embedded and over 100 practices reporting twice weekly.	4	4	16	4	4	16	4	3	12	On Going	No	Feb-23	Mar-23	Zara Jones Executive Director of Strategy and Planning	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care
05	22/23	If the ICB does not sufficiently resource EPRR and Business Continuity functions and strengthen emergency preparedness policies and processes it will be unable to effectively act as a Category 1 responder which may lead to an ineffective response to local and national pressures.	Audit and Governance Committee	Corporate	4	4	16	• ICB active in Local Health Resilience Partnership (LHRP) and relevant sub groups • On-call staff are required to receive Met Office Weather Alerts. These will be cascaded to relevant teams who manage vulnerable groups • Executive attendance at multi agency exercises. • Internal Audits have evaluated Business Continuity preparedness. • Derbyshire-wide Incident Plan in existence • Joint Emergency Services Interoperability Protocol (JESIP) training made available to on-call staff • Staff member trained in Business Continuity and member of professional body • Staff member competent to train Loggists internally and there are sufficient number now trained • Derby and Derbyshire ICB represented on LHRP and LRF sub-groups including, HEPOG, Training and Exercising sub-group. Risk Assessment Working Group, LRF Tactical, Human Aspects and Derbyshire Health Protection Response Group. • On-call rota being revised to introduce two tier system with improved resilience • Comprehensive training undertaken for On-call staff to National Standards	• The On Call Forum has met regularly and has provided an opportunity to share experience and knowledge •The former CCG fully participated in the response to the COVID pandemic and submitted evidence to NHSEI as part of the 2020/21 EPRR National Core Standards • Continued collaborative working with Provider organisations and other stakeholders including the LRF and NHSEI Regional teams	January Head of EPRR has now started in post, additional recruitment is ongoing, and plans are being drafted to be updated in line with new requirements under the CCA 04. Work plan including training and exercising for embedding has been created and being followed - therefore risk can be reduced in score. February Recruitment process continues for the Band 7 post. Further plans continue to be signed off with IRP, Adverse Weather now completed, Business Continuity is ready for sign off at A&G and the emerging infectious disease group will commence in March 2023. System planning is now in place to commence in march also in relation to mass casualty and evacuation and shelter. Further reduction in risk score impact due to the plans and processes.	2	4	8	2	3	6	2	2	4	On going	No	Feb-23	Mar-23	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Chris Leach Head of EPRR
06	22/23	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.	Finance and Estates Committee	Finance	4	4	16	Internal management processes – monthly confirm and challenge by Finance & Estates Committee, including deep dive reports of key areas of interest. Monthly reporting to NHSEI Development of system I&E reporting including underlying positions by organisation and for the system as a whole. Development of a System Medium Term Financial Plan to consider long-term transformation and hence delivery of a sustainable financial position. A detailed risk log has been created for Finance and Estates Committee. This log breaks down this overriding risk into smaller mitigations and actions; each with individual risk owners. These include a focus on ePMO, decision making architecture, maintenance of estates and digital systems, triangulation of planning, and System risk ownership.	With the risk to the financial position, particularly in future years, the System needs to take prompt action to reduce spend. The impact of failing to deliver a financial break even position within the first two years of the ICB's existence, will be the need of the ICB to recover the deficits from its predecessor CCGs. Actions required include development and close monitoring of the ePMO, strengthening the architecture of the Delivery Boards, maintenance of our estate and digital systems, triangulation of operations, finance and workforce, and System cash management. February update: A number of actions have been taken, which include: - JUCD DoFs meeting at least weekly; reviewing and challenging the financial position. - System wide meetings taking place at various levels to drive forward a triangulated 2023/24 plan - ICB Board Development Session and NHSE Executives have met to review Operational Plan process for 2023/24 - System DoFs have agreed a series of 'Protocols' to agree how to distribute the allocations received for JUCD - Initial Plan will be submitted 23/02/2023, however this will be followed by a further review of planning assumptions - Detailed review (possibly independent) of baseline expenditure to be carried out to understand how this has grown over recent years	As of 31st January 2023 the system result is a £22.8m deficit. The JUCD are committed to delivering the deficit of £19.0m for the 2022/23 financial year, as acknowledged by NHSEI. The roadmap to move the system from the current YTD position to the £19.0m FOT has been developed and therefore there is a high degree of confidence that this is achievable. There remains a significant challenge going into 23/24 due to recurrent deficits, but also the level of transformational efficiencies required. Actions taken for continued improvements: - Month on month improvement in year to date position continues to be seen. - System planning group meeting regularly. Timetable has been developed to ensure all partners and disciplines working towards same timeframe, to ensure triangulation of plans. The risk to future years should be noted in that: - the majority of efficiencies delivered in the current financial year have been non-recurrent schemes, - there continues to be limited capital resources, and restraints on digital system investments.	4	4	16	4	4	16	2	3	6	On going	Yes	Feb-23	Mar-23	Keith Griffiths, Chief Financial Officer	Dan Green, Acting Operational Director of Finance Donna Johnson Acting Assistant Chief Finance Officer
07	22/23	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	Audit and Governance Committee	Corporate	4	3	12	• Staff files from Scarsdale site are to be moved to a locked room at the TBH site. This is interim until the new space in Cardinal is available. There are still staff files at Scarsdale and Cardinal Square they are safely secured. Due to Covid-19 the work has been placed on hold as staff are all working from home. • EA's/PA's at Cardinal Square have been contacted and a list is being pulled together of names and files (current or leavers) held ensuring that these are all securely saved in locked filing cabinets. Work is being completed at Cardinal Square by staff who do regularly attend site to compile the list and confirm who may be missing. • Consider an electronic central document management system (DMS) This action remains once we are in a position to move the project forward.	• A project team has been organised to work on the risks, ensuring that a standardised format and tick list is developed of the relevant paperwork to keep in HR files. This piece of work will take a significant amount of time before the ICB can even consider looking at a document management system. • Information Governance are currently working to secure a contract for archiving, this will ensure that staff leavers files are securely archived with the correct paperwork. • Project team are obtaining guidance with other NHS organisations to consider a document management system.	January: Audit of HR files completed and the large majority of employees have an up to date electronic HR file. HR to review the paper HR files for current employees and resource required to scan any documents not held electronically onto the network. Leavers file to be sent to the ICB archive company Restore for storage. Risk score to remain unchanged. February: No change, work in progress.	2	3	6	2	3	6	1	2	2	Nov-23	No	Feb-23	Mar-23	Amanda Rawlings, Chief People Officer	James Lunn, Head of People and Organisational Development
09	22/23	There is a risk to patients on Provider waiting lists due to the continuing delays in treatment resulting in increased clinical harm.	System Quality Group	Clinical	4	4	16	• Risk stratification of waiting lists as per national guidance • Work is underway to attempt to control the growth of the waiting lists – via MSK pathways, consultant connect, ophthalmology, reviews of the waiting lists with primary care etc. • Providers are providing clinical reviews and risk stratification for long waiters and prioritising treatment accordingly.	• An assurance group is in place to monitor actions being undertaken to support these patients which reports to PCDB and SQP • Providers are capturing and reporting any clinical harm identified as a result of waits as per their quality assurance processes • An assurance framework has been developed and completed by all providers the results of which will be reported to PCDB • A minimum standard in relation to these patients is being considered by PCDB • Work to control the addition of patients to the waiting lists is ongoing	• Monthly groups are in place with all 4 providers represented • Completion of assurance framework quarterly is undertaken by all providers and reports to PCDB quarterly, and to SQG • Identified harm is reported on STEIS and all providers are monitoring this • A risk stratification tool is being piloted by providers July: The required reporting is now incorporated in the Quality Schedule so will be a quarterly formal report presented to the Provider Clinical Quality Review Groups (CQRGs). August: Reporting via the quality schedule (QS13) has now commenced, with Q1 report due this month for presentation to System Quality Group and CQRGs. September: No Change, quarterly reporting in place October/November: Risk score was proposed to be decreased due to improved processes are in place for assurance: embedded in Quality Schedule with quarterly reports to SQG, and updates to SQPC. Not agreed at SQG due to critical incident situation. December: No change to previous month. January: No change this month. More information will be available from Quarter 3. Now a Standing Agenda Item at monthly CQRG. At present, no known increase in risk due to critical incident and strikes September: No Change, quarterly reporting in place February: No change this month.	4	4	16	4	4	16	3	2	6	Mar-23	No	Jan-23	Feb-23	Brigid Stacey, Chief Nursing Officer & Deputy Chief Executive	Letitia Harris Clinical Risk Manager
11	22/23	If the CCG does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change	Audit and Governance Committee	Corporate	4	4	16	Helen Dillistone, Net Zero Executive Lead for Derbyshire ICS NHSE Memorandum of Understanding in place NHSE Midlands Greener Board established and meets monthly Derbyshire ICS Greener Delivery Group established and meets bi monthly NHSE Midlands regional priorities identified Derbyshire Provider Trust Green Plans approved by individual Trust Boards and submitted to NHSE Derbyshire ICS final draft Green Plan has been approved through the Derbyshire Trust Boards during March and May. The CCG Governing Body approved the Green Plan on the 7th April 2022. Approved ICS Green Plan submitted to NHSEI end March 2022 and confirmed CEO and GB sign off 7th April 2022. Derbyshire ICS Green Plan Action Plan in place and priorities identified for 2022/23. Development of Derbyshire ICS Green Plan Dash Board. Monthly Highlight Reporting to NHSE in place. Quarterly review meetings with NHSE Green Director Lead	Helen Dillistone, Net Zero Executive Lead for Derbyshire ICS NHSE Memorandum of Understanding in place NHSE Midlands Greener Board established and in place Derbyshire ICS Greener Delivery Group established and in place NHSE Midlands regional priorities identified Derbyshire Provider Trust Green Plans approved by individual Trust Boards and submitted to NHSE Derbyshire ICS final draft Green Plan will be approved through the Derbyshire Trust Boards during March and approved by the CCG Governing Body on the 7th April 2022. Derbyshire ICS final draft Green Plan has been approved through the Derbyshire Trust Boards during March and May. The CCG Governing Body approved the Green Plan on the 7th April 2022. Approved ICS Green Plan submitted to NHSEI end March 2022 and confirmed CEO and GB sign off 7th April 2022	Net Zero – One year on Staff Communication from Helen Dillistone, Net Zero Lead. Former CCG Team Talk staff engagement session on the Greener NHS and Derbyshire arrangements in place – November 2021 Derbyshire ICS Green Plan workshop 16th December 2021 and Derbyshire ICS Green Plan and action plan in development and was approved by the CCG Governing Body on the 7th April and ICB Board 21st July 2022. Medicines Executive Lead is a member of the Derbyshire ICS Delivery Group Medicines Management Lead is a member of the Derbyshire ICS Delivery Group Climate Change National Audit Office best practice risk assessment presented to Audit Committee November 2021 January 2023 - Proposal for spend will be approved at the ICS Greener Group Feb 2023. Quarter 4 - January Highlight Reports reported to NHSE 25.1.2023 SRO Review Meeting with NHSE February 2023 The current risk score 3x3 = high 9, is reasonable this cannot be reduced until the ICS starts to achieve its targets through the action plan for 2022-23. The risk does not require an escalation in risk score. February 2023 - MOU Funding commitments approved at the ICS Greener Group Feb 2023. Lithsare Scheme Project underway and Proposed launch Q1 2023/24. Air Quality Project with 2 Derbyshire School in process. ICS Dashboard being developed. Quarter 4 - January Highlight Reports reported to NHSE SRO Review Meeting with NHSE took place 1st March 2023. The current risk score 3x3 = high 9, is reasonable this cannot be reduced until the ICS starts to achieve its targets through the action plan for 2022-23. The risk does not require an escalation in risk score.	3	3	9	3	3	9	3	2	6	Nov-23	No	Feb-23	Mar-23	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Suzanne Pickering Head of Governance

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
13	22/23	Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties.	Public Partnerships Committee	Corporate	4	4	16	• Detailed work programme for the engagement team • Clearly allocated portfolio leads across team to share programmes * Assessment of transformation programmes in ePMO system underway to quantify engagement workload. January: Ongoing assessment of ePMO programmes nearing conclusion. January: System comms leads have agreed distributed leadership approach to assessing work programmes within delivery boards and other system groups. Mapping to take place January & February, with review session planned for 2 March.	•Implementation of planning tool to track and monitor required activity, outputs and capacity •Links with e-PMO to embed PPI assessment and EIA processes into programme gateways •Distributed leadership across system communications professionals being implemented to understand delivery board and enabler requirements •Establishment of workstream approach to main programme areas to take place July/August 2022 to ensure prioritisation of projects is clear across system.	•Wrike planning tool in training phase (31.5.22); implementation during July/August 2022 •Agreement (8.6.22) on positioning of PPI assessment and EIA tools within e-PMO gateway processes, for implementation July 2022. Access to system granted to engagement team; training on system and assessment of activity to start August 2022. •Distributed leadership agreement among system communications group; paper to System Leadership Team (8.7.22) to confirm arrangements and flag risks deferred to future meeting. PPI Guide agreed at Engagement Committee, Senior Leadership Team and presented at Team Talk - will be developed into training programme with the aim of standardising the approach to engagement progression and equipping project teams to progress their own schemes with technical expertise provided from the engagement team. Revision and refresh of Communications and Engagement Team portfolios and priorities undertaken July 2022. September/October 2022 - Ongoing assessment of activity emerging within ePMO to quantify resource requirements. September/October 2022 - Resource requirements to support place engagement pilots also being scoped. November 2022 - Resourcing review as part of ICB structure discussions in Executive Team. December 2022 - review of ePMO schemes underway, to be completed January 2023. Current assessment identifies limited number of schemes for engagement activity. Review of engagement team portfolios to maximise equality of work and efficiency of process. System discussion ongoing regarding distributed leadership, including Provider Collaborative Leadership Board. January: Ongoing assessment of ePMO programmes nearing conclusion. January: System comms leads have agreed distributed leadership approach to assessing work programmes within delivery boards and other system groups. Mapping to take place January & February, with review session planned for 2 March. February: No update this month.	3	3	9	3	3	9	2	2	4	tbc	tbc	Feb-23	Mar-23	Helen Dillistone - Executive Director of Corporate Affairs	Sean Thornton - Deputy Director Communications and Engagement
15	22/23	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	Audit and Governance Committee	Corporate	4	4	16	The former CCG team worked closely with the NHSEI team to understand current and future operating model, the work transferred, the staff required and the governance arrangements. This work enabled understanding of the detail of the transfer and shaped the transfer so that capacity could be ensured or better understand and plan for any gap. If a gap was identified, this would be escalated within the ICB for further discussion. Discussing were taking place around the possibility of the existing team remaining as presently - as a centrally managed team. This would limit the risk that the team fragments and any loss of economy of scale.	Pre-delegation assurance framework process September 2022. It is likely that the NHSEI East/West Midlands team will be retained but risks remain re potential contractual costs and capacity. Derbyshire is not required to take on delegated functions until 2023.	Jan: No further detail received as yet with regard to the shape and size of the resource required by DDICB to enact our responsibilities with regard to the delegated functions. Risk score remains unchanged. February: Meetings are taking place to discuss how ICBs in the region will work with the host ICB and this will help clarify the role of each individual ICB and the resource required to fulfil our obligations. No change in risk score.	3	3	9	3	3	9				tbc	tbc	Feb-23	Mar-23	Helen Dillistone - Executive Director of Corporate Affairs	Chrissy Tucker - Director of Corporate Delivery
16	22/23	With the pending review of the ICB structures there is risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being.	Audit and Governance Committee	Corporate	4	3	12	Regular communication with staff. Sharing information with staff as soon as this became available. Continuation of regular 1 to 1 wellbeing checks. Compliance with Organisation Change & Redundancy Policy.	No significant change in sickness absence.	January: Promotion of wellbeing activity timetable for Winter 2023 along with wellbeing apps and support for mental health and wellbeing. Sickness absence levels peaked during October 2022 at 4.41% and reduced in both November (3.98%) and December (3.04%). Anxiety/Stress/Depression/other psychological illness continues to account for the majority of sickness days lost (31.8%) followed by infectious diseases (17%). Risk score to remain unchanged. February: Continued promotion of wellbeing offers and access to our employee assistance provider - Confidential Care. Sickness absence levels have reduced in January. Risk score to remain unchanged.	3	3	9	3	3	9	3	2	6	Jul-23	tbc	Feb-23	Mar-23	Amanda Rawlings, Chief People Officer	James Lunn, Head of People and Organisational Development
17	22/23	Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised.	Public Partnerships Committee	Corporate	4	3	12	The system has an agreed Communications & Engagement Strategy which continues to be implemented. This includes actions supporting broadening our communications reach across stakeholders, understanding current and future desired relationships and ensuring we are reaching deeper into the ICB and components parts to understand priorities and opportunities for involvement. The Public Partnership Committee is now established and is identifying its role in assurance of softer community and stakeholder engagement. Communications and Engagement Team leaders are linked with the emerging system strategic approach, including the development of place alliances, seeking to understand the relationships and deliver an improved narrative of progress. January: IC Strategy framework document developed for sharing across boards and other key groups to update on progress and socialise approach. Programme of presentations across all groups being finalised. Public involvement approach to IC strategy continues to be developed and will align to engagement/consolation in JWP.	*- Continued and accelerated implementation of the Communications and Engagement Strategy actions plan priorities across stakeholder management, digital, media, internal communications and public involvement. *- Continued formation of the remit of the Public Partnership Committee *- Key role for C&E Team to play in ICB OD programme *- Continued links with IC Strategy development programme *- Continued links with Place Alliances to understand and communicate priorities	November/December: *- Comprehensive programme of communications and engagement delivered to support ICB transition in July 2022 *- Communications and Engagement Strategy action plans in place 30/9/22 *- Agreed approach to communicate place alliance progress during October 22 *- Links made with proposed ICB OD supplier and HR team *- Public Partnership Committee Development session on role and function held 20/9/22 *- Programme of 1:1 visits to MPs by CEO *- Continued alignment of priorities across JUCD C&E Group January 2023:IC Strategy framework document developed for sharing across boards and other key groups to update on progress and socialise approach. Programme of presentations across all groups being finalised. Public involvement approach to IC strategy continues to be developed and will align to engagement/consultation in JWP. The score remains the same this month as there is still delivery required against the mitigating factors before we will see an improvement. February: Further development of the engagement approach into IC Strategy, including workstream meeting to agree plan. February: Seeking involvement in the JWP developments to secure appropriate engagement.	4	3	12	4	3	12	3	2	6	tbc	tbc	Feb-23	Mar-23	Helen Dillistone - Executive Director of Corporate Affairs	Sean Thornton - Deputy Director Communications and Engagement
18	22/23	There is a risk of patient harm through existing safeguarding concerns due to patients being able to pro-actively view their medical record from 1st November 2022. This is a result of national changes to the GMS contract required by NHSEI.	Population Health & Strategic Commissioning Committee	Primary Care	4	3	12	Information cascaded to all practices detailing processes needing to be put in place before 1st November. Signposting to National webinars and hosting of local webinar. Local Information cascaded including contact details for support through NECS CSU. Work with Derbyshire LMC & FAQs circulated including a range of options for practices prior to 1st November including the application of a system code which if applied prior to the 1st of November can block patient access – to no records (practice ready for go live date) /to all records/ to patients were records still need to be reviewed. Linked with JUCD Communications team and patient facing information developed.	The GMS Contract has included Patient access to medical records since 2019, this has not been enforced, NHSE/I communicated with systems during September 2022 to inform that this would go live on1st November 2022. Nationally, patients registered with practices using System One and EMIS IT Systems will have full access to their prospective medical records from the 1st of November 2022 (Access to retrospective records will be sought through existing processes). All records where there is a potential for patient harm to occur as a result of viewing the record need to be reviewed before the 1st of November 2022, all records where there is an existing safeguarding concern need to be reviewed There remain a number of uncertainties re; what will be viewable and when including Secondary Care Communications/ Local Authority Communications A survey has been circulated asking for practices to inform which option they have adopted in order to target support to those practices who require support. To continue to communicate updates to general practice. Working with communications – circulate information to support patients and practices.	November/December: Surveyed all General Practice and as of 26th November 17 practices have applied the code not to share for over 80% of their patient population. As part of the survey practices have submitted a plan to support increasing the level of access for their patients. January 2023 - NHSE have requested practices to submit plans for access from those practices who have applied code 104 to over 80% of their population, TPP will be enabling access as of 1st February, practices have again received the option to pause if required. No change to risk score. February 2023 NHSE have requested practices to submit plans for access from those practices who have applied code 104 to over 50% of their population, TPP will be enabling access as of 1st February, practices have again received the option to pause if required. No change to risk score.	3	3	9	3	3	9	2	2	4	Mar-23	tbc	Feb-23	Mar-23	Zara Jones Executive Director of Strategy and Planning	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care
19	22/23	Failure to deliver a timely response to patients due to excessive handover delays and transfer of patients to the appropriate care setting from Acute Hospitals. Risk of leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential significant levels of harm.	System Quality Group	Clinical	5	5	25	1. Discharge Flow workstream 2. P1 Strategy events 3. POG actions re: Surge beds 4. Focussed work re: Stockport discharges 5. 100 day challenge 6. SEC and SORG interventions. 7. EMAS Four pillars of Demand action plan. 8. Implementation of EMAS Hospital Handover Harm Prevention Tool at Acute Trusts. 9. Ongoing work in commissioning Same Day Emergency Care and direct access to specialties such as surgery, gynaecology and urology and community providers implementing urgent two-hour community response to suitable patients, thereby increasing the number of patients who can be safely treated in their own homes. 10. Regular monitoring of Actions and risk by CQRG. 11. Local system governance structures to manage difficult decisions: Derbyshire System pressures quality review panel. Decisions and discussions held at SORG.	System actions to reduce hospital handover delays. System urgent care improvement action plans. Pathway 1 work commenced with Chesterfield Locality focusing on LOS & opportunities to integrate health and social care. Roll out to High Peak & Dales. Pathway 1 "scrums" key system partners working together to unblock delays & focused actions to support with flow. Application to EMAHSN for funding to review current interagency tool Application for non-recurrent funding for IT SME to support with development of interagency tool to support with whole system flow. Strength based Approach to be rolled out at UHDB Medicine ward from November. Pathway 3 - D2A pathway for those requiring Nursing care commenced – spot purchased capacity initially with project to block book capacity commenced	November: UEC Handover Summit held on the 19th October 2022. Systems to decide five key interventions likely to provide improvement. December: alternative risk description agreed following November SQG. January: Due to industrial action and pressure on the system EMAS are trying to effect 15 minute handovers. SEC is meeting daily at present due to Critical Incident. February: All required mitigations in place, continuously reviewed by the Discharge Transformation Team. Escalation in place via SORG and OCC.	5	4	20	5	4	20	2	5	10	Apr-23 2023	tbc	Feb-23	Mar-23	Brigid Stacey Chief Nursing Officer & Deputy Chief Executive	Jo Hunter Director of Quality
20	22/23	Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum Seekers and unaccompanied asylum seekers with undertaking health assessments.	System Quality Group	Clinical	4	5	20	Local Partners continue to work closely together and meet regularly with the Home Office, SERCO and the East Midlands Councils Strategic Migration Team to discuss any issues, concerns or points to escalate in regard to the Contingency Hotels. Health and Social Care are providing services to meet the needs of the service users placed within our area.	Regular meetings with the Home Office, Serco and East Midland Councils Strategic Migration team to discuss concerns/ issues identified and points to escalate further - meetings have been taking place weekly and now going to be fortnightly DDICB are working closely with Primary Care Networks/ GP practices to commission/ deliver Primary Care Services to asylum seekers placed with our geographical area - all hotels and IAA have GP practice cover Both Health and Social Care services to continue to meet the statutory needs of looked after children - although under significant pressure Looked after children services are being offered All partners working closely together to try and meet the needs of asylum seekers and raise any concerns to the Home Office, SERCO and East Midlands Councils Strategic Migration team - concerns/ issues identified are being raised via meetings. Formal letters of concern have also been written to the Home Office.	January 2023: Due to the increasing concerns and demand placed on local services the ICS, System Quality Committee were asked to consider adding this issue on the System and Quality Risk Register – this was agreed by the committee. This risk is also on the Derby and Derbyshire Safeguarding Children Partnership. February 2023: There can be no reduction in the risk score this month - the Home Office and SERCO have made the decision to open another Contingency Hotel adding additional pressure on local services provisions.	4	4	16	4	4	16	3	3	9	Apr-23	tbc	Feb-23	Mar-23	Brigid Stacey Chief Nursing Officer & Deputy Chief Executive	Michelina Racioppi Assistant Director for Safeguarding: Children/ Lead Designated Nurse for Safeguarding Children

Appendix 2 - ICB Risk Register - Movement - January and February 2023

Risk Reference	Risk Description	Previous Rating (December)			Residual/ Current Risk Rating (January)			Movement - January	Rationale	Previous Rating (January)			Residual/ Current Risk Rating (February)			Movement - February	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating			Probability	Impact	Rating	Probability	Impact	Rating					
01	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the ICB constitutional standards and quality statutory duties.	5	4	20	5	4	20	⟺	The volume of attendances remains high.	5	4	20	5	4	20	⟺	The Winter initiatives that were put in place for winter 22/23 are being reviewed and discussions taking place regarding a plan for once the funding ends at the end of March 2023 regarding stepping down initiatives or whether they are able to be continued.	Zara Jones Executive Director of Strategy and Planning	Catherine Bainbridge, Head of Urgent Care Dan Merrison Senior Performance & Assurance Manager	
02	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the ICB.	3	4	12	3	4	12	⟺	Awaiting Government response to the consultation and date for implementation.	3	4	12	3	4	12	⟺	No further information available from the Government on the implementation date.	Brigid Stacey - Chief Nursing Officer & Deputy Chief Executive	Bill Nicol, Head of Adult Safeguarding Michelle Grant, Designated Nurse Safeguarding Adults/MCA Lead	
03	There is a risk to the sustainability of the individual GP practices across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.	4	4	16	4	4	16	⟺	Review of Opel reporting by practice including update to definitions and guidance for practices developed by winter team (ICB, LMC, GPPB, DHU). Winter team meeting with practices reporting Opel 4 to undertake review against resilience checklist and support areas identified.	4	4	16	4	4	16	⟺	Opel reporting embedded and over 100 practices reporting twice weekly.	Zara Jones Executive Director of Strategy and Planning	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care	
05	If the ICB does not review and update existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known and unknown risks to the Derby and Derbyshire ICB, which may lead to an ineffective response to local and national pressures.	3	4	12	2	4	8	↓	Head of EPRR has now started in post. Work plan including training and exercising for embedding has been created and being followed - therefore risk can be reduced in score.	2	4	8	2	3	6	↓	Further reduction in the risk score impact due to the plans and processes in place.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Chris Leach, Head of EPRR	

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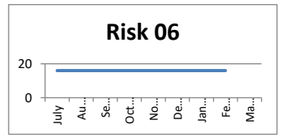
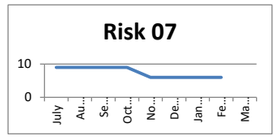
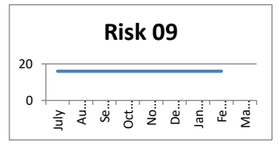
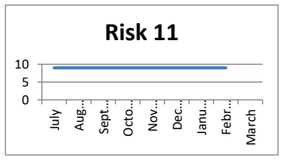
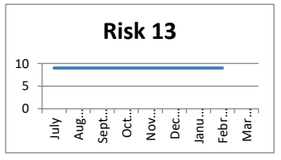
		Probability	Impact	Rating	Probability	Impact	Rating			Probability	Impact	Rating	Probability	Impact	Rating					
06	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.	4	4	16	4	4	16	⟺	JUCD DoFs meeting at least weekly; reviewing and challenging the financial position.	4	4	16	4	4	16	⟺	There remains a significant challenge going into 23/24 due to recurrent deficits, but also the level of transformational efficiencies required.	Keith Griffiths, Chief Financial Officer	Darran Green, Acting Operational Director of Finance	
07	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to the former Derby and Derbyshire CCG this data is not held consistently across the sites.	2	3	6	2	3	6	⟺	HR to review the paper HR files for current employees and resource required to scan any documents not held electronically onto the network.	2	3	6	2	3	6	⟺	Work in progress.	Amanda Rawlings, Chief People Officer	James Lunn, Head of People and Organisational Development	
09	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	4	4	16	4	4	16	⟺	Now a Standing Agenda Item at monthly CQRG.	3	4	16	3	4	16	⟺	No Change, quarterly reporting in place.	Brigid Stacey, Chief Nursing Officer & Deputy Chief Executive	Letitia Harris Clinical Risk Manager	
11	If the ICB does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change	3	3	9	3	3	9	⟺	The risk score cannot be reduced until the ICS starts to achieve its targets through the action plan for 2022-23.	3	3	9	3	3	9	⟺	The risk score cannot be reduced until the ICS starts to achieve its targets through the action plan for 2022-23.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Suzanne Pickering Head of Governance	
13	Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties.	3	3	9	3	3	9	⟺	Ongoing assessment of ePMO programmes nearing conclusion.	3	3	9	3	3	9	⟺	Ongoing assessment of ePMO programmes nearing conclusion.	Helen Dillistone - Executive Director of Corporate Affairs	Sean Thornton - Deputy Director Communications and Engagement	

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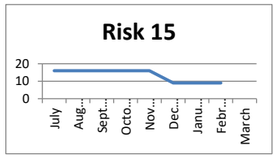
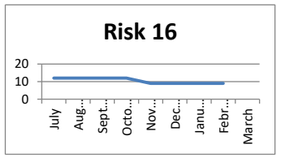
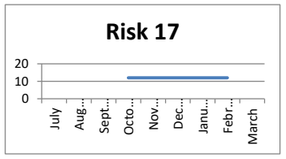
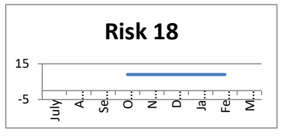
		Probability	Impact	Rating	Probability	Impact	Rating			Probability	Impact	Rating	Probability	Impact	Rating					
15	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	3	3	9	3	3	9	⟺	No further detail received as yet with regard to the shape and size of the resource required by DDICB to enact our responsibilities with regard to the delegated functions.	3	3	9	3	3	9	⟺	Meetings are taking place to discuss how ICBs in the region will work with the host ICB and this will help clarify the role of each individual ICB and the resource required to fulfil our obligations. No change in risk score.	Helen Dillistone - Executive Director of Corporate Affairs	Chrissy Tucker - Director of Corporate Delivery	
16	Risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being.	3	3	9	3	3	9	⟺	Promotion of wellbeing activity timetable for Winter 2023 along with wellbeing apps and support for mental health and wellbeing.	3	3	9	3	3	9	⟺	Continued promotion of wellbeing offers and access to our employee assistance provider - Confidential Care.	Amanda Rawlings, Chief People Officer	James Lunn, Head of People and Organisational Development	
17	Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised.	4	3	12	4	3	12	⟺	The score remains the same this month as there is still delivery required against the mitigating factors before we will see an improvement.	4	3	12	4	3	12	⟺	Further development of the engagement approach into IC Strategy, including workstream meeting to agree plan.	Helen Dillistone - Executive Director of Corporate Affairs	Sean Thornton - Deputy Director Communications and Engagement	
18	There is a risk of patient harm through existing safeguarding concerns due to patients being able to pro-actively view their medical record from 1st November 2022. This is a result of national changes to the GMS contract required by NHSE/I.	3	3	9	3	3	9	⟺	NHSE have requested practices to submit plans for access from those practices who have applied code 104 to over 80% of their population.	3	3	9	3	3	9	⟺	NHSE have requested practices to submit plans for access from those practices who have applied code 104 to over 50% of their population.	Zara Jones Executive Director of Strategy and Planning	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care	

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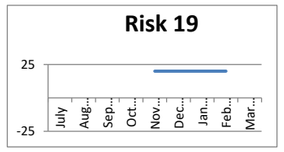
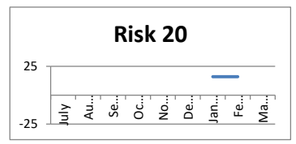
		Probability	Impact	Rating	Probability	Impact	Rating			Probability	Impact	Rating	Probability	Impact	Rating					
19	Failure to deliver a timely response to patients due to excessive handover delays and transfer of patients to the appropriate care setting from Acute Hospitals. Risk of leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential significant levels of harm.	5	4	20	5	4	20	⟺	Due to industrial action and pressure on the system EMAS are trying to effect 15 minute handovers. SEC is meeting daily at present due to Critical Incident.	5	4	20	5	4	20	⟺	All required mitigations in place, continuously reviewed by the Discharge Transformation Team. Escalation in place via SORG and OCC.	Brigid Stacey, Chief Nursing Officer & Deputy Chief Executive	Jo Hunter, Director of Quality	
20	Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum Seekers and unaccompanied asylum seekers with undertaking health assessments.	5	4	20	5	4	20	NEW RISK	Due to the increasing concerns and demand placed on local services the ICS, System Quality Committee were asked to consider adding this issue on the System and Quality Risk Register – this was agreed by the committee. This risk is also on the Derby and Derbyshire Safeguarding Children Partnership.	5	4	20	5	4	20	⟺	There can be no reduction in the risk score this month - the Home Office and SERCO have made the decision to open another Contingency Hotel adding additional pressure on local services provisions.	Brigid Stacey, Chief Nursing Officer & Deputy Chief Executive	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children	

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

16th March 2023

Item: 108

Report Title	Child Death Overview Panel Annual Report 2021/22							
Author	Juanita Murray, Designated Nurse Safeguarding Children, Chair of Child Death Overview Panel Dr Nic Medd, Designated Doctor for Child Death							
Sponsor (Executive Director)	Brigid Stacey, Chief Nurse Officer and Deputy Chief Executive Officer							
Presenter	Juanita Murray, Designated Nurse Safeguarding Children, Chair of Child Death Overview Panel							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Child Death Overview Panel Annual Report 2021/22							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Senior Leadership Team Executive Team Meeting System Quality Group Quality and Performance Committee							

Recommendations
The ICB Board are recommended to **NOTE** the Child Death Overview Panel Annual Report 2021/22 for assurance.
Purpose
The Child Death Overview Panel (CDOP) Annual Report is written on behalf of the Child Death Review Partners to give assurance that the child death review arrangements are in place and are effective in meeting the statutory requirements set out in Working Together (2018) and Child Death Review Statutory and Operational Guidance (2018). The Annual Report sets out local patterns and trends in child deaths, learning and actions taken to prevent future deaths.
Background
Despite ongoing challenges for services across the partnership the child death review team and CDOP members have continued to review child deaths within the framework of the statutory guidance. Through the activity of the child death review team and CDOP, learning has been disseminated across the partnership with an aim to drive improvements in service provision and prevent future child deaths.
Report Summary
The Annual Report is written to reflect the activity and performance around child death management and review between April 2021 and March 2022. The report includes data concerning the deaths that have occurred and those deaths that have been reviewed within this

timeframe. The report reflects the link between child death and deprivation and some comparative data over a three-year period.

The report considers the activity of the CDOP meeting in reviewing child deaths and the identification of modifiable and contributory factors all of which assist in learning and activity to support practitioners and organisations in preventing future deaths.

Learning
This year's report focuses on learning from a themed panel on sudden and unexpected deaths in teenagers. Five themes were identified by the panel that appeared to be important factors in the lives of these young people and potentially contributed to their death. It is important to consider these themes within the context of how knowledge of these factors may influence and inform the assessment of young people in the future:

- The presence of Autistic Spectrum Disorder
- The presence of bullying
- The presences of Adverse Childhood Experiences – ACE's
- Previous self- harm
- Being a young carer

Recommendations were made for each of theses learning themes as well as overarching recommendations. A learning briefing was developed and disseminated across partners and organisations.

The child death review team held a CDOP Seminar. The theme was sudden and unexpected death. Speakers attended from the Police, Coroner and Professor Marta Cohen. This event was very well attended from across the partnership.

Keeping Babies Safe (KBS)
KBS is a priority for the Derby and Derbyshire Safeguarding Childrens Partnership during this reporting year. The KBS Steering Group is a sub-group of CDOP. The significant amount of activity and performance on KBS is reflected in this report. The highlights are:

- Publication of the multi-agency KBS strategy
- Training of 100 KBS Champions across the partnership
- Stakeholders conference – The Three Steps for Baby Safety

This report also considers the importance of the voice of the child within the child death review process and the CDOP meeting and outlines how we achieve this in Derby and Derbyshire.

The report concludes with the impact of COVID 19, positive practices, challenges and achievements and the key priorities for 2022/23.

Identification of Key Risks

The Child Death Review Partners are assured of the progress of CDOP to review child deaths in line with the statutory guidance quarterly by the Chair of CDOP. The partners are also made aware of any risks or concerns regarding the functions of CDOP.

Has this report considered the financial impact on the ICB or wider Integrated Care System?

Yes ☐	No☐	N/A☒
Details/Findings		**Has this been signed off by a finance team member?** Not applicable to this report.

Have any conflicts of interest been identified throughout the decision making process?

None noted.

Project Dependencies					
Completion of Impact Assessments					
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**	
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**	
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**	

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable to this report.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable to this report.

Derby and Derbyshire Child Death Review and Child Death Overview Panel Annual Report

1st April 2021 – 31st March 2022

Authors:

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Chair of the Derby and Derbyshire Child Death Overview Panel

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Designated Doctor for Child Death for Derby and Derbyshire

Introduction from the Authors

This year's child death review and CDOP annual report is written within the context of the continuing COVID 19 pandemic. Despite ongoing challenges for services across the partnership the child death review team and CDOP members have continued to review child deaths within the framework of the statutory guidance. Through the activity of the child death review team and CDOP, learning has been disseminated across the partnership with an aim to drive improvements in service provision and prevent future child deaths.

This reporting year has allowed us to hear the unique stories of 51 children, young people and their families. Their stories matter and the privilege of hearing from them allows us to look for ways to prevent and reduce the future deaths of children across Derby and Derbyshire.

We are grateful to all those families who decided to contact us to share their feedback and concerns and give us their child's voice. We will continue to hold the voices of children and their families at the very heart of what we do.

We remain grateful to those members of our partner organisations who time after time go out of their way to make the lives of children and their families their absolute priority. And who, despite often challenging circumstances, work above and beyond to give children the experience that they deserve.

Finally, we would like to thank the members of the Child Death Review Team, the Child Death Review Partners and members of CDOP for their hard work, support and commitment to the review of all child deaths in Derby and Derbyshire.

Juanita Murray

Chair of the Derby and Derbyshire Child Death Overview Panel

Dr Nic Medd

Designated Doctor for Child Death for Derby and Derbyshire

Child mortality and deprivation

The National Child Mortality Database (NCMD) produced a thematic report on child mortality and deprivation. A key finding was that 'there was a clear association between the risk of death and the level of deprivation for children who died in England between April 2019 and March 2020. This association appeared to exist for all categories of death except malignancy'. Further analysis also suggested that over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived. This equates to 700 fewer children dying per year (NCMD 2021).

The number of notifications for 2021-2022 in Derby/Derbyshire shows a similar trend to that found nationally. Deaths were more common among children living in the most deprived areas, particularly for neonatal deaths.

The proportion of deaths with identified modifiable contributory factors increased with increasing deprivation; with factors relating to the social environment being most frequently reported. To achieve a more systematic collection and analysis of the contributory and modifiable factors, specific and structured questions related to social deprivation is now collected within the reporting forms for child death reviews.

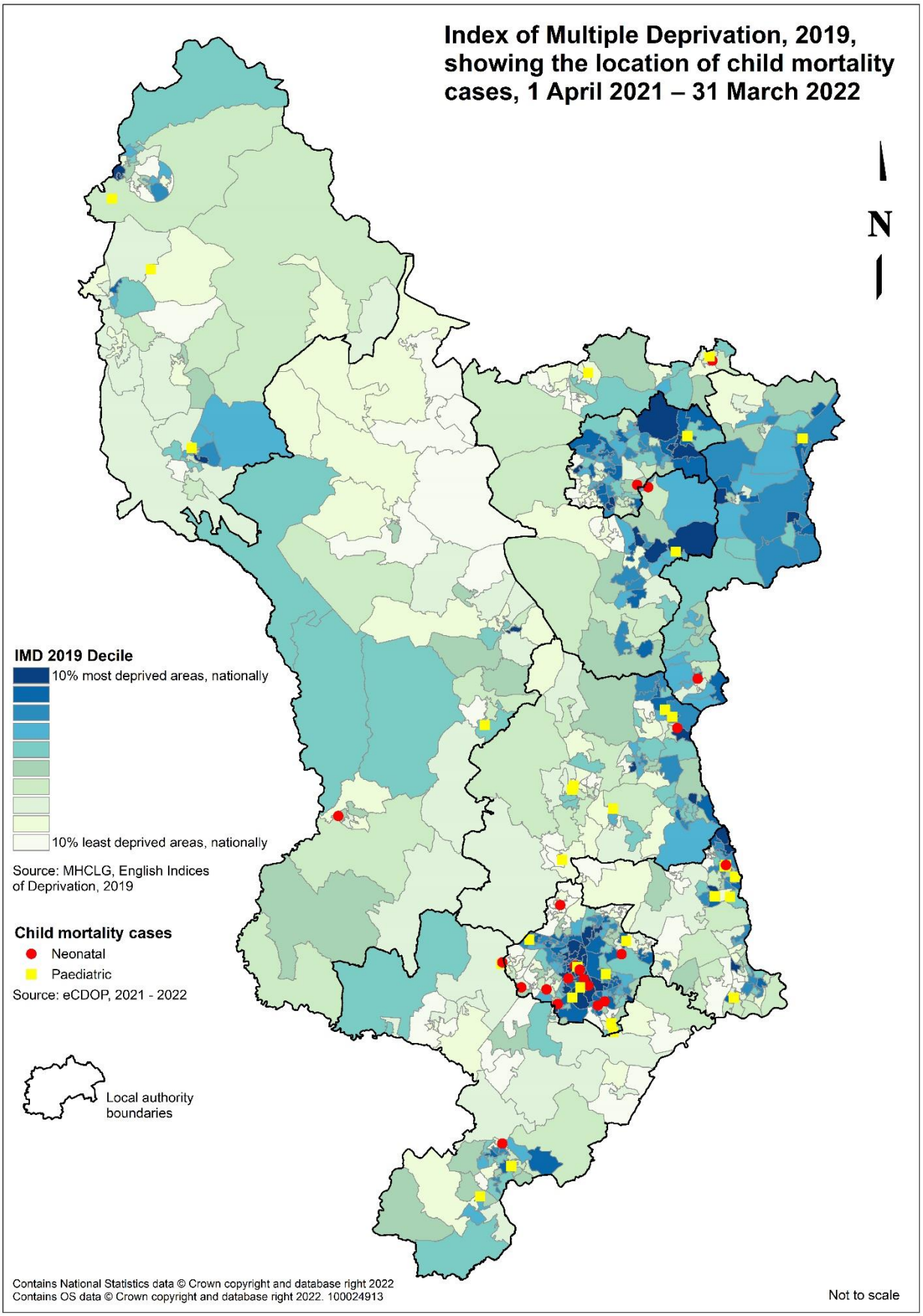
The Child Safeguarding Practice Review Panel in the report Out of Routine (2020) review identified that environmental factors, such as deprivation and overcrowding, when combined with other risk factors were associated with sudden and unexpected deaths (SUDI) (Out of Routine)

Pregnancy is recognised as a key time to reach families. However, due to time constraints and caseload pressures, the review identified that there was often little opportunity to build relationships and explore family vulnerabilities. This was particularly evident in areas of high social deprivation.

Within Derby and Derbyshire, identifying vulnerabilities (including the potential impact of deprivation) within families is a key focus of the multi-agency Keeping Babies Safe strategy, particularly when promoting safer sleep. Parents may consider deprivation being out of their control and therefore they may not feel that anything they do will make a difference to what happens to their baby. Timely and accessible preventative services have a key role in supporting families in these circumstances, particularly where there is enhanced home visiting, to build trust and engage parents in making safe and appropriate decisions about the sleep environment.

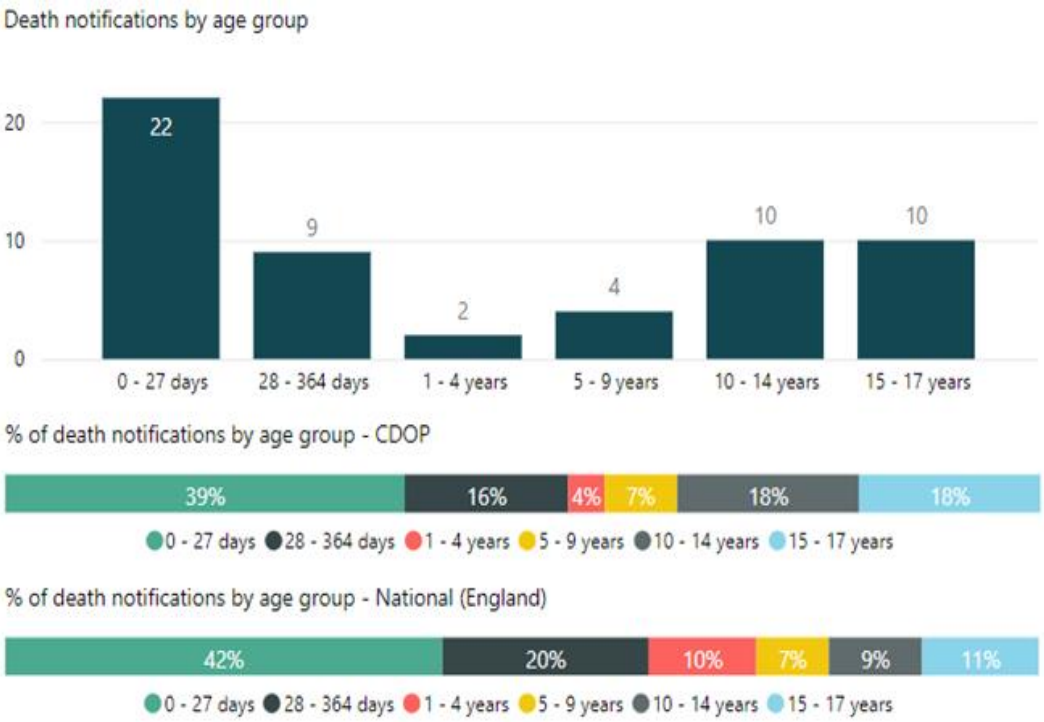
Being able to build a relationship in order to explain how the situational risk of deprivation interacts with other risk factors in relation to SUDI (sudden and unexpected death in infancy) and discussing practical solutions, may help parental understanding and promote behaviour change, particularly when considering safer sleep in 'out of routine' situations.

Notifications of Child Death April 2021 – March 2022



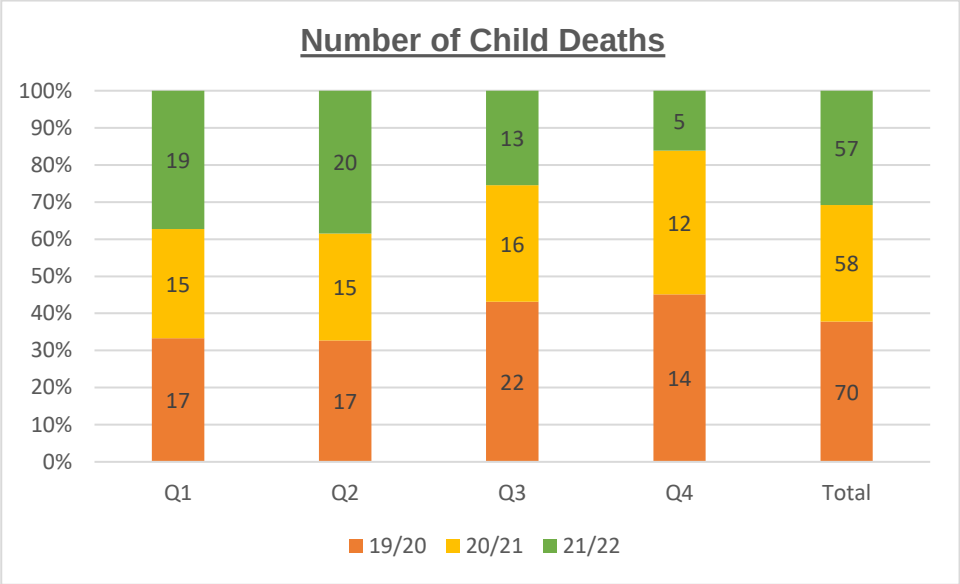
57 Child Deaths between April 2021 and March 2022

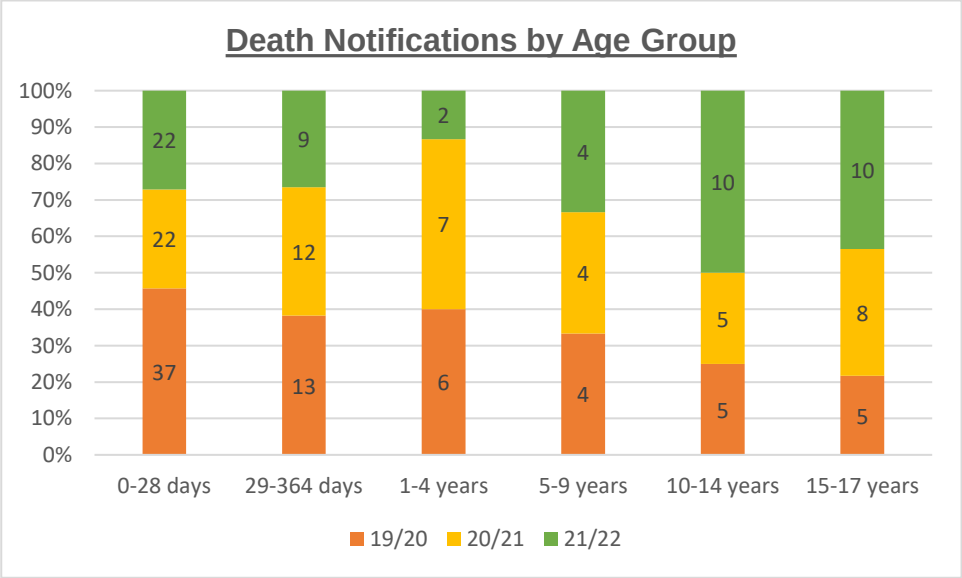
Notifications of Death



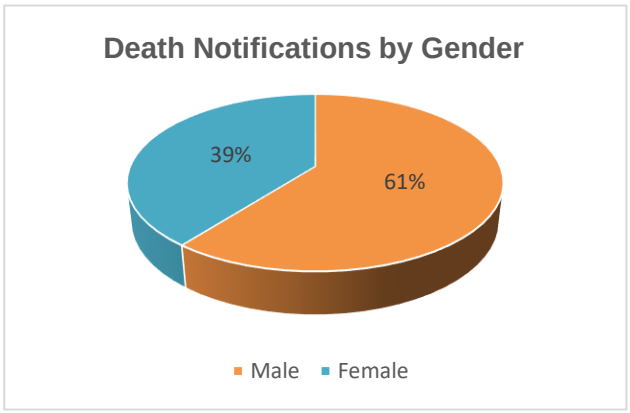
Notifications of death should be submitted via ECDOP within 48 hours of the death of a child by the health provider where the child has died. The majority of notifications are for neonatal deaths at 39% this number has remained static from the previous year. The numbers of neonatal deaths are below the England average. There has been an increase rate of deaths of children between 10 -17 years at 36% of all deaths when the national average is 19%, however there is a significant drop in child deaths of 1 - 4-year-olds at only 4%. As in previous years the numbers of child deaths fluctuate month by month.

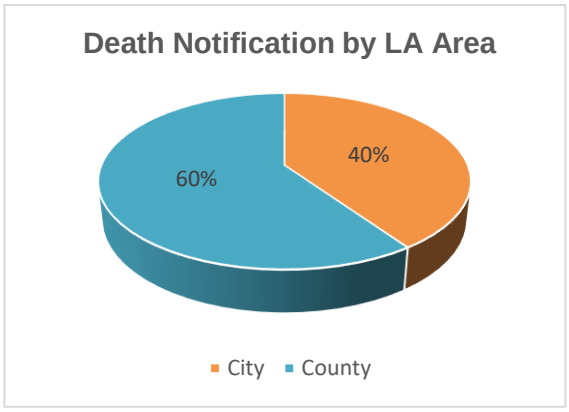
Comparison of data over 3 years

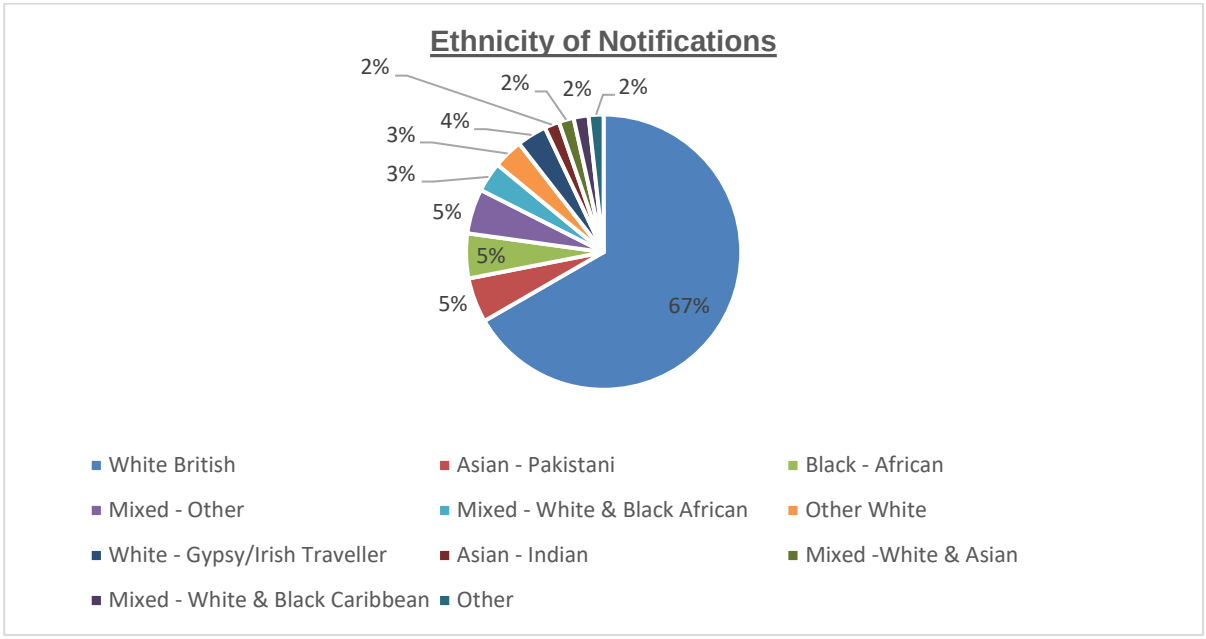




Over the last three years the numbers of child deaths have reduced from 70 in 2019/2020 to 57 in this reporting year. Within this year there has been a significant increase in child deaths of older children. Of the 20 deaths in children 10 years and over 11 deaths were sudden and unexpected due to external causes including trauma. This will be monitored in subsequent years to see if there are any themes or trends.







Child Population

The child population data from the 2021 census - Age by single year - Office for National Statistics (ons.gov.uk) is now available.

Local Authority Area	Child Population 0 -17 years
Derby City	58,627
Derbyshire	151,608
Total	**210,235**

These figures account for the child population on one day in the year when the census was taken and there will be some small inaccuracies. Derby City account for 28% of the total child population and Derbyshire for 72%. The comparison with child deaths in the graphs above for this reporting year is that more child deaths have occurred in Derby City as a percentage of their child population size. This is not unexpected due to the known links between child death and deprivation as Derby City have more areas of deprivation according to IMD decile.

The Child Death Overview Panel

The panel comprises of senior representatives from key partner agencies who together have expertise in a wide range of services regarding children's health and wellbeing.

The attendance at CDOP meetings has been very good over the last year and in line with the terms of reference for the group. The continued contribution from CDOP's Lay Member is valued by the group MST has not been a barrier for attendance however the supportive element of the CDOP meeting is more challenging to achieve virtually.

The commitment and hard work from panel members should be recognised this year.

Child Death Review Team

A small team including the Designated Doctor for Child Death, Lead Nurse for Child Death Review and the CDOP Coordinator manage and prepare all the children's stories to ensure they are reviewed at CDOP in a timely manner.

The Development of the child death review processes, planning and innovation is managed by the team led by the Designated Nurse Safeguarding Children on behalf of Derby and Derbyshire Integrated Care Board

The Child Death Review Partners

The three partners are the two Directors of Public Health for Derby City and Derbyshire and the Chief Nurse for Derby and Derbyshire CCG. The partners are assured of the progress of CDOP to review child deaths in line with the statutory guidance quarterly by the Chair of CDOP. The partners are also made aware of any learning, positive practice, risks or concerns regarding the functions of CDOP.

Child Deaths Reviewed

51 Child Deaths have been reviewed between April 2021 and March 2022

CDOP Meeting	Number of deaths reviewed	Number of cases closed
April	8	8
May - Themed Panel	4	4
June	4	4
July – Neonates	5	5
August	3	3
September	2	2
October – Neonates	6	5
November	3	3
December	3	3
January - Neonates	7	8 (1 from Oct Panel)
February	4	4
March	2	2
Total	**51**	**51**

The children reviewed are not necessarily the same children who have died within this reporting year. Review at CDOP can be delayed significantly by coronial processes and criminal proceedings.

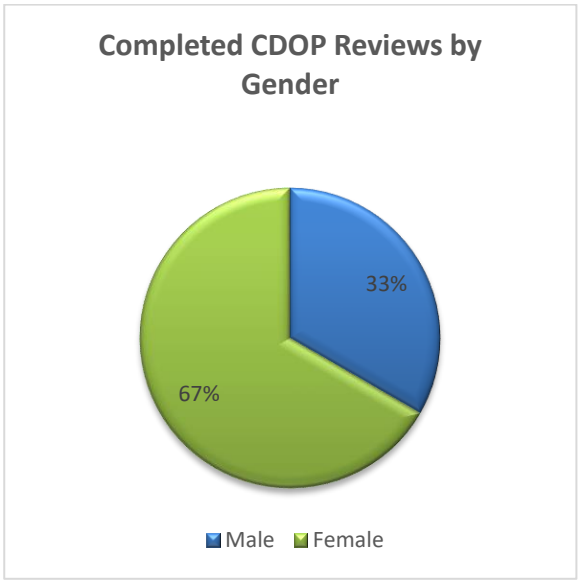
There has been a small increase in the numbers of child deaths being reviewed by CDOP this reporting year. The COVID 19 pandemic has continued to influence the timeliness of the child death review process as information is slower to be shared with the child death review team from provider organisations however this has been an improving picture across the year.

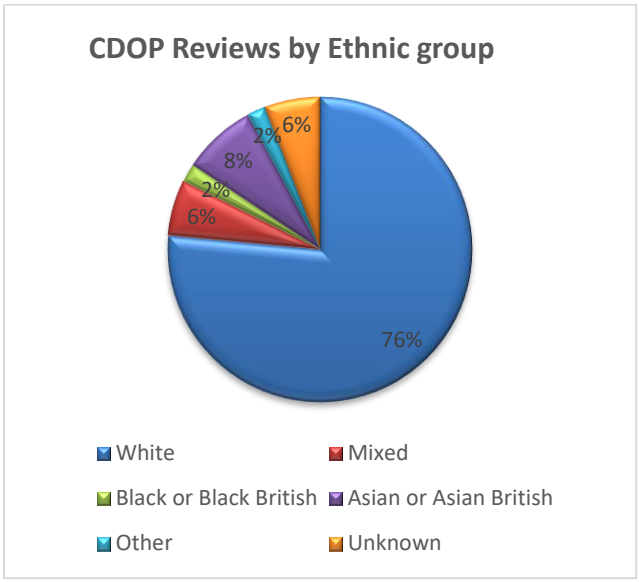
Demographics of Completed Reviews

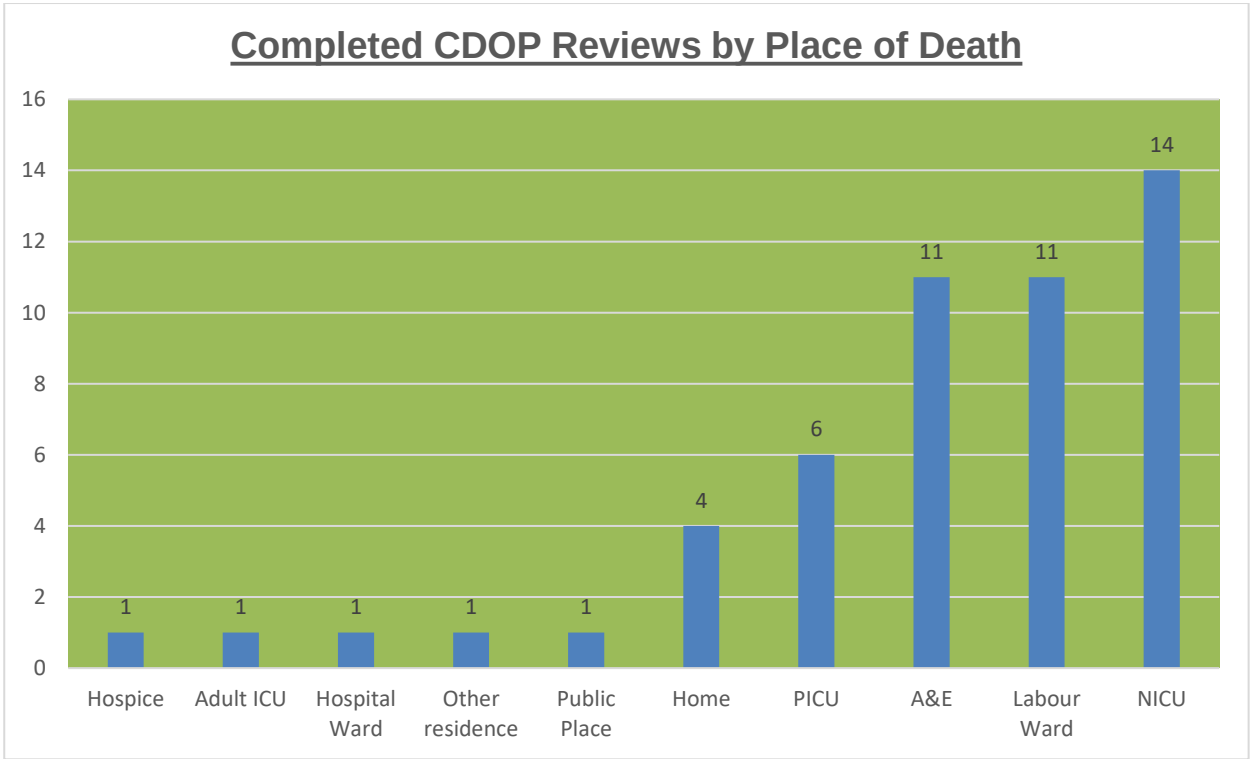
Neonatal deaths are the most common type of event reviewed by the panel and are reviewed as a themed panel to enhance the learning. This is followed by children with chromosomal or genetic conditions. There is an increase of children where the death is categorised as suicide or deliberate self-harm this is because CDOP held a themed panel related to sudden and unexpected deaths in teenagers where 4 children's deaths were reviewed.

City-County split of the deaths reviewed

Local Authority Residence	Number of Deaths Reviewed	Proportion of deaths reviewed
Derby	14	27%
Derbyshire	37	73%


Completed CDOP Reviews by Gender
33%
67%
Male
Female


CDOP Reviews by Ethnic group
76%
6%
2%
8%
2%
6%
White
Mixed
Black or Black British
Asian or Asian British
Other
Unknown


Completed CDOP Reviews by Place of Death
16
14
12
10
8
6
4
2
0
1
1
1
1
1
4
6
11
11
14
Hospice
Adult ICU
Hospital Ward
Other residence
Public Place
Home
PICU
A&E
Labour Ward
NICU

Modifiable Factors

Modifiable Factors

These are defined as factors which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future deaths (Working Together 2018).

The definition of modifiability is challenging and there is a lack of consensus nationally of how to define if a factor is modifiable or not. There is a drive nationally to look at the standardization of modifiable factors.

This year the Child Death Review Team and CDOP have focused on having a more consistent approach to modifiable factors. There is rich discussion in the CDOP meeting and guidance available locally to support decision making.

CDOP have increased the identification of modifiable factors from 27% last year to 47% this year this is higher than the national average of 37%

Top Five Modifiable Factors

Smoking in pregnancy

Household smoking

High maternal BMI

Parental substance misuse

Accessing treatment

Identifying modifiable factors supports learning and any initiatives or activity that takes place with the aim of improving health and preventing future deaths.

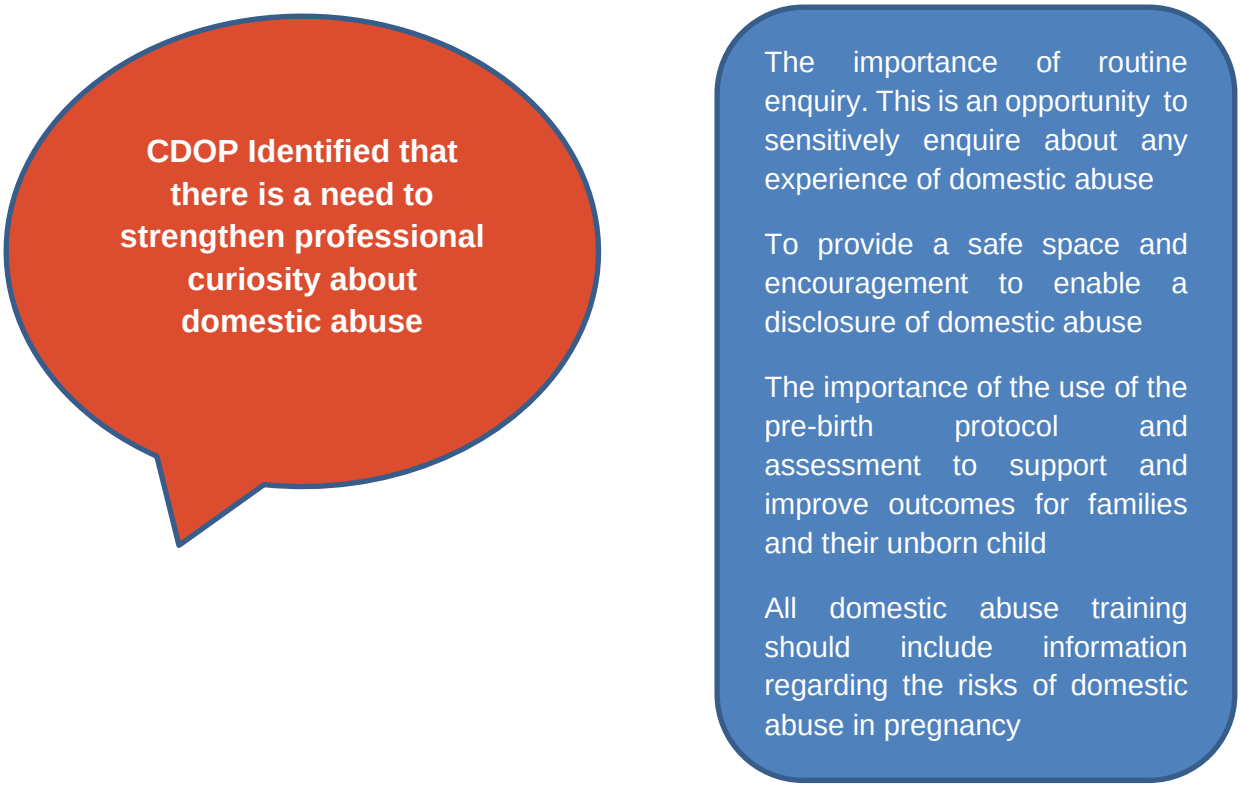
Most Common Modifiable factors identified

Modifiable Factor	Number
Smoking in pregnancy	6
Household smoking	6
High maternal BMI	5
Parental Substance Misuse	4
Accessing treatment	4
Bullying	3
Poor communication	3
Internet searches	2
Relationship difficulties	2
Consanguinity	2
Deprivation	2
No routine enquiry for domestic abuse	2
Lack of information sharing	2
Lack of professional curiosity	2

Contributory Factors

A contributory or vulnerability factor is a factor that may contribute to the outcome of a child's death. Some factors may have a direct impact on the outcome and some may increase a child's vulnerability such as domestic abuse or smoking. Some children may present with several factors that will have an impact on their life and death.

Contributory Factors	Number	Percentage present in cases reviewed
Child medical conditions	36	71%
Gestation	26	51%
Birth weight	23	45%
Maternal medical condition	16	31%
Known to CSC	15	29%
Household smoking	15	29%
Service provision	15	29%
Treatment	14	27%
Development delay	12	24%
Communication	12	24%
Parental mental health	11	22%
Care concerns	11	22%
Smoking in pregnancy	11	22%



The Child Death Overview Panel are more accurately recording vulnerability factors as part of the child's review. The table above depicts those contributory factors that are recorded in 20% of cases and above. Recording contributory factors provides rich data on the circumstances of the child and allows the panel to understand some of the lived experience of the child. The most common factors this year are the child's medical condition, gestational age and birth weight which is as expected. There are less families known to children's social care and an increase in household smoking when compared to previous years. Smoking remains a significant factor both maternal smoking as a modifiable factors and household smoking as a contributory factor.

Learning Themes

The Importance of Learning from Child Deaths

All child deaths are important to CDOP. We can all learn from individual deaths by sharing of positive practice as well as consideration of improving practice across the partnership. CDOP has a role to look at themes and trends and to focus on any improvements that can be made to prevent future deaths and improve care and services to children.

Themed Panel on Sudden and Unexpected Deaths in Teenagers

The Child Death Overview Panel is in the privileged position to conduct themed panels to maximise the learning by reviewing and analysing deaths where there are common factors. This methodology is supported and encouraged in Child Death Review: Statutory and Operational Guidance (DOH 2018)

The cases chosen for this themed panel were of children where the mode of death was similar. To ensure that all learning is utilised CDOP invited a number of experts in child and adolescent mental health and suicide prevention to support the panels review and enhance any learning themes from current practice and research.

The Child Death Overview Panel heard the individual stories for each child including hearing what the child was like, what they enjoyed and were interested in. The panel heard examples of good practice and where improvements in practice should be made. The panel identified a number of vulnerability factors for these children that need to be considered as part of the learning.

Vulnerability Factors

- Relationship problems
- Victim of bullying
- Previous self-harm
- Identity Issues
- Prescence of ACES
- Victim of abuse
- Parental mental health
- Autistic Spectrum Disorder
- Young Carer
- Home schooling

Five themes were identified by the panel that appeared to be important factors in the lives of these young people and potentially contributed to their death. It is important to consider these themes within the context of how knowledge of these factors may influence and inform the assessment of a young people in the future.

The presence of Autistic Spectrum Disorder (ASD) and other neurodevelopment conditions

The panel heard the stories of some young people with ASD where this affected their social relationships. They could be drawn to forming friendships with other young people who were vulnerable or who self - harmed. These young people sometimes talked about things related to death or displayed concerning behaviours, however, this was felt to be the influence of ASD rather than a coexisting mental health concerns. Other significant associations were rigid thinking, challenges of effectively communicating and hearing the child's voice, young people affected by change and potentially having difficulties forming relationships. It is acknowledged that ASD can be a risk factor for people who take their own life

Considerations for young people with ASD:

- Being alert to early warning signs in young people with ASD
- Effective meaningful communication with young people with ASD so that their voice is heard
- Consideration of a concomitant mental health problem or disorder
- Safety planning taking into consideration a young person with ASD
- Holistic assessment taking into account any additional vulnerability factors

Recommendations

- The multi-agency partnership needs to consider how ASD is highlighted and understood as a significant factor for children who are considering self-harm or taking their own life.
- Training and awareness in communicating effectively with young people with ASD and other developmental impairments should be included in suicide prevention training

strategies across the Derby and Derbyshire Suicide Prevention Partnership and Safeguarding Children's Partnership.

- Assessments and safety planning should take into account young people with ASD and the support required to help them regulate their feelings and strategies to enable them to manage their responses to stressful situations.

The presence of an Adverse Childhood Experience (ACE)

The presence of ACE's was identified as a significant factor for the young people reviewed in the themed panel. This included a history of abuse both directly and within the extended family. All of the children reviewed were victims of bullying which is a recognised ACE.

It is important to understand that the young person themselves may not be able to draw the link between the ACE and their current feelings and symptoms and so professionals need to be aware of ACEs, their effects and be able to spot when this is having a significant impact on a young person.

Considerations for practitioners:

- The importance of identifying ACEs and then providing appropriate support
- Assessment of the effect of the ACEs on that individual young person and an understanding of their coping mechanisms
- Consider how the young person responds to stress and including this in any safety plan
- There is increasing evidence that collaborative trauma informed services are important to work with individuals and families to reduce the effect of ACEs.

Recommendations:

- Any suicide prevention training to include an awareness of the potential effect and risks of ACEs on young people and adults.
- Raise awareness amongst frontline practitioners of the significance of ACEs for young people and the increased risks this may pose for young people's mental health.
- Consideration of a multi-agency strategy to support young people and their families when ACE's have been identified, this should include primary prevention and ACE informed practice.
- Development of children's personal resilience to enable them to overcome adversity and avoid its harmful effects. This can be achieved by resilience programmes or by providing individual support

The presence of bullying

Bullying was a significant factor for all of the children reviewed by the themed panel. It is important to be aware that whilst historically the majority of bullying occurred face to face, the rise in online and remote bullying via social media has increased significantly. Research does not clearly define a link between bullying and suicide as the relationship is complex. It is important to remember that young people with neurodevelopmental problems such as ASD have a higher incidence of experiencing bullying

Recommendations:

- Practitioners and schools to quickly identify bullying as an issue for individual young people and offer appropriate support.

- The multi-agency partnerships to continue to support educational settings with their work with children to reduce bullying and its consequences.

Previous Self Harm

All of the children reviewed had previously self - harmed. This included cutting, taking of medications and previous application of a ligature. It also included young people withholding food from themselves, not due to an eating disorder, but in order to self- harm.

Health Education England (2018)5 state: 'The relationship between self-harm and suicide is complicated. Although people who self-harm are significantly more likely to die by suicide or to harm themselves using more serious methods than the general population who do not self-harm, people may have many motivations for self-harm and are not always intent on dying. Suicidal intent may not be evident early on, but often emerges over time. Self-harm should always be taken seriously, as it will inevitably reflect an attempt to manage a high level of psychological distress. Therefore, it is important to work with the child or young person to understand their motivations and to not assume the motivations for self - harm are the same every time.

If a full assessment does not take place this prevents the child's voice being heard and management strategies or a safety plan being put into place to prevent further escalation. It is also a common misconception that suicide is inevitable and cannot be prevented and asking someone whether they are suicidal doesn't increase the risk. It is important that practitioners feel confident to talk to young people about how they are feeling and explore if they want to harm themselves. Self-harm can often be secretive and so professional curiosity is essential when talking to young people.

Recommendations:

- Strengthen practitioners practice so that they feel confident to discuss with young people how they feel and explore if they want to self-harm.
- A holistic assessment should be carried out in line with NICE guidelines and the child's voice should always be heard as part of the assessment. The assessment should include needs, strengths, and risks for the child with a clear safety plan within the child's family and social environmental context.
- Increase awareness amongst professionals in health and education of the NICE recommendation to refer for an assessment after any self - harm episode.

Young carers

Young minds estimate that there are 700 000 young carers in the UK. All local authorities have an obligation to complete an assessment of a young carer if notified. Being a young carer is an increased vulnerability for young people

Recommendations:

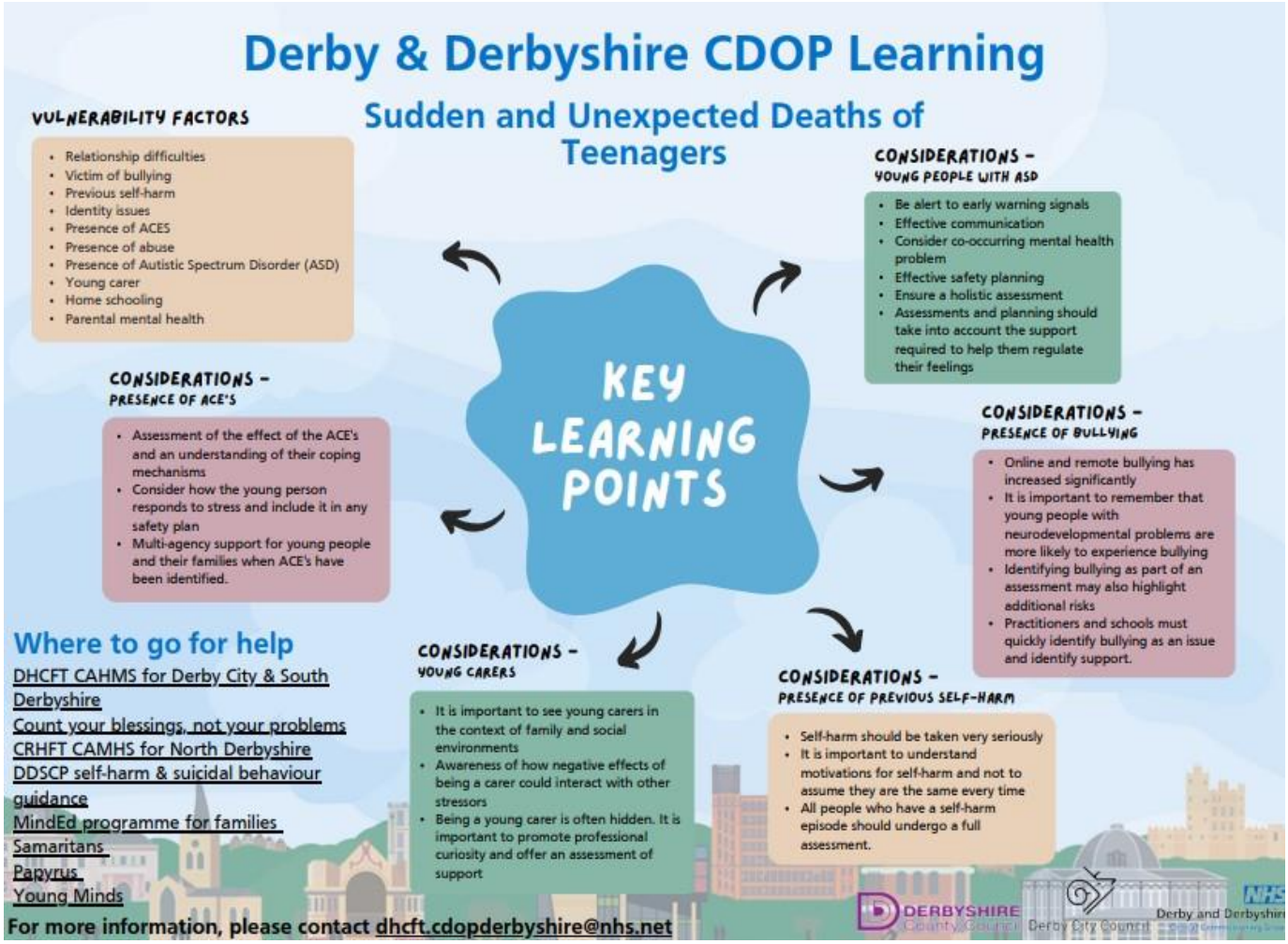
- Being a young carer is often hidden. It is important to promote professional curiosity of children who maybe young carers and offer an assessment of support to the child and family.
- Promote awareness of the potential burden of being a young carer, the vulnerabilities, isolation, interrupted education and financial concerns. These factors are likely to have an effect on a young person's mental health.
- Increase awareness of the young carer assessment provided by the Local Authority.

Overarching Recommendations for the multi- agency partnership to consider:

The report from the themed panel was shared with the three Child Death Review Partners, the Derby and Derbyshire Safeguarding Childrens Partnership and the Derby and Derbyshire Suicide Prevention Partnership with the following recommendations:

- Consideration to be given of strengthening assessments and safety planning taking into account the five areas of learning.
- To gain an understanding and perspective from young people of why they harm themselves and what services would help to support them at a time of crisis.
- To raise awareness of the 'Tomorrow Project' who provide bereavement support to anyone affected by suicide. http://www.tomorrowproject.org.uk/
- Suicide prevention training with a focus on children and young people.
- Produce a briefing document on the themes of the report.
- The themes from the panel to be shared as part of the CDOP Seminar Learning Event.

Learning Briefing



CDOP Learning Seminar

This year the child death review team organised and offered a virtual learning opportunity. The learning theme was the sudden and unexpected deaths in children. The seminar had several experts within their field to take the learner through the journey of a child and their family following an unexpected death. The participants heard about:

- The joint agency approach in SUDC (Sudden and Unexpected Deaths in Children)
- An interview with the Coroner explaining their role in these cases
- The role of the paediatric pathologist in the Investigation of SUDC
- The role of CDOP and the child death review process
- Learning from the two themed panels on Sudden and Unexpected Deaths in Infants and Sudden and Unexpected Deaths in Teenagers

There were 117 participants from a range of backgrounds and professional groups. Feedback was received from 37% of participants. The evaluations were very positive with 60% rated the seminar 5 out of 5 and 35% rating the experience as 4 out of 5. The child death review team will plan another seminar in 2 years.

Keeping Babies Safe in Derby and Derbyshire

The Keeping Babies Safe Strategy – the Three Steps for Baby Safety was published in 2021 and underpins the work this year around the number one priority of Derby and Derbyshire Safeguarding Partnership – The Safety of Babies.

The Keeping Babies Safe steering group in Derby and Derbyshire is a sub-group of CDOP. This group will support and develop and monitor the work being developed to promote the safety of babies. The Strategic Lead for Keeping Babies Safe is the Designated Nurse Safeguarding Children who chairs the steering group. The focus of the group is to consider the vulnerabilities of babies and how the group can support practitioners to provide research-based information, share learning from Child Practice Reviews and CDOP and provide advice and support to families to ensure that babies are cared for safely and protected from abuse and neglect.

There have been some fundamental developments within the KBS agenda all of which have had a focus on a multi-agency consistent approach to the messages regarding KBS. The strategies principles are:

- Safer Sleep
- Safe Handling
- Safe Space

Keeping Babies Safe Champions

The vision for Derby and Derbyshire is to have KBS Champions across the partnership including all health providers, children's social care and police. Over 100 Champions have been trained in this reporting year and 2 network events have been held to support the champions. The Champions are trained and supported by the Lead Nurse for Child Death Review and the Designated Nurse Safeguarding Children.

The role and responsibility of the Keeping Babies Safe Champions are:

- Be a resource regarding baby safety within their team and agency
- Attend training and updates on baby safety and share good practice
- Disseminate any learning from child practice reviews and CDOP regarding baby safety
- Raise the awareness of the importance of Safe Sleep, Safe Handling and Safe Space and the use of the strategy and toolkit to support families with babies

Keeping Babies Safe initiatives and projects

The Derby and Derbyshire Safeguarding Partnership - Keeping Babies Safe Conference and the briefing document 'Promoting the Safety of Babies – Learning from Reviews' was held this year and information disseminated widely across the partnership with the focus on the vulnerabilities of babies.

The safeguarding partnership identified a strategic lead to manage and develop the KBS agenda across the partnership. The lead is the Designated Nurse Safeguarding Children who is supported by leaders from each agency and the partnership manager. The strategic lead manages the KBS Action Plan and reports to the DDSCP quarterly on the progress of the action plan.

Achievements this year:

- Publication of the KBS Strategy – the Three Steps for Babies Safety
- Training of over 100 KBS Champions across the partnership
- Health audit and report completed on safer sleep and the delivery of the Parent Education Programme 'Shaking your Baby is Just Not the Deal' including the voices of parents and families
- Multi-agency audit and report on the safety of babies
- Development of an online Level 2 course on KBS
- Delivery of the Level 3 training via MST on KBS
- Development of an assessment tool for co-sleeping and bed sharing to be used with and by parents/carers will be launched in Quarter 1 2022

Developments for the next year of KBS work:

- Development of the Every Baby Matters Vulnerability Tool
- Update the video 'Never Ever Shake Your Baby' which supports the Parent Education Programme
- Development of messages to be used with parents at the 8-week baby check in General Practice
- Develop a multi-agency check list for home safety

- Develop information regarding the key messages of KBS for Early Years settings

The voices of Parents and the Child in the Child Death Review process and CDOP

When a child dies it is a tragedy for any family no matter what the circumstances are. Families and individuals manage the death of a child in their own way. Some will want to have an understanding about the child death review process and want to contribute their thoughts and feelings about their child's care and share personal information about their child, others want to grieve in their own way and do not wish to contribute the processes following the death.

It is important to Derby and Derbyshire Child Death Review Team that we contact every family following the death of their child and encourage a dialogue and the sharing of information if that is what a family wish to do. This is very much in the hands of the family. The team respect the wishes of families and their decisions.

The CDOP meeting will always consider the voice of the child and if the family have shared any views or information or would like any feedback following CDOP meeting. As time has progressed there has been an increase in families contacting us. In this reporting year 23 families contacted the Child Death Review Team. Some of the reasons for contact are:

- To inform us of care concerns they have had for their child. The Lead Nurse signposted to the provider of services or to the Coroner in these cases as appropriate
- To talk about their experience of services around the time of the death
- To tell us about their child, their likes and dislikes, their interests and about their personality. This information is always shared in the CDOP meeting to ensure the voice of the child is heard
- To provide photographs for the CDOP review. This brings the child into the room and has a positive impact on the importance of reviewing the child's story and subsequent death
- To tell us about the importance of clear communication with families particularly at the time of the death and in those early weeks
- To let us know what the legacy of their child's death has meant for them: For example - fund raising or charity events

The Lead Nurse for Child Death Review is a link for the families regarding the child death review processes. This includes liaising with the Coroner around care concerns, signposting families to support and bereavement services and answering any questions regarding the CDOP processes and meetings.

Any family requesting feedback will receive a letter from the Chair of CDOP thanking them for their contribution and with any learning that has been gained from hearing their child's story.

The team and CDOP believe it is important to get the balance between an independent review of a child's death and remembering the importance of the child's life and voice and how this can enrich any learning for CDOP and our wider partnership.

COVID 19 Pandemic

The COVID 19 pandemic continued to be the dominant and pervasive factor for health services, practitioners, the community and across the partnership during this reporting year. Rates of Covid 19 remained high and fluctuated however the rates of serious ill health and death reduced across the year. The booster campaign was the major focus across the year for health services and partners to ensure the workforce and public were safe and that services were protected. The

impact of Omicron was apparent across services due to the high rates of infection and the impact on sickness levels and service delivery.

All services were being affected by the pandemic however as rates appeared to decrease the restoration of services commenced. Although the rates of COVID were a challenge for services this did not appear to have a detrimental effect on the child death review process or attendance at CDOP.

A contingency plan had been in place for child death review and CDOP during the first year of the pandemic. Elements of the contingency plan have remained and have formed part of the processes around child death review during this year:

- RAG rating of child deaths that are open to CDOP
- Virtual CDOP meetings by MST
- Quarterly reporting to the Child Death Review Partners

RAG Rating

Green	Ready to be Reviewed
Amber	Awaiting Further Information or the CDRM needs to be held
Red	Awaiting Coronial or other Investigations

CDOP have seen the impact of COVID 19 in some of the deaths that have been reviewed.

Impact of COVID 19 on service delivery:

- Some bereavement support was being offered by phone/letter rather than face to face.
- The negative effect on communication when staff had to wear full PPE.
- Booking appointments was often via the telephone, which was particularly challenging for patients who did not speak English.
- There were delays in Coroner inquests, particularly when families requested a face-to-face inquest (rather than virtual).
- Delays in learning disability assessments as nurses within the team were re-deployed during the height of covid.
- Delay in identification of deteriorating ill health due to delay in accessing hospital support due to the fear of covid and GP reviews being by telephone rather than face to face.

Positive Practice highlighted during CDOP reviews

- Supporting families with the transition between services.
- Supporting emotional wellbeing.
- Education identifying and supporting vulnerable children during lockdown.
- The role of the key worker to facilitate communication between teams and family and providing support for the family.
- Supporting a family's wish for the child to die at home by providing care outside of a commissioned service.
- Religious and faith support for families.

- Excellent planning for end-of-life care, ensuring that families are involved in decision making
- Examples of continuity of practitioners, particularly in the antenatal period.
- Examples of excellent multi-agency communication and information sharing.
- Evidence that the neonatal bereavement pathway is having a beneficial impact on care received by parents.

Challenges for the Child Death Review Team

- Maintaining the child death review process to a high standard throughout the COVID 19 pandemic
- High number of coronial cases being delayed due to the COVID 19 pandemic

Achievements for the Child Death Review Team

- The Contingency Plan for Covid 19 has been reviewed and was successful in maintaining child death review processes and the CDOP throughout the restrictions of COVID 19
- Quarterly reporting to the Child Death Review Partners was started and has continued throughout this year.
- CDOP have held a themed panel on the Sudden and Unexpected Deaths of Teenagers from which the learning has been widely disseminated.
- Developed a visual briefing document on the Themed Panel for Sudden and Unexpected Deaths in Teenagers
- The Child Death Review Seminar was held virtually and was positively evaluated
- A Neonatal Pathway for Child Death Review has been disseminated and is being used by provider for both provider organisations
- The reviews of children with a learning disability has been strengthened with specific questions related to learning disability being addressed and with the attendance of a LeDeR reviewer at the CDOP meeting
- Regular child death review learning newsletters have been developed and disseminated the across the partnership
- The team have developed a guideline for modifiable factors to support CDOP members
- The CDOP page on the Derby and Derbyshire Safeguarding Childrens partnership website has been developed
- The Designated Doctor for Child Death has shared the concerns of the lack of 24-hour palliative care services with strategic groups for children and cancer care

Key priorities to be completed in 2022 to 2023:

- Monitor the impact from the learning the themed panel for Sudden and Unexpected Deaths in Teenagers
- Influence leaders of the multi-agency partnership on the findings and recommendations of the Themed Panel for Sudden and Unexpected Deaths in Teenagers
- Ensure that ACES are recorded by CDOP when reviewing child deaths
- Develop and deliver multi-agency Joint Agency Response (JAR) training with the Police
- Commence a long - term audit of non - accidental injuries in children who are presented at CDOP
- Produce CDOP learning newsletter on the dangers of water particularly open water to children
- Monitor maternal BMI and the risks associated with neonatal death and strengthen CDOP links with the Maternity Transformation Programme

- Develop guidance for practitioners on completing child death review reporting forms
- Develop a child death review and CDOP escalation pathway
- Plan a Themed Panel on deaths by trauma
- CDOP will continue to monitor the progress of the commissioning of community palliative care services for children

MINUTES OF THE AUDIT AND GOVERNANCE COMMITTEE

HELD ON 22 DECEMBER 2022 VIA MS TEAMS AT 2.00PM

Present:		
Sue Sunderland	SS	Non-Executive Director/Audit Chair
Richard Wright	RW	Non-Executive Director
In Attendance:		
Helen Dillistone	HD	Executive Director of Corporate Affairs (part)
Debbie Donaldson	DD	EA to Chief Finance Officer (note taker)
Darran Green	DG	Acting Operational Director of Finance
Keith Griffiths	KG	Chief Finance Officer (part)
Richard Heaton	RH	Business Resilience Manager
James Lunn	JL	Head of Human Resources and Organisational Development
Nicola Jane Smith	NJS	Assistant Director Children's Strategic Commissioning (for AOB Item only)
Chrissy Tucker	CT	Director of Corporate Delivery
Apologies:		
Dr Buk Dhadda	BD	GP
Donna Johnson	DJ	Acting Assistant Chief Finance Officer
Usman Niazi	UN	Client Manager, 360 Assurance
Suzanne Pickering	SP	Head of Governance
Chris Leach	CL	Head of EPRR
Kevin Watkins	KW	Business Associate, 360 Assurance

Item No.	Item	Action
AG/2223/104	**Welcome, introductions and apologies** Sue Sunderland as Chair welcomed all members to the meeting. Apologies were received from Dr Buk Dhadda, Suzanne Pickering, Donna Johnson, Kevin Watkins, Usman Niazi and Chris Leach. It was noted that Helen Dillistone and Keith Griffiths would be joining this meeting after attending an urgent System Escalation Call.	
AG/2223/105	**Confirmation of quoracy** The Chair declared the meeting quorate.	
AG/2223/106	**Declarations of Interest** The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the Integrated Care Board (ICB).	

	Declarations declared by members of the Audit and Governance Committee are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: www.derbyandderbyshire.icb.nhs.uk No declarations of interest were made at today's meeting.	
FOR DECISION		
AG/2223/107	**Human Resources Policies** James Lunn presented 2 policies for review by the Committee: **Travel and Expenses Policy**: Committee were advised that this policy was largely a 'lift and shift' from the CCG to the ICB but had also been updated to reflect that the ICB now uses an electronic system for processing expense claims (EASY eExpenses). Accordingly references to some paper forms and processes had been removed and replaced with refence to the EASY eExpense system. The Chair referred to page 10 of 22, where it stated (a) driving licence (paper and photo card), she thought that was incorrect, it was either or. James Lunn agreed to update this on the policy before it was published. It was stated on the policy (EASY eExpenses page 11 of 22) that completed forms were required to be submitted by the first working day of the month, the Chair felt this was not correct. James Lunn agreed claims could be submitted at any point but should be made no later than 3 months after the event. James Lunn agreed to review and update this section of the policy. It was noted that most employees were claiming expenses electronically, but there were instances where paper copies would still be used to claim expenses, for example interviewee expenses who were not employees of the ICB. James Lunn reported that since writing the Travel and Expenses Policy, the NHS Terms and Conditions had been updated to provide a slightly higher rate for motor vehicles from 56p to 59p/mile up to 3,500 miles and then from 20p to 24p/mile over 3,500 miles. The policy would be updated to reflect this from 1 January 2023. **Audit and Governance Committee APPROVED the Travel and Expenses Policy.** **Working Time Directive:** Committee were advised there were no significant material changes to this Directive, only minor amendments/inclusions in terms of ICB branding and a 'lift and shift' from the CCG to NHS Derby and Derbyshire ICB.	JL JL

	Audit and Governance Committee APPROVED the Working Time Directive.	
FOR CORPORATE ASSURANCE		
AG/2223/108	**External Audit** **Draft External Audit Plan 30 June 2022** It was noted that, unfortunately, KPMG had not attended Committee to present the Draft External Audit Plan. The Chair confirmed that she was happy to proceed with this item without a representative from KPMG being present. Darran Green reported that he had gone through the draft Audit Plan with Donna Johnson and Chloe Foreman; there was nothing in there that raised any concerns. Regarding the fees being charged by KPMG, Darran Green reported that, again, there were no concerns. It was noted that the ICB had received extra funding for the audit fees, which covered the amount being charged. Richard Wright referred to the section regarding 'going concern', and asked Darran Green whether he had any extra concerns in view of our cash worries? Darran Green responded that should Derby and Derbyshire ICB cease to exist for whatever reason, there would still be an NHS organisation responsible for commissioning healthcare services for the people of Derbyshire; it was a public service that would continue regardless of who provided it. It was noted that many NHS organisations would be heading towards serious cash issues in the coming months; it was hoped that guidance of how to meet this challenge would be received in due course. Darran Green reported that ICBs did not have a cash limit, unlike the CCGs had, so there would always be the opportunity to drawn down additional cash, but that we would have to clearly state the case for that. **The Audit and Governance Committee APPROVED the External Audit Plan.**	
AG/2223/109	**ICB Financial Position Review – M8** Darran Green presented the ICB financial position review for M8 and highlighted the following: • As at 30th November 2022, the ICB had reported a forecast break-even position in its Integrated Finance Report (IFR) to NHS England. • Whilst forecasting a break-even result for the IFR return, work had continued to address the underlying issues to achieve	

	additional savings with a commitment to meet the £19m deficit agreed for the system with NHSE. • The current potential savings identified had improved the position significantly by £10.2m from the M7 savings challenge of £4.4m to a £5.8m surplus. • £6.7m of the savings were identified during M8 and through the Executives and their teams it was agreed that the uncommitted expenditure could be used to improve the position. • £1.3m of the improvement was due to the National Winter Funding with the remainder £2.2m the net impact of other movements. • The mitigated forecast outturn position of £5.8m was likely to be used to offset overspends within the system. The Chair reported that this was a helpful paper, it picked up the risks and gave a good view of where we were sitting as an ICB. It was noted that the Finance and Estates Committee were aware of the wider system issues and how it linked into that. The Chair was happy that the report flagged up the key elements that was needed for assurance purposes. Both the Chair and Richard Wright felt the ICB were setting a good example across the system and asked that their thanks be passed to the Finance Team for producing this report in the way that it had been done. **The Audit Committee NOTED the M8 ICB Financial Position.**	
AG/2223/110	**Scheme of Delegation and Reservation** Darran Green reported the ICB's Scheme of Reservation and Delegation (SoRD) was largely inherited from its predecessor CCG whilst the ICB's objectives and system working was evolving. It was complex and could create a lengthy bureaucratic process for approvals of commissioning and business cases. The ICB had carried out a review of its current delegation arrangements within its Governance Handbook. This report outlined the move to a more simplified SoRD to: • Enable Budget holders to make decisions within their budgeted allocations • Accelerate the decision-making process, • Reduce the demands at Committee meetings, • Produce a less complex and more comprehendible SoRD. • Whilst simplified, the SoRD proposed would continue to maintain a high level of control. A detailed comparison of the changes was included in the report appendices, along with the minor changes to the SFIs to ensure continued consistency. Budget holder and budget manager training was currently being rolled out to ensure a solid financial foundation to support the management of budgets and ultimately decisions.	

	It was noted that the revisions improved the accountability of expenditure and supported the achievement of financial sustainability. Darran Green highlighted the following key changes from the report: **Commissioning/investment decisions:** (Dis)Investment decisions and tender ratifications would no longer require approval from PHSCC. Instead, PHSCC would review clinical business cases alongside the below delegations. (Dis)investments decisions that were within budget (ensuring recurrent budget/funding was available where required), the decisions would be the responsibility of the below: • <£50k annual cost - Functional Directors (Budget managers) • <£100k annual cost - Executive Directors (Budget holders) • <£1m annual cost - The Executive Team Committee • <£1.5m annual cost – PHSCC (where the Committee has a specific delegated budget). • >£1m annual cost – ICB Board Anything above budget (including expenditures that continue beyond available budgets/funding) would require Executive Director of Finance (DoF) sign-off following discussion at the Executive Team Committee, were in line with the above limits. **Role of Delivery Boards/System Forums:** Whilst (dis)investment decisions would be discussed at Delivery Boards, Provider Collaborative, and other such forums to ensure there was a multi-disciplinary and system consideration, those forums do not hold a budget and the Executive Director was ultimately accountable for decisions made. Hence, such forums were not delegated to approve potential (dis)investments. Darran Green clarified that we were looking for Committees to support decisions and give Executive Directors a steer. As the delegations would go to the Executive Director (and they would be held accountable), it ultimately had to be them that authorised any decisions. Richard Wright agreed with this proposal as it would take a lot of the approval process away from System Finance and Estates Committee and would allow that Committee to look at the bigger plan. **Staff Establishment:** The Executive Team Committee would no longer be required to have oversight of the staffing establishment. This would be delegated to the Functional Directors to manage within the budgeted allocation.	

	The Chair agreed with the need to streamline decision making and ensuring that it lies within the appropriate place. It was noted that this would help us move things forward and give Committee's time to focus on strategic planning and monitoring. **The Audit and Governance Committee NOTED the ICB Scheme of Reservation and Delegation Update.**	
AG/2223/111	**EPRR and Business Continuity Update** Richard Heaton presented EPRR and Business continuity update and highlighted the following: **Core Standards 2022-23**: • There had been a completely different process this year; we had submitted our own self-assessment and had the added responsibility of looking at all Provider self-assessments. • We had reached a final general level of consensus and presented it to the Derbyshire Local Health Resilience Partnership (LHRP) and NHSE. • The overall position for Derbyshire was of partial compliance. • Some organisations had moved forward quite a bit from last year. • The overall compliance for the CBRN aspect for Derbyshire was substantial. • The intent was to report this position to the ICB Board in January 2023, with clear workplans and engagement processes in place to ensure compliance was improved across the Derbyshire footprint. • NHSE would collate all the responses for the region and submit up to the National Board in March. • A working group would be established in the Spring 2023 to better ensure preparedness for system audit 2023/24. • There were no major concerns regarding CRH and Derbyshire Healthcare being non-compliant two years running. • DCHS had made substantial improvements this year. • Chrissy Tucker explained that when we were going through the assessment process a lot more documentary evidence was called for, which Providers had struggled to provide. We now had a plan to take us through next year to get us all into a better position. • There would be regular focus on how all the organisations were getting on with their actions/standards. A monthly EPRR meeting had been set up, together with the Health Emergency Planners Group Meeting to draw out the best of the organisations and keep focus on this area. **Industrial Action:** • The risks associated with Industrial Action and its impact to NHS services had escalated.	

	• Within Derbyshire the RCN did not secure a mandate for strike action, however surrounding ICB areas had eg Nottinghamshire - the ICB was working with partners to understand potential impacts specifically around the trauma elements provided by NUH. • The GMB, Unison and Unite had managed to secure a mandate for strike action which does affect East and West Midlands Ambulance Services. This posed a significant risk to the local system with potential for ambulance response, emergency control centres, 111 and patient transport services being affected. Dates have been set for the 21st and 28th December for Ambulance strike action. Both nationally and locally, unions and Ambulance services were negotiating to set derogations for the action to safeguard care to patients. • The ICB had stepped up an IMT in place of its weekly system planning call, this meets twice a week (Tuesdays and Thursdays from 1000-1100) to discuss preparedness, risks, gaps, and mitigations. This was then placed into a plan managed strategically by the SORG. The IMT was made up of all key partners within the ICB area and includes acute, community, mental health, ambulance, communications, and Derbyshire Health United colleagues to ensure planning was holistic and linked together, encouraging a joint understanding of the risks posed. • Key issues at present related to derogations not being fully determined, both in relation to the RCN and Ambulance Strikes. It was difficult to predict what the full impact would be and as such the IMT had taken the approach to work with the worst-case scenario of significant impact, the response could then be scalable to the situation faced on the day. • Incident Command and Control would be established via the OCC with significant EPRR support to ensure robust management and response to the incident. **Operational Control Centre (OCC):** The OCC had now become operational (as of 1 December); it was staffed 7 days a week 8am-8pm. It had worked well in its first few weeks. The priority remains to ensure recruitment was completed to ensure rota coverage could be maintained, at present the UEC team were still providing the core workforce to manage and sustain the OCC. The OCC was being prepared and briefed to lead on system coordination this winter which includes the response and management of Industrial Action events that may transpire. **Exercise Arctic Willow:** On the 30th of November 1st December and 2nd December, the ICB delivered Exercise Arctic Willow across the ICB footprint of Derbyshire. This exercise tested system preparedness for the	

	potential winter events of surge and demand, procurement issues, industrial action, and utility disruption. Several health providers from across Derbyshire took part with clear indication that there was a high level of internal preparedness in place across the region to respond to these types of incidents. Key areas of discussion and therefore further work were linked to: • Mutual aid activation and what this looked like for Derbyshire. • Linked up system approach required to planning and response to incidents. • Clear potential impacts for PTS in relation to Industrial Action. It was noted that learning from this exercise had been submitted to NHSE and the UKHSA; the ICB awaited feedback from the national/regional debriefs. **Incident Response Plan:** Richard Health reported that attached to this paper was the draft Incident Response Plan for Derby and Derbyshire ICB. This now included all key aspects required for a Cat 1 responder and details: • Activation processes • Command and Control process • Reporting arrangements • Key roles within the IMT response • Action cards • CBRN/HAZMAT response • Mass Casualty Response The plan had been sent to providers and partners to ensure a linked-up approach. The plan could then be exercised early 2023 under Exercise Apollo, which would include system partners to ensure all assumptions were considered within the response process. The plan was now ready for formal sign off by Audit and Governance Committee with awareness that likely minor changes would be needed post exercise and incidents in the winter 2022. **EPRR Strategy:** Richard Heaton reported that to ensure consistency and a defined approach of what EPRR was and how it would be delivered within the ICB, an EPRR Strategy had been constructed that would detail what the primary roles were of key personnel within the ICB in relation to EPRR and how EPRR would be delivered across the ICB over the next year.	

	Also contained within this section was the ICB training needs analysis to ensure that staff were appropriately trained for incident response. The Strategy had received approval from NHSE and covered several of the core standards required of the ICB. The plan was now ready for formal sign off by Audit and Governance Committee with awareness that likely minor changes would be needed post exercise and incidents in the winter 2022. The Chair thanked Richard Heaton for this very detailed report which she felt had addressed the ICB's extra responsibilities and this Committees initial concerns. It was noted that we were now in a much stronger position with the EPRR Strategy, plans and work cards in place setting out everyone's responsibilities very clearly. It was noted that the ICB and system were now in a critical incident, which may continue into January and in effect were testing out the processes and plans put in place. Chrissy Tucker reported that we were encouraging on call staff to go to as many exercises as possible that the LRG had set up in order that they would feel more comfortable when incidents happened. It was noted that an exercise had been set up early in the New Year, and an invitation was extended to Audit and Governance Committee members to take part if interested. **The Audit and Governance Committee NOTED the EPRR and Business Continuity Update and APPROVED the Incident Response Plan and EPRR Strategy.**	
AG/2223/112	**Conflicts of Interest Report** Chrissy Tucker informed members that this report summarised the activity that the ICB had undertaken to manage conflicts of interest, since the last report to the Audit and Governance Committee in September 2022. A Forward Planner for 2022/23 was attached at Appendix 1, to assure the Committee further on the work that was planned for this financial year. Chrissy Tucker reported that we had a discrepancy with the online training figures currently. It was reporting an incorrect number of people who had not completed training. HR were picking this up with the ESR team to rectify this. As a result, Board, Corporate Committee members and decision makers would be asked to check and update any declarations of interest early in January. The Chair referred to page 1 of the report under the executive summary where it talked about protecting the ICB, its Board, decision makers and employees from allegations and perceptions	

	of wrongdoing. She thought that when we agreed the COI policy, we had said it needed to be wider than GP practices and should include all system partners sitting on our committees. The Chair went on to add that system partners sitting on our committees were also asked to complete ICB online mandatory training unless they could prove that this had already been completed as part of their partner organisation. Chrissy Tucker agreed to check on both issues as an action and report back to Committee next time. **The Audit and Governance Committee NOTED the report and RECEIVED assurance on the following:** • **Conflicts of Interest Forward Planner** • **Decision Makers' Register of Interests** • **ICB Board & Committee Members' Register of Interests** • **Confidential Register of Interests – nil return** • **Summary Register for Recording Any Interests During Meetings** • **Gifts, Hospitality and Sponsorship Register** • **Procurement Register** • **Breach Register – nil return**	CT
AG/2223/113	**Internal Audit Recommendations Report** Chrissy Tucker reported that the Internal Audit Recommendations Tracker details the recommendations required from the outcome of the individual audit reports. Responsible leads were required to upload evidence to demonstrate the completion of the required recommendations and actions. The online tracker also identified those that were outstanding, and the Corporate Delivery Team were required to monitor and request updates on these to ensure that the ICB meets its aim of a 100% completion on all actions. This percentage was a key area of the Head of Internal Audit Opinion. At October's Audit and Governance Committee, the Internal Audit Recommendations Tracker identified one outstanding action which had a deadline due date of 30th September 2022. This action was subsequently marked as complete by Internal Audit within their October 2022 report to Audit and Governance Committee. It was noted therefore, all actions were now complete. The Chair asked that Committees thanks be passed to the Corporate Delivery Team for their hard work in ensuring that all actions were complete. **The Audit and Governance Committee REVIEWED and NOTED the Internal Audit Recommendations Tracker.**	

AG/2223/114	**Mandatory Training and Compliance Report** Chrissy Tucker reported that the purpose of this paper was to provide assurance to the Audit and Governance Committee of the ICB's compliance regarding mandatory training. Compliance levels as at the 5 December 2022 were detailed in this report. It was noted that mandatory training continued to be encouraged through line managers, appraisal processes and reminders generated by our online system. Chrissy Tucker, however, reported that currently there was a discrepancy with the online system being used to generate this report, which was showing an incorrect representation of people who had not completed training. For example, there were several people who had completed the conflicts of interest training, but who were showing as still required to complete. This was being raised with the relevant team (ESR) by HR colleagues. **The Audit and Governance Committee RECEIVED the Mandatory Training Compliance Report.**	
AG/2223/115	**ICB Committee Meeting Log** The purpose of this report was to inform the Audit and Governance Committee of the discussions and decisions made at the following NHS Derby and Derbyshire ICB committees: • Finance & Estates – October and November 2022 • People & Culture – July, September, and December 2022 • Population Health & Strategic Commissioning – October and November 2022 • Public Partnerships – October and November 2022 • Quality & Performance – September, October, and November 2022 **The Audit and Governance Committee NOTED the Committee Meeting Log.**	
FOR INFORMATION		
AG/2223/116	**Non-Clinical Adverse Incidents** Chrissy Tucker reported that there had been no non-clinical adverse incidents. **Audit and Governance Committee thanked Chrissy Tucker for this update.**	
MINUTES AND MATTERS ARISING		
AG/2223/117	**Minutes from the Audit and Governance Committee meeting held on 24 November 2022**	

	The minutes from the meeting held on 24 November 2022 were agreed as a true and accurate record of the meeting.	
AG/2223/118	**Action Log from the Audit Committee meeting held on 24 November 2022.** The action log was reviewed and updated during the meeting.	
	CLOSING ITEMS	
AG/2223/119	**Forward Planner** The Chair asked for the forward planner to be rolled forward, as from February 2023 this Committee would be moving to bi-monthly meetings. **The Audit and Governance Committee ACCEPTED the Forward Planner.**	CT/SP
AG/2223/120	**Any Other Business** The Chair reported that the following late paper had been received for noting: **All-age Early Intervention and Prevention Service for Eating Disorders Procurement Award.** Nicola Jane Smith apologised for the late receipt of this paper and asked Committee to note the decisions made by the Mental Health System Delivery Board under the revised scheme of delegation from PHSCC, to award the contract for an all age eating disorder prevention service to First Steps ED. It was noted that we had followed the request for quotation process as advised by procurement colleagues, and First Steps ED did not quite meet the threshold. It was noted that CSU procurement colleagues were assured of the quality of the service First Steps ED were offering, and it was more about the way that they had completed the forms, rather than issues contained within their submission. CSU procurement colleagues advised that, where the commissioner could satisfy themselves that a decision to award was safe and in the interests of patients, PPCC regulations confer the ability to award the highest bidder, without a need to cancel the procurement. When the spend was below the PCR threshold (£663,540) procurements needed to comply with Procurement, Patient Choice & Competition Regulations (2) 2013 (PPCC). These regulations were governed by NHSI and not the UK Courts. These regulations did not state that a procurement must be undertaken or even advertised but they did state that commissioners must:	

	• Act in the best interest of patients • Award to the most capable provider • Encourage integration of services • Secure best value • Treat all providers equally • Act proportionately An RFQ was a robust process that meets these requirements, though it was the requirements themselves that were necessary, not the RFQ. Given the nature of the minor reservations, the quality assurance found in the bid as a whole, and the requirement to act proportionately, in the best interests of patients, Procurement colleagues assured the Commissioner that exercising discretion in these circumstances was appropriate. With support from Procurement colleagues and the ICB's Senior Leadership Team, approval was gained from MH, LD&A, CYP System Delivery Board on the 8th December 2022, under the revised scheme of delegation, to conclude the RFQ with an award to First Steps ED. The Chair asked whether there was anything we could do to help potential providers with completing submissions correctly; we did not want to lose out working with providers because they could not complete the forms correctly. Nicola Jane Smith agreed with the Chair, that there was a piece of work that we needed to do with procurement colleagues to provide some support to organisations with this. The Mental Health Board and the Children's Delivery Board had now got VCSE representation, and part of their role was to support some of the smaller providers in terms of procurements and filling out the forms and making sure that we hold events that would enable them to do that. It was noted that we had gone out to procurement and managed to get two quotes back out of a potential eight; this did not give us much of a choice. Nicola Jane Smith reported that procurement colleagues were due to come to Committee to discuss contracts and how they were awarded in the next couple of months. It was reported that we struggled sometimes to get providers interested in making a submission. Richard Wright asked whether procurement colleagues had obtained feedback from the six providers who had expressed an interest initially as to why they had not submitted a quotation. Chrissy Tucker reported that we could ask procurement colleagues if they would do that for Committee. Nicola Jane Smith agreed to take this action. It was feared that in future we may have to pay a	NJS

	premium to get providers interested in tendering for services or try and bring services in-house. The Chair reported that this paper had come to Audit and Governance Committee today specifically because of the unusual approach to the procurement of this service, together with the fact that neither of the bids had originally passed the threshold. Nicola Jane Smith had given Committee extra information around the procurement process, and members were asked to confirm that they felt that this was an appropriate process to have gone through. It was noted that members felt assured that the decision to award the contract to First Steps ED was taken following a robust process and Committee understood the reasons why it had been done this way. **The Audit and Governance Committee NOTED the All-age Early Intervention and Prevention Service for Eating Disorders procurement award to First Steps ED, as agreed by the MH, LD&A, CYP System Delivery Board under the revised scheme of delegation from PHSCC.** Helen Dillistone and Keith Griffiths joined the meeting at this point. There was no further business.	
AG/2223/121	**Assurance Questions** • Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? **Yes.** • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? **Yes.** • Were papers that have already been reported on at another committee presented to you in a summary form? **Yes**. • Was the content of the papers suitable and appropriate for the public domain? **Yes** • Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? **No, there were a couple of late papers.** • Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? **No.**	

	• What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? **No.**	

DATE AND TIME OF NEXT MEETING
Date: Thursday 9 February 2023
Time: 2.00PM
Venue: MS Teams

Signed: …… Dated: ……..
(Chair)

MINUTES OF THE ICB PEOPLE & CULTURE COMMITTEE (ICB PCC)

HELD ON WEDNESDAY 07 DECEMBER 2022, VIA MICROSOFT TEAMS, 0900-1100

Present:		
Gildea, Margaret	MG	ICB Non-Executive Member and Chair of ICB PCC
Bayley, Susie	SB	General Practice Taskforce Derbyshire – Medical Director
Dawson, Janet	JD	NED DCHS and Chair of PCC
Garnett, Linda	LG	Programme Director, People Services Collaborative
Lowe, Jaki	JL	DHFT Director of People & Inclusion
Rawlings, Amanda	AR	ICB and UHDB Chief People Officer
Skila, Jen	JS	Assistant Director HR, Derbyshire County Council
Tidmarsh, Darren	DT	DCHS Chief People Officer / Deputy Chief Executive
Wight, Jeremy	JW	CRH Non-Executive Director and Chair of PCC
In Attendance:		
Bradley, Faye	FB	CRH Interim Deputy Director of HR & OD – on behalf of Caroline Wade
Broadhurst, Kim	KB	Head of Retention – People Services Collaborative
Cooke, Nancy	NC	ICB System Workforce Planning Lead
Mahil, Sukhi	SM	Assistant Director Workforce Strategy, Planning and Transformation
Smith, Beverley	BS	NHS Derby and Derbyshire CCG, Director of Corporate Strategy & Development
Thompson, Helen	HT	Executive Assistant to Amanda Rawlings
Usman Niazi	UN	Client Manager, 360 Assurance
Watkins, Kevin	KW	Client Lead, 360 Assurance
Apologies:		
Blackwell, Penelope	PB	Place Board Chair and NHS Derby and Derbyshire CCG Governing Body GP
Crapper, Emma	EC	Derbyshire County Council, Director of OD and Policy
Dhadda, Bukhtawar	BD	NHS Derby and Derbyshire CCG, Non-Executive Director and ICB Non-Executive Member Quality & Performance
Gulliver, Kerry	KG	EMAS, Director of Human Resources & Organisational Development
Knibbs, Ralph	RK	DHFT Non-Executive Director and Chair of PCC
Moore, Liz	LM	Derby City Council, Head of HR
Sharma, Vijay	VS	EMAS, Non-Executive Director
Street, Joy	JS	UHDB Non-Executive Director and Chair of PCC
Wade, Caroline	CW	CRH Director of HR & OD

Item No.	Item	Action
PCC/2223/25	**Welcome, introductions and apologies** Attendees were welcomed to the meeting, introductions were made and apologies were noted as above.	
PCC/2223/26	**Confirmation of quoracy** The meeting was confirmed as quorate.	
PCC/2223/27	**Declarations of Interest**	

	MG reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the ICB. No declarations were made at this meeting.	
FOR APPROVAL		
PCC/2223/28	**Board Assurance Framework (BAF) – Strategic Risks and Risk Management** ICB PCC received the report which sighted committee members on the PCC strategic risks discussed at the last ICB Board, to seek agreement and to discuss how the detailed work on developing the BAF will progress. ICB PCC noted that two People and Culture strategic risks to the delivery of the ICBs strategic priorities have been identified and allocated to the ICB PCC :- ▪ There is a risk that the system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans. ▪ There is a risk that the system does not create and enable One Workforce to facilitate integrated care. ICB PCC received suggestions from committee members regarding the two potential additional risks which can either be incorporated in the first two or could be separate on workforce resilience and workforce wellbeing and in addition the inclusion of culture to enable and integrate workforce into One Workforce. ICB PCC received a presentation from Kevin Watkins from 360 Assurance on risk management and BAF. The presentation included a brief focus on the committees' risk management responsibilities, risk tolerance versus risk targets and feedback on the BAF format. KW was asked to share his presentation to ICB PCC members. ICB PCC noted that the next steps would be to populate a more detailed BAF template and to articulate in more detail what strategic risks are around those headlines and can draw out different elements that might sit behind. SB noted are talking about system risks, but need to be aware that as the system risks grow, the individual risk that staff are taking is also growing, e.g. medical indemnity. LG noted that will be quite challenging to be able to populate and think about what are some of the mitigations and controls, as a lot of the risks are out with our direct control as don't fall to us as employers. JD queried how the risks at ICB level interact with the risks at Trust level, as a lot of the mitigation is clearly in the hands of the individual employers, so it would seem that the very high level risks	KW

	are the ones that ICB PCC should be considered and we should be tasking or encouraging the individual providers to feedback how they are mitigating those risks effectively on the ICBs behalf. Would therefore need to make sure that the ICB risks and the Trust risks are aligned and the mitigations that feed in are the ones that the individual Trusts are seeing and being escalated and fed into the ICB management of those risks. AR suggested that herself and peers, including local authorities, would populate the high-level risks / BAF template and circulate to ICB PCC members for comment, before they go to the January ICB Board. **ICB PCC noted the BAF / Strategic Risks and the actions as outlined above.**	AR
ITEMS FOR ASSURANCE		
PCC/2223/29	**Annual Plan Progress, Winter Preparedness and Agency Spend** ICB PCC received the presentation which provided an update on Workforce Oversight, including annual plan and agency overspend and analysis. DT highlighted the following key points:- ▪ Planned workforce growth in the bridge analysis which evidences as a system that have put significant investment into workforce in the five providers within the Derbyshire system. ▪ Now into a rhythm of reporting and monitoring workforce actuals to plan. Have presented the information both with and without East Midlands Ambulance Service (EMAS). ▪ At month 7 can tame some assurance that the vacancy position has significantly reduced. Vacancies against a planned growth from a high month 5 that has slowly reduced down to month 7 and helped at month 7 by the fact that continue to recruit well. Recruitment functions across the providers are performing well. Attraction does not seem to be overly problematic. Have also had a significant reduction in people leaving the four providers in JUCD in month 7 ▪ Substantive planning numbers are still well below plan, recognising that was fairly ambitious growth. This has meant that throughout the year and will continue to remain the case for the remainder of the year, is that there is a higher dependency on temporary staffing than was plan ed and particularly around agency spend. ▪ Agency cap at JUCD was £22.5m and has already exceeded that at £23.1m at month 7 and forecast outturn is £38.7m. Comparatively are still in the mix in terms of the total amount of agency used as a system as a proportion of revenue. That said, probably put in a too ambitious plan as a system around agency reduction based on that planned substantive growth which have not been able to deliver. Medical agency is a significant proportion of agency staffing.	

	▪ There is an issue with triangulation with Finance and disconnect between the finance plan and finance actuals ▪ Believe can take some assurance – continue to recruit well, retention improved in month 7 and agency reduction so there is some level of control. ▪ Immediate actions – to see some details as a committee, some detailed analysis of the agency spend and have already commissioned, so can start to understand the detail and the individual provider actions. ▪ Many of the posts for agency spend are for medical agency – there are longer term solutions around training posts and international recruitment – believe there is an ask for organisations to look at the triangulation of finance and staffing costs, actuals and planned staff numbers to the end of the year, so are looking at forecast outturn and then need to look ahead to 2023-2024 and make sure priority for the committee. Need a high level of assurance of what the 23/24 plan looks like. Need to have consistent approach as there are clearly some differences in approach between providers. Need to also make sure see the workforce for the actual ICB and keep an eye on growth and costs for the ICB and need to include primary care and particularly general practice ▪ Can take some assurance at month 7 due to the improving position both in terms of vacancy reduction and agency control but need to closely monitor that to the end of the financial year. ▪ Are asking the committee to receive information on a deeper analysis of agency spend and the controls that will be put in place by providers to the end of this year and into 23/24 and believe are asking each of the providers to review triangulation between finance and workforce to forecast outturn and then to support preparations for 23/24. JD raised a query regarding announcement this morning regarding using the private sector to address backlogs, and the potential impact on NHS providers of doing that and; possibly of staff being pulled out of the NHS to deliver the work; funding sources and whether funding will come out of NHS budgets. DT noted that already see that, particularly in things like the MSK space. Regarding mobilisation of workforce trained and commissioned by the NHS, migrating to private providers, that is the kind of things you intuitively would expect, so will need to keep close eye on and ensure our offer is as competitive and not just in terms of pay but wider kind of workforce offer particularly around flexibility and protection of wellbeing. MG summarised outcomes:- ▪ Can note limited assurance but take heart from positive movement. ▪ Prepare to receive more detailed dive on agency spend. ▪ Individual sovereign trusts and employers look at the triangulation of own people numbers and finance plans and	

	do what they can to mitigate any risks that arise from discrepancy there. **ICB PCC noted the presentation.**	
PCC/2223/30	**One Workforce Strategy and Workforce Plan** ICB PCC received the report and presentation which provided an update on the planned approach to develop a One Workforce Strategy for the Joined Up Care Derbyshire ICS. The presentation included the following key highlights, which SM explained in full:- ▪ What does our One Workforce Strategy need to set out – defining the why, how, what and who. ▪ Key activities including diagnosis, planning, vision and purpose / framing and planning. ▪ Case for change (why) ▪ Our Vision – what will be different. ▪ Creating the conditions for success – our principles (draft). ▪ Moving from our current state to our desired state. ▪ Strategy development – high level approach and timeline ▪ Mobilisation ▪ Resourcing SM noted that would need to set the vision and purpose collectively as a system and ensure that all partners are included (primary care, social care, voluntary sector) and would also work with everyone to ensure capture thinking and aligning with other models of care including integrated care strategy, ICB five year forward plan, clinical strategies etc. SM also highlighted the huge piece of work that would need to take place around the People Services Collaborative 7x5 work programme, including ensuring have the right things in place to be able to deliver what need to. May need to reassess some of the programmes of work and scale things up or down or change things to ensure efforts are being put behind the right things and the things that will make the most significant difference. JL noted would like to see in terms of the case for change in having system wide approaches, is how we develop a workforce that is diverse. ICB PCC members agreed that the draft principles as outlined, with the inclusion of JL's suggestion regarding a diverse workforce mentioned above. KB suggested the need to ensure the approach and in particular the messaging is landed with the whole workforce across the provider spectrum very carefully in terms of how will be interpreted – something around the language of One Workforce whether it is working differently or an allied workforce or a connected workforce. SM thanked KB for her suggestions and noted that would be part of the engagement and part of the conversation to kick start the process.	

	AR noted that the 7x5 work programme was developed and has been driving the work programme this year. When SM goes through this engagement process and pulls it all together, the 7x5 process could fundamentally change. AR noted that following the recent Provider Leadership Collaborative, the System HRDs have been tasked to think of and work through an options appraisal of the things that really want to take forward at scale across the system. FB queried whether compassionate inclusive leadership should be included as will play a key role in shaping the culture of trusts across the system to delivery high quality care. **ICB PCC noted the report.**	
PCC/2223/31	**Industrial Action** ICB PCC received a verbal update and AR highlighted the following key points:- ▪ First ballot result was RCN. ▪ Two acute trusts did not meet the threshold for industrial action but DCHS and DHFT did. ▪ RCN initial strike dates identified as 15th and 20th December 2022. ▪ Potential that RCN may re-ballot organisations that did not meet the threshold. ▪ Unison did not meet threshold across providers in Derbyshire and therefore will not be taking industrial action. ▪ Complicated bit before Christmas is the Unite, GMB and combination of unison and the impact on the ambulance sector. ▪ UHDB falls under both EMAS and WMAS and both of these will be taking action on the 21st and 28th December, so do have the scenario of understanding the impact around the ambulance sector over Christmas within geographies. Part of emergency planning response is now understanding between now and Christmas the impact around emergency responses. ▪ Exercise ran last week called Artic Willow which broughs providers, ICB and emergency planners together, looking at a range of options that could provide problems over winter, e.g. industrial action but also power disruptions. ▪ ICB to provide Operational Control Centre and oversight on a daily basis, of system risk and System Oversight Resilience Group (SORG). Centre to be manned 7 days a week. ▪ Need to keep on agenda as the mandate from the RCN runs until May 2023. **ICB PCC noted the update.**	
PCC/2223/32	**Retention Work Programme** ICB PCC received a presentation from KB and key highlights included:- ▪ Plan ▪ Learning so far	

	▪ Retention cycle ▪ Retention journey building blocks LB outlined the plan as below:- ▪ 30 days scoping - inaugural project group meeting to take place on 12/12/22. ▪ 60 days to formulate strategy to present back to ICB PCC on 08/03/23. ▪ 9 months for implementation of recommendations – will be coming back to this committee with recommendations of focus and looking for support. ▪ Nationally there are some imposed expectations on what to do about retention – letter of 5 impact nursing and midwifery retention actions, with intensive tool to complete. ▪ For the Midlands, Derbyshire will be co-ordinating some action learning set funding investment, as it has been identified that AHP profession are looking for training opportunities. KB noted learning thus far including:- ▪ Need for genuine and comprehensive flexible working offer – options include 'branded school shifts' / self-rostering. ▪ Age friendly employer. ▪ Disability and Long-Term Conditions – improved offer. ▪ Co-ordination minimising duplication – bringing to the awareness everything that is happening across the system. ▪ Sharing of work across the system – creating an environment to support this. ▪ Communication to individuals and services / leaders. ▪ Better data / identifying the links with existing programmes. KB advised that will propose that JUCD approach the programme of work in a retention cycle model, including:- ▪ Positive on-boarding – lean and responsive process, welcome programme, culturally intelligent offer. ▪ Staff experience and wellbeing – how are you conversations, people plan objectives ▪ Ready for something new / growing in your role – supporting movement and development within the Derbyshire system. ▪ Positive off-boarding – people will leave – lets leave an impression that makes them want to return. Offers of assistance and suggestions for inclusion were noted in the meeting chat, including:- ▪ UHDB have a long standing transfer scheme. ▪ Need to ensure linked in with the work on talent management – have just produced a draft of a new appraisal document which has more focus on peoples aspirations and will align really well. ▪ May wish to meet with the leadership development and talet group. JL noted comments including:-	

	▪ Need to ensure culturally intelligent offer which creates sense of belonging for all people of all backgrounds of all protected characteristics is crucial. ▪ Need to ensure disabilities and long-term conditions is at top of agenda as think are behind curve. ▪ Need to think about growing capability within a role for those who may wish to develop but not move from the role they are in. ▪ Need to review data and look at what are the priority areas for the 9 months – that may be outliers in our system in terms of retention that may need to put some priority actions – link to workforce plan / agency spend. KB was asked to share the slides with committee members. **ICB PCC noted the update.**	KB
PCC/2223/33	**People Services Collaborative (PSC) 7x5 Programme Update** ICB PCC received the presentation which provided an update on and described the objectives and progress made for the PSC 7x5 programme. Key highlights were noted as below:- ▪ Over the last 6-8 weeks have moved from mobilisation phase to established work programme. ▪ All programmes have now been populated on ePMO system that are using across all the transformation programmes in Derbyshire, to capture and monitor progress. ▪ Going forward will be able to give ICB PCC much greater assurance about whether or not on track with where said wanted to be. ▪ From the updates in the pack, believe can take a good level of assurance that are making progress across all areas. ▪ Next phase now is to identify three opportunities and to work at scale and this may then shape and influence where focus resource across programme. I**CB PCC noted the report.**	
PCC/2223/34	**Workforce Advisory Group – draft minutes 18/11/22** ICB PCC received the draft minutes, which had been circulated for information and noting. AR confirmed that the WAG meeting on the 18/1/22 had been the inaugural meeting of the group. AR advised that had been joined at the meeting by two members from the PVI sector and the first part of the meeting had been utilised for them to share their world of work, recruitment and retention. MG noted would take assurance from the existence of the group and the joined up working around workforce for the whole of Derbyshire, including PVI and social care. **ICB PCC noted the draft minutes of the ICS Workforce Advisory Group held on 18/11/22.**	
ADMINISTRATION		

PCC/2223/35	**Minutes from the ICB PCC Meeting held on 07 September 2022** The minutes of the meeting held on 07 September 2022 were accepted as a true record. MG asked that the minutes and action log be moved to start of future agendas. **ICB PCC noted and accepted the minutes as a true record.**	
PCC/2223/36	**Action Log** The action log was noted. **ICB PCC noted the action log.**	
CLOSING ITEMS		
PCC/2223/37	**Any Other Business** No specific items were raised. MG asked for feedback on meeting effectiveness, but no comments were made. MG indicated that if anyone has any comments that wish to share privately, to let her know. MG noted that some items had identified progress to be reported by January 2023 and noted will need to decide how might best receive or comment on those items.	
DATE AND TIME OF NEXT MEETING		
Wednesday 08 March 2023, 0900-1100, via Microsoft Teams		

MINUTES OF THE PUBLIC PARTNERSHIPS COMMITTEE

HELD ON 29 NOVEMBER 2022, 10:00 – 12:00

VIA MS TEAMS

Present:		
Julian Corner	JC	Non-Executive Member ICB **(Chair)**
Steven Bramley	SB	Lay Representative
Helen Dillistone	HD	Executive Director of Corporate Affairs, DDICB
Karen Lloyd	KL	Head of Engagement, DDICB
Chris Mitchell	CM	Public Governor Derbyshire Dales and High Peak, Derbyshire Healthcare NHS Foundation Trust
Harriet Nicol	HN	Engagement & Involvement Manager, Healthwatch Derbyshire
Tim Peacock	TP	Lay Representative (Attended part of the meeting)
Margaret Rotchell	MR	Lead Governor, Chesterfield Royal Hospital
Jocelyn Street	JS	Lay Representative
Sue Sunderland	SS	Non-Executive Member, ICB
Maura Teager	MT	Lead Governor, University Hospitals of Derby and Burton NHS Foundation Trust
Lynn Walshaw	LW	Deputy Lead Governor, Derbyshire Community Health Services NHS Foundation Trust
In Attendance:		
Lucinda Frearson	LF	Executive Assistant, DDICB (Admin)
Katy Hyde	KH	Involvement Manager, DDICB
Carol Warren	CW	Lead Governor, Chesterfield Royal Hospital (Observing)
Apologies:		
Sean Thornton	ST	Deputy Director Communications and Engagement, DDICB
Michelle Butler	MB	Strategy and Engagement Manager, Healthwatch Derby

Item No.	Item	Action
PPC/2223/35	**Welcome, Introductions and Apologies** Julian Corner (JC) as Chair welcomed all to the meeting, introductions were made around the virtual room welcoming Carol Warren (CW) who will be replacing Margaret Rotchell (MR) who was attending her last meeting as her term as a Governor was coming to an end. Apologies were noted as above.	
PPC/2223/36	**Confirmation of Quoracy** The Chair confirmed the meeting as quorate.	

PPC/2223/37	**Declarations of Interest** JC reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the Integrated Care Board (ICB). Declarations declared by members of the Public Partnerships Committee (PPC) are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: www.derbyandderbyshire.icb.nhs.uk Declarations of interest from today's meeting: No declarations of interest were made during today's meeting.	
FOR DISCUSSION		
PPC/2223/38	**Discussion around the development, role, and purpose of the ICB Public Partnerships Committee (PPC)** Sean Thornton (ST), who was unable to attend today's meeting, had prepared a paper entitled 'Further defining the role of the ICB Public Partnerships Committee' following previous development sessions. The paper outlined 2 main areas of the Committee, overseeing and assurance, and ensuring the ICB follow process whilst driving the wider service. Following establishment of the PPC, a review was underway to ensure that the role and remit of the Committee enables the discharge of its broad duties as defined in its Terms of Reference and as one of five sub-committees of the ICB Board. The paper seeks to further define the role of the PPC, in the context of it being: – A driver of citizen engagement in planning and service development processes. – An assurer of engagement activities against ICB statutory duties. – A component of the ICB Board sub-committee structure. Consideration was required around: – Overlap of responsibilities – Capacity to provide assurance – Alignment of business – Membership And matters for discussion were set out as: – Pipeline – Terms of Reference – Sub Committees Business Plan – Capacity to support the work of the PPC – Membership – Reporting	

	The Committee offered the following comments and questions: - • Sue Sunderland (SS) felt this to be a helpful report particularly the pipeline in terms of setting out the flow through but wished to flag a slight concern that the responsibilities of the Population Health and Strategic Commissioning Committee (PHSCC) with regard to the interplay of affordability, quality and workforce may not be fulfilled by a simple paragraph in a cover sheet that confirms assurance has taken place in other committees. Helen Dillistone (HD) believed this may be more of a detailed business case rather than a paragraph on a cover sheet. • SS also requested clarity around the subgroups, whether they were needed and how they would fit in, and what they are expected to deliver alongside the working groups. Karen Lloyd (KL) advised that as there was often not the depth of discussion within the meeting some functions could be separated out to give more focus. • Jocelyn Street (JS) commented on the very good paper which made it clear the areas that required discussion outlining the key to be the co-production framework. However, she had concerns about the subgroups, highlighting that if there were a lay representative subgroup it would negate the lay representation on the main Committee and the proposal shows no independent lay membership envisaged on the overall PPC. • Steven Bramley (SB) pointed out that the final list of 'who is and who is not there' did not mention existing lay representatives but renumerated lay representatives who would be part of the system, so they are not truly independent. Overall SB liked the direction of the paper but thought it was over complicated. • MR stated the paper was really helpful on focusing members' minds but there were things that required more consideration. The PPC needs to be earlier in the pipeline with the subgroups being more task and finish groups when there is not time within the PPC to delve down to the details. MR also believed to have renumerated people did not fit given the financial position at the moment. • Maura Teager (MT) was struggling with the complexity, also capacity and capability, not just officers but also the volunteers. Capacity is stretched and she agreed with the lay chair issue in that once it becomes renumerated it becomes part of the system. The paper was good as it had opened up the conversation.	

	• Tim Peacock (TP) complimented the paper indicating it was what was required to get started but had concerns around the lay issue and questioned who would fill the important roles on these committees as there will be a time commitment. TP did not wish to dismiss renumerated lay representation suggesting them to be responsible to lay representatives. • TP had concerns around the pipeline which seemed to suggest projects needed to go through all committees before they get started and would not want the PPC to review proposals for all engagements nor deep diving into all projects, mechanisms are required to identify concerns not scrutinising every case for change in the NHS and social care. • HD thanked everyone for their really helpful comments acknowledging a sense of proportionality was required where significant and substantial changes were being made. JC summarised there was a need for more clarity of role and work of the subgroups, the position of the PPC on the pipeline and proportionality of the pipeline moving through and renumeration and general lay representation alongside the financial burden on the NHS. Also, lay chairs being accountable to lay representatives to build sense of a wider system and how this sits in the system and wider progress. No concerns were raised around the amendments to the Terms of Reference. **Action: JC to take the TORs to the ICB Board** Pipeline is a common committee business plan with coherent lines required between all the committees and flow between them, JC offered to present to the ICB Board. **Action: JC to present pipeline information to the ICB Board** The Public Partnerships Committee **DISCUSSED** and **NOTED** the paper. The Public Partnerships Committee **AGREED** the Terms of Reference.	**JC** **JC**
PPC/2223/39	**GP Access – Deep Dive** The PPC are recommended to **DISCUSS** the information collected regarding GP access in Derbyshire. The information was provided in response to an earlier request made for a 'Deep Dive' around general practice services. It also follows a recent period of public engagement in relation to enhanced access to general practice that was reviewed by the PPC. PPC were requested to **AGREE** any further steps required to provide assurance on development activity and engagement related to GP access and service provision.	

KH presented the report explaining engagement was undertaken as an Integrated Care System (ICS) rather than through GP practices as it was felt not all GPs were giving the same opportunity to patients or they had the facilities to carry out the engagement. There were over 1000 responses and clearly general practice is an area of concern, both County and City Adult Health Scrutiny Committees have asked primary care to be presented to their next committees.

The Committee offered the following questions and comments: -

- SS commented on how helpful it was to have all the data and assumed the appointments were at the practice and not necessarily seen by a GP. Whilst overall there may be increases in appointments it would be helpful to see comparison between those seeing a GP or another member of staff. If the public is still unhappy with the access they are getting we need to look how to manage expectations and get across the seeing other people and not just GPs.

- TP felt as the PPC the results were not really what we should be diving into. It should be about the approach to engagement, what was planned, what happened against those plans and what influence did talking to the Derbyshire citizens have. It is critical to ensure the population understand what difference its input is making.

- SB believed the engagement work had been done correctly and thoroughly. To be able to pass reassurance back to the ICB, it would have helped to have information on which GPs and PCNs were included in the survey and which areas the 1000+ responses were from to give assurance that it had reached the right people.

- JC asked if there was a way of integrating service and patient data. KH advised it had been omitted due to the huge data sets but was available.

- JS suggested data at a PCN level would be helpful and updated members on a presentation to the PPG network of a pilot project that was collecting anonymous data from GP practices and extracting appointment information. JS also raised the issue of people being concerned about access to GPs and acknowledged the point about seeing others in the practice, but people are concerned about the continuity of care now they are getting access.

- LW commented on the great piece of work that gave clarity around a baseline of what is out there, it was possibly not what the PPC was looking for but gives a

	base to start to interrogate more. It is an indicator of using demographics in a different way. • MT believed the report focuses where we need to look at the moment and we need to understand what it is telling us and listen. • MR stated some of the data indicated where more engagement was needed and perhaps need to do more engagement with the public around different appointments with different professionals. Sometimes it is useful to us to have this data. It is how we use this work that is important. • HD felt it interesting to hear the discussion and points made linking to the previous paper and was a good example of the role and purpose of the PPC going forward. • SB agreed to a point made by JC that we are learning as a committee, for us to provide assurance we need to ask the correct questions to get the information to give the assurance. This was a very useful piece of work and if the demographic information had been broken down to give an idea of the areas where all these things happen that is where we would benefit. • SS was thinking if there may be an issue about engaging more, about expectations and around additional roles in GP practices if the Committee believed further engagement was required would we feedback to the PHSCC to see if that was something that needed to be developed, to ensure we do not lose things in discussion which may be directed elsewhere. The Public Partnerships Committee **DISCUSSED** the information provided. The Public Partnerships Committee **AGREED** its role was to decide areas of further engagement. **TP left the meeting.**	
FOR CORPORATE ASSURANCE		
PPC/2223/40	**Strategic Risk / Risk Report November 2022** HD reminded members these were risks that sat on the ICB Operational Risk Registrar, identified through the Public Partnerships Committee and so the committee has oversight of the issues. There were currently 3 risks, 2 in the public session and 1 related to a confidential risk.	

	Risk 13: *Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties.* There were no changes proposed to Risk 13 which still remains high but there are mitigating circumstances which are being worked through currently. **Risk 17**: *Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised.* There are no changes proposed to Risk 17 due to planning work that is underway across the team. The Public Partnerships Committee **APPROVED** the risks responsible to the Committee. The Public Partnerships Committee **ACCEPTED** no changes to **Risk 13**. The Public Partnerships Committee **ACCEPTED** no changes to **Risk 17**.	
PPC/2223/41	**Confidential Risk Report** The Public Partnerships Committee were asked to **APPROVE** a new confidential risk relating to the Glossop boundary change. During the transition of Glossop into our boundary we were made aware that there would be potential differences in policies. Work is being undertaken across the ICB to understand the scale of the changes and any timescales required for any engagement that may be required around the differences and what it means for the people of Glossip and population of Derbyshire. The Committee provided the following comments and questions: - • SS asked whether there was a plan or timeline as to how the engagement will be carried out alongside the timetable for changing the policies or was that still in development. HD advised that as part of the transition it was decided not to change anything in the first year and use as a transitional year, so that work has now begun. The Public Partnerships Committee **APPROVED** the new risk, **Confidential Risk 06c**.	

MINUTES AND MATTERS ARISING		
PPC/2223/42	**Minutes from the meeting held on:** • **20 September 2022** • **18 October 2022** The Public Partnerships Committee accepted both sets of Minutes as an accurate record of the meetings following the addition of Maura Teager's apologies on the 18 October 2022 Minutes.	**LF**
PPC/2223/43	**Action Log from the meeting held on: 18 October 2022** The action log was reviewed and updated during the meeting. <u>PPC/2223/18 - 20.09.2022</u> Although several discussions had taken place this item was still in progress and was to remain on the action log. <u>EC/2223/044 – 21.06.22</u> MT would contact ST with a list of smaller charities as set out in the action, prior to the next meeting. JC was not clear on the PPC's relationship with the voluntary sector and believed it would be helpful for the committee to understand that role and consider at a future meeting. **Action: LF add to forward planner** MT noted there was no representative from the Derbyshire Healthcare Foundation Trust. **Action: ST to follow up.**	**LF** **ST**
CLOSING ITEMS		
PPC/2223/44	**Any Other Business** JS commented that it had been a very good meeting everyone had had a chance to speak up and put their point across and felt this was one of the few meetings at this level were independent lay representatives get to express their opinions so felt it was very important. JC thank MR for her contributions to the Committee. MR thanked all her colleagues on the Committee and was sad to be leaving.	
DATE AND TIME OF NEXT MEETING		
Date: Tuesday 24 January 2022		
Time: 10:00 – 12:00		
Venue: MS Teams		

MINUTES OF THE PUBLIC PARTNERSHIPS COMMITTEE

HELD ON 24 JANUARY 2023, 10:00 – 12:00

VIA MS TEAMS

Present:		
Julian Corner	JC	Non-Executive Member ICB **(Chair)**
Steven Bramley	SB	Lay Representative
Helen Dillistone	HD	Executive Director of Corporate Affairs, DDICB
Karen Lloyd	KL	Head of Engagement, DDICB
Harriet Nicol	HN	Engagement & Involvement Manager, Healthwatch Derbyshire
Tim Peacock	TP	Lay Representative
Jocelyn Street	JS	Lay Representative
Sue Sunderland	SS	Non-Executive Member, ICB
Maura Teager	MT	Lead Governor, University Hospitals of Derby and Burton NHS Foundation Trust
Sean Thornton	ST	Deputy Director Communications and Engagement, DDICB
Lynn Walshaw	LW	Deputy Lead Governor, Derbyshire Community Health Services NHS Foundation Trust
In Attendance:		
Lucinda Frearson	LF	Executive Assistant, DDICB (Admin)
Leanne Hawkes	LH	Director, 360 Assurance
Claire Haynes	CH	Senior Public Equality and Diversity Manager, DDICB
Katy Hyde	KH	Involvement Manager, DDICB
Usman Niazi	UN	Client Manager, 360 Assurance
Apologies:		
Carol Warren	CW	Lead Governor, Chesterfield Royal Hospital
Chris Mitchell	CM	Public Governor Derbyshire Dales and High Peak, Derbyshire Healthcare NHS Foundation Trust

Item No.	Item	Action
PPC/2223/45	**Welcome, Introductions and Apologies** Julian Corner (JC) as Chair welcomed all to the meeting, introductions were made around the virtual room. Apologies were noted as above.	
PPC/2223/46	**Confirmation of Quoracy** The Chair confirmed the meeting as quorate.	
PPC/2223/47	**Declarations of Interest** JC reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the Integrated Care Board (ICB).	

	Declarations declared by members of the Public Partnerships Committee (PPC) are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: www.derbyandderbyshire.icb.nhs.uk Declarations of interest from today's meeting: No declarations of interest were made during today's meeting.	
FOR CORPORATE ASSURANCE		
PPC/2223/48	**Risk Management & Board Assurance Framework (360 Assurance)** Leanne Hawkes (LH) and Usman Niazi (UN), of 360 Assurance, who provide internal audit and counter fraud services to the ICB, attended to provide information on risk management and the Board Assurance Framework (BAF). The information included a brief focus on some of the Committee's risk management responsibilities, risk tolerances, targets and capacity followed by a feedback discussion on the BAF format. The Committee were informed that this was a System BAF and populated with strategic risks agreed at the ICB Board meeting in November, these risks are then broken down into a number of threats. An assurance level is required for each risk which will be informed by the sources of assurance received over a period of time and Committees would need to keep under review at each meeting. The Committee offered the following comments and questions: - • Helen Dillistone (HD) explained that the work carried out was routed in work done with the ICB Board around objectives and strategic risks, the part this Committee plays is how we seek assurance and mitigate those risks. The corporate team would bring forward to Committee the work being done to mitigate some of those risks. The challenge would be getting a degree of consistency around the scoring from each committee. • Sean Thornton (ST) reflected that the risk owned was not delivered or mitigated by the Committee although they had responsibility to manage it. • Jocelyn Street (JS) had concerns around having responsibility and giving assurance when the Committee had no control, influence, or relevant knowledge. • Steven Bramley (SB) highlighted the fact that there were no comparisons and did not know how it compared to other ICB areas.	

	• Lynn Walshaw (LW) raised the issue of consistency and benchmarking and asked as a committee would we be supported to work through a systematic way of scoring effectively. LW liked the process of having the BAF broken down making it clearer, but the scoring was not clear. • Tim Peacock (TP) stated that the Committee would be providing the assurance but have little or nothing to base it on at the moment and this should be priority. • HD wished the Committee to focus on the BAF risk, in terms of benchmarking it was important, but there was a need to be concerned more about what we feel is important in Derbyshire and what we need to do for our population. The second part was the ongoing assurance, and it would be helpful to get a steer from Committee what they wish to see to be assured. The Public Partnerships Committee **NOTED** the information provided. **LH left the meeting.**	
PPC/2223/49	**Risk Report January 2023** <u>BAF Strategic Risk</u> A draft had been circulated to committee members prior to presentation to the ICB Board. The BAF takes a more strategic view and links to some of the system work happening. It was suggested discussing further at the February development session picking up any themes raised during this morning's meeting. **Action: Agenda February meeting** <u>Risk Register</u> The risk is linked to the organisational risk register and more operational day to day risks. The Committee is asked to **RECEIVE** and **NOTE** the risks in terms of the January position. Risk No 13: There is a risk around resources in the comms and engagement team that this could be insufficient in terms of the scale of work that requires undertaking Risk No 17: Related to the pace of change and ensuring that due process is followed but recognising there is a risk around the speed at which the work is being undertaking The Committee offered the following questions and comments: - • Sue Sunderland (SS) suggested as part of the development session to include some of the actions proposed against the threat and how committee will measure the impact of those actions.	**LF**

	• TP had concerns regarding the comms and engagement team's level of resource adding that at some levels good work was being done and then there was not enough resource for work needed on the engagement element and if there was going to be more resource to help push things along. HD advised that there were no further monies in the running costs allocation to fund additional posts but there may be some flexibility within budgets in other parts of the directorate to focus. HD explained that from a benchmarking perspective it was not under-funded it was about prioritisation and how that team is supported around key prioritises. The Public Partnerships Committee **RECEIVED** and **NOTED** Risk 13 and Risk 17. **LW left the meeting**	
PPC/2223/50	**PPI Assessment Log** Katy Hyde (KH) presented informing Committee that they had been collated slightly differently and any comments on the layout would be welcomed. KH highlighted one project had been identified as a reputational risk as there had been criticism over the number of services removed from the Buxton High Peak area, this was a service not being delivered from March. The Committee offered the following questions and comments: - • TP stated that the logs were being reviewed not the forms which was headline items and appropriate to the committee. It was good to see the overview but requested some indications of primary care, community, etc and asked with regard to it being made public. • SB felt the log had been well collated and suggested highlighting projects whether system wide or provider specific but was not sure if it required being on the public platform as not necessarily a format that most people would look for. • JS believed available information did not necessarily have to be widely accessed but should be available if required. The Public Partnerships Committee **REVIEWED** and **RECEIVED ASSURANCE** that the forms were being completed appropriately. JC noted a thank you to KH for a well-received piece of work which gives further foundation for improving.	

ITEMS FOR DECISION		
PPC/2223/51	**Equality Delivery System** Claire Haynes (CH) presented the paper and began by explaining that the Equality Delivery System (EDS) was used by NHS England to publish and showcase equality and diversity work across the whole system. Derbyshire had always used the specific tool available but had now been given the chance to work with NHS England on a new tool. Derbyshire Community Health Services (DCHS) have been involved in a pilot and was assisting Derbyshire to write the new report for this year. CH invited all committee members to a system wide scoring event taking place on the 28 February 2023. The Committee provided the following comments and questions: - • Maura Teager (MT) asked whether there were any emerging challenges from the work DCHS were doing in terms of population, expectations, access etc. CH explained that everyone that works in equality wants the best for our patient population and are finding areas that need development, but DCHS are making good in roads. • JS felt CH seemed more positive and would like to know more about the tool being provided, it seems to give credit where projects succeed in the equality challenge. • SB felt it was good to have a refresh on the approach but was an important aspect of engagement ensuring we have that equality across the system. The Public Partnerships Committee **NOTED** the update and felt good progress was being made.	
ITEMS FOR DISCUSSION		
PPC/2223/52	**Primary Care Legal Duties** Karen Lloyd (KL) had carried out research to clarify legal duties with regard to primary care. Statutory law does not apply to general practice only NHS Trusts and large statutory hospitals but as commissioners we have a statutory duty to ensure we inform, involve, or consult on any service change. There is a contractual duty for Primary Care Networks but no statutory duties so KL had produced a paper to clarify what the requirements are for primary care to inform the commissioner of any service changes so the appropriate steps can be taken. The Committee provided the following comments and questions: -	

	• TP noted a great paper, and its communication was very useful clarification for everyone but particularly this committee's members. • JS thanked KL for the clarification, it was good to know but having this responsibility one removed was not great and would prefer to see a direct responsibility. • SS asked whether it was already in the existing GP contracts and highlighted that there were certain changes that general practice could only do with the involvement of the commissioner. KL advised the requirement was for a Patient Participation Group (PPG) only within GP contracts. The Public Partnerships Committee **APPROVED** the paper. **TM left the meeting.**	
PPC/2223/53	**'Further developing the role of the Public partnerships Committee'** ST presented a continuation from last month's committee discussion which will be carried through to next month's meeting also. Slides were shown which were a recap from the previous discussion and included: • Defining the role of the Committee • Proposals/summary • Further work • Reflections The Committee provided the following comments and questions: - • JS remembered that there were concerns that if sub committees were for lay members, then it would do away with the representation on the main Committee. • SB stated that the way the structure was put together it showed that the lay members were not on the committee these were renumeration representatives and that independent viewpoints were required to put forward at Committee. • ST explained that lay representatives were proposed to be Chairs of the sub committees and would also be members on the committee and strengthen the role of the lay representatives but could not expect each to put so much time in and not be renumerated for all the work. • SS highlighted the critical role lay representatives played and it was getting that balance when requiring more from them and did not think getting some nominal renumeration would compromise independent thinking.	

	The Public Partnerships Committee **NOTED** the information provided.	
MINUTES AND MATTERS ARISING		
PPC/2223/54	**Minutes from the meeting held on: 29 November 2022** The Public Partnerships Committee **ACCEPTED** the Minutes as a true and accurate record of the meeting.	
PPC/2223/55	**Action Log from the meeting held on: 29 November 2022** The action log was reviewed and updated during the meeting.	
CLOSING ITEMS		
PPC/2223/56	**Forward Planner 2022/23** The Forward Planner was **ACCEPTED** by the Committee.	
	Assurance Questions: a) Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? **Yes** b) Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? **Yes** c) Were papers that have already been reported on at another committee presented to you in a summary form? **n/a** d) Was the content of the papers suitable and appropriate for the public domain? **Yes** e) Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? **Yes** f) Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? **No** **g)** What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? **None at this time.**	
PPC/2223/57	**Any Other Business** No further business was raised.	

DATE AND TIME OF NEXT MEETING
Date: Tuesday 28 February 2023 – **Development Session**
Time: 10:00 – 12:00
Venue: MS Teams

MINUTES OF THE ICB QUALITY & PERFORMANCE COMMITTEE HELD ON

THURSDAY, 22ND DECEMBER 2022 MS TEAMS, AT 09:00AM

Present:		
Dr Buk Dhadda (Chair)	BD	GP and Chair
Robyn Dewis	RD	Director of Public Health – Derby City Council
Kay Fawcett	KF	Non-Exec Director – ICB
Brigid Stacey	BS	CNO & Deputy Chief Exec - ICB
Gemma Poulter	GP	Director of Public Health – Derbyshire County Council
Chris Weiner	CW	Chief Medical Officer – DDICB
Richard Wright	RW	Non-Exec Director – DDICB
In Attendance:		
Dan Merrison	JC	Head Of Performance And Assurance - DDICB
Jo Hunter	JH	Director of Quality - DDICB
Jo Pearce (minutes)	JP	EA to Brigid Stacey - ICB
Apologies:		
Margaret Gildea	MG	Non-Exec Director – DDICB
Zara Jones	ZJ	Exec Director Of Strategy And Planning – DDICB
Jayne Stringfellow	JS	Non-Exec Director – CRHFT
Sheila Newport	SN	Non-Exec Director – DDICB
Craig Cook		
Christine Fearns	CF	Non-Exec Director - UHDBFT

Item No.	Item	Action
Q&P/2223/062	**Welcome, Introductions And Apologies** Attendance and apologies were noted as listed above	
Q&P/2223/063	**Confirmation Of Quoracy** It was noted that the meeting was quorate.	
Q&P/2223/064	**Declarations Of Interest** BD reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the ICB. Declarations declared by members of the ICB Quality and Performance Committee are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/?cn-reloaded=1 Declarations of interest from sub-committees No declarations of interest were made.	

	Declarations of interest from today's meeting No declarations of interest were made.	
QP/2223 /065	**Integrated Performance Report and Ongoing discussion around the development of the Integrated report** The paper was taken as read. DM spoke about the performance element of the report and highlighted the issues around ambulance handover delays and long stay patients at the end of pathways. In terms of planned care, the number of patients on the waiting lists was decreasing however this has hit a plateau. Cancer referral rates continue to increase but the number of patients that go over the two-week wait is stable. There is some variation in the metrics for mental health around health checks, perinatal and eating disorders. JH spoke about the quality element of the report and highlighted two areas. One was the increasing number of contingency hotels cited around Derbyshire which are resulting in ongoing pressures on local services. Consideration is being given as to whether this should be included as a risk on the Risk Register. The other area to highlight is CDiff rates across both acute providers. There are more cases than the current trajectory. This has been discussed with both CRHFT and UHDBFT as well as NHSE CDiff collaboration and appropriate action is underway by both acute providers. *There was a confidential discussion which is recorded in the confidential minutes of this meeting.* RW informed the Committee that the System Finance and Estates Committee (SFEC) are beginning to focus on the 5yr plan and analyse the longer-term estates plan and digital plan. Spend is being analysed by the delivery boards which shows how much money is being allocated to Acute, Community and Primary Care. RW also commented on the amount of rework and readmission rates which is high in some areas and is quite a concern. The reality of the situation is becoming stark when looking at the Integrated Performance Report and the question to be raised is how can the discharge rate be improved. JH confirmed that there is a plan for the Discharge Team to present an update at the Quality and Performance Committee in January 2023. RW questioned how this Committee gains assurance on whether the actions that are in place are delivering the desired results. BS acknowledged the comments and assured the Committee that Local authority colleagues are doing all they can to support outflow from the hospitals however care is needed around how the Social Care market is managed. Transformation needs to be around how the health system can support the social care market and its workforce. There is ongoing work around recruiting to "one" workforce recruited through the NHS and which can be deployed where needed. BS is also working with the national colleagues around Derby and Derbyshire ICB being a pilot site in developing workforce and inter-relationships.	

	KF also noted the importance of having an equal focus on prevention as well as discharge. BS referred to the National Oversight Framework (NOF) and informed the Committee that the Derby and Derbyshire ICB NOF rating has increased from 2 to 3 which is due to concerns around performance. BS suggested that a robust conversation around performance takes place at the meeting in January 23 to ensure the Committee are well cited on the issues. BD welcomed the suggestion. CW wished to bring to the Committee attention a key piece of transformation work around Virtual Beds development which increases capacity as well as managing people on their home setting. There is value in allowing people to look after themselves in an environment which is comfortable to them as well as reducing the risk of deconditioning. However, the virtual bed delivery is not delivering as planned and majority of the beds are being delivered by DHU, the system has not managed to get virtual bed capacity established in the acute hospitals. CW gave assurance to the Committee that actions are being taken against this. Capacity has been increased within he delivery team to enable more engagement. The leadership has been transferred over to the Deputy Medical Director of DCHS. It has also been raised on the agenda at the Urgent and Emergency Delivery Board meeting. CW then asked the Committee members to refer to page 24 of the meeting papers and the long stay patients at Royal Derby Hospitals, CW noted the significant change in performance for September and expressed his opinion that this is the type of data that this Committee should be looking at to identify any system learning. BD agreed to discuss performance in more detail at the meeting in January and requested a detailed breakdown on cancer 62-day performance.	
Q&P/2223/066	**Risk Register** The paper was taken as read. JH explained that the Risk Register has been discussed on a regular basis at the SQG. The Risk Register is in progress and work is ongoing with colleagues from Derbyshire County Council. JH noted that aggregate scoring will be carried out once the risks from DCC are received. Mitigations will sit with the individual providers and care is being taken not to overload the Risk Register with too much detail whilst at the same time ensuring the SQG are cited. JH asked the Committee for agreement that the SQG will have responsibility of the Risk Register whilst the Quality and Performance Committee have oversight. The Committee agreed that the Risk Register will be monitored by SQG, and Quality and Performance Committee will have oversight. Escalation will take place as required. JH noted that the sovereignty of the provider in terms of managing the risk will remain.	

Q&P/2223/067	**Strategic Risk / Draft Board Assurance Framework** The paper was taken as read. JH presented the paper on behalf of the Corporate Governance team. Quality and Performance Committee are asked to discuss and agree the draft strategic risks and the proposed risk ratings. The agreed risks will be presented at the NHS Executive meeting and ICB Board. **Strategic Risk 1** - *There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to delivery consistently safe services with appropriate levels of care.* RW raised a concern that the risk is written around coping with inevitable increases rather than mitigating increases through prevention. The Committee approved the risk score of 20 for SR1. **Strategic Risk 2** - *There is a risk that short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.* RD noted the national decline up to 2020 in terms of healthy life expectancy with the figures for Derby being particularly concerning. The data shown in the report is up until March 2020 and RD highlighted that the first Covid-19 case reported in Derby was 6th March 2020 and therefore this data does not show the impact of Covid-19. The Committee approved the risk score of 20 for SR2. JH noted the comments made by the Committee and will feed back to Suzanne Pickering.	
Q&P/2223/068	**DDICB Escalation Policy for Ratification** JH informed the Committee that the DDICB Escalation Policy has been previously shared with the Senor Leadership team and SQG and all relevant comments have been considered and appropriate amendments made. He policy is based on the output of the National Quality Group Risk Escalation Framework. The Committee approved the DDICB Escalation Policy.	
Q&P/2223/069	**Assessment of the Winter Plan from a Quality and Safety Perspective** The paper was taken as read. JH explained that this paper has previously been to SQG who have agreed the mechanisms that have been put in place for Quality Assurance and Clinical/Safety Risk identification and escalation.	

	In reference to the following *Assurance is given that Quality and Safety Leads from all Providers, organised at System level, will ensure robust controls are put in place to survey and respond to clinical harm/safety issues.* Discussions took place around having regular winter plan safety and assurance panel meetings however it was felt that there were mechanisms in place already around strategic and operational escalations. Since the paper was discussed at the SQG meeting on 6th December 2022 the Operational Coordination Centre which focuses on system urgency, winter plans, industrial action etc is now in place and functioning.	
Q&P/2223 /070	**System Quality Group Assurance Report** The paper was taken as read. The paper covers the period of September, October, and November 2022. There is the intention for the report to be presented to this Committee on a monthly basis following each SQG meeting. There was discussion around the link between Quality and Performance Committee and the System Quality Group and BS noted her confidence that SQG has the correct representation and attendance from system partners. BS suggested the possibility of a joint Committee meeting between Quality and Performance Committee and SQG to give assurance that the right issues are being discussed and escalated appropriately. **ACTION**. JP to field for a suitable date for Quality and Performance Committee members to attend a SQG meeting in the new year and then potentially every quarter.	**JP**
Q&P/2223 /071	**Minutes from the meeting held on 24th November 2022** The minutes from the meeting held on 24th November 2022 were agreed as a true and accurate record.	
Q&P/2223 /072	**Action Log from the meeting held on 24th November 2022** The action log was reviewed and updated as necessary.	
Q&P/2223 /073	**Any Other Business** **National Oversight Framework (NOF) Templates** The Quality and Performance are asked to note and approve the NOF templates prior to being presented at the NHS Executive meeting and ICB Board. The Committee approved the NOF templates.	

Q&P/2223/074	**Forward Planner** The Forward planner was noted.	
	Assurance Questions • Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient information and clear recommendations? • Were papers that have already been reported on at another committee presented to you in a summary form? • Was the content of the papers suitable and appropriate for the public domain? • Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? • Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? • What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting?	
DATE AND TIME OF NEXT MEETING		
Date: 23rd February 2023		
Time: 9:00am to 10:30am		
Venue: Florence Nightingale Room, Cardinal Square, DE1 3QT		

MINUTES OF THE ICB QUALITY & PERFORMANCE COMMITTEE HELD ON

26th JANUARY 2023 MS TEAMS, AT 09:00AM

Present:		
Dr Buk Dhadda (Chair)	BD	GP and Chair
Lynn Andrews	LA	Non-Exec Director
Robyn Dewis	RD	Director of Public Health – Derby City Council
Christine Fearns	CF	Non-Exec Director - UHDBFT
Margaret Gildea	MG	Non-Exec Director – DDICB
Brigid Stacey	BS	CNO & Deputy Chief Exec - ICB
Jayne Stringfellow	JS	Non-Exec Director – CRHFT
Chris Weiner	CW	Chief Medical Officer – DDICB
Richard Wright	RW	Non-Exec Director – DDICB
In Attendance:		
Phil Sugden	PS	Assistant Director of Quality - Community
Jo Warburton	JW	Derbyshire Interim Discharge Flow Lead
Dean Wallace	DW	Chief Operating Officer- DCHS
Craig Cook	CC	Chief Data Analyst - DDICB
Lisa Falconer	LF	Head of Clinical Quality (Acute)
Usman Niazi	UN	360 Assurance
Leanne Hawkes	LH	360 Assurance
Jo Pearce (minutes)	JP	EA to Brigid Stacey - ICB
Dan Merrison	DM	Senior Performance & Assurance Manager
Apologies:		
Zara Jones	ZJ	Exec Director Of Strategy And Planning – DDICB
Kay Fawcett	KF	Non-Exec Director – ICB

Item No.	Item	Action
Q&P/2223/075	**Welcome, Introductions And Apologies** BD welcomed Committee members and apologies were noted.	
Q&P/2223/076	**Confirmation Of Quoracy** It was noted that the meeting was quorate.	
Q&P/2223/077	**Declarations Of Interest** BD reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the ICB. Declarations declared by members of the ICB Quality and Performance Committee are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following	

	link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/?cn-reloaded=1 Declarations of interest from sub-committees No declarations of interest were made. Declarations of interest from today's meeting No declarations of interest were made.	
QP/2223 /078	**Deep Dive – Discharge and Outflow** JW and DW shared the presentation entitled "Discharge Update" with Committee members. The presentation included the following points: o An explanation of the different pathways between P0 to P3. Majority of people are discharged via P0. o Discharge Team details. Interim Discharge Flow lead (Jo Warburton) was appointed in June 2022, this is a fixed term post and is supported by Kirsty McMillan, Director of Social Care in Derby City and Dean Wallace as Exec Discharge Lead. o Initial Deep Dive into discharge P1 highlighted significant issues in terms of Length of Stay (LOS) in Derbyshire County. o Evidence of the current position. o Support around discharging people back into their own homes. o What the data is telling us. Number of patients with a right to reside is increasing with a significant rise at UHDBFT. o 46% of people over 85 will die within 1 year of hospital admission and EoL elements need to be linked into the discharge work. o LOS – improvements are being seen at UHDBFT. CRHFT are seeing significant increases in delay days. o Community provision shows around 25-30% of people in P2b beds are in delay and awaiting discharge. o Delays out of P1/P2a beds for people awaiting a long-term package of care. o Work that has been carried out to date including agreement on discharge priorities, P1 strategy, P1 transformation, VCSE and Data & IT solutions. o Lessons learnt – Scrums, Reducing P1 OLS in County, Staffing and Co-production of the JUCD P1 strategy. JS referred to the slides around people meeting the right to reside criteria, noting the differences between UHDBFT and CRHFT. JS asked if there is a breakdown available for people having to move into the South Yorkshire system and if the delays are being caused by issues that Derbyshire cannot directly influence. BD asked what ongoing support is provided to patients to enable them to achieve a level of function comparable to what they had prior to their hospital admission. JW replied to say the support offer is variable due to the system having a mixed model of care. One of the pieces of work that is underway is around *"What Does Good Look Like"* for the Derbyshire system and how patients can be discharged into the community.	

	CF referred to her time working in the NHS and noted the repetitive conversations she has witnessed around the barriers in making improvements into the discharge process. CF asked what changes are needed, both from a cultural and leadership behaviour perspective to implement the lessons learnt, and who would be held to account if changes cannot be made. CW noted the difference in risk tolerance between clinicians within the system and raised the question on how this is managed. MG agreed with the points raised and suggested that the CE discuss the cultural and leadership behaviours, the lessons learnt and accountability. BD noted the comments and suggestions made and agreed that a regular update should be presented at future Quality and Performance Committee meetings. RW asked how much of the work around discharge and outflow is being carried out at a more localised level. DW explained that the Integrated PLACE Executive is the lead for discharge and the granulated work takes place at a PCN level. RW referred to staffing and noted the number of WTE staff in Derbyshire had grown by 9.9% between March 2020 and November 2022 which equated to approx. 2,000 staff. However, despite this, it seemed that the system was being less productive in their delivery of activity. DW replied and explained that HSJ analysis reported more investment into innovation, specialist treatment and specialist pathways and less investment into Public Health, Community Care, Social Care and Primary Care. In addition, the population is generally more ill post COVID 19. These factors along with absence and sickness in Social Care staff has impacted staffing capacity. BS informed Committee members that the ICB Executives had been asked to review the triangulation of workforce activity, finance and productivity. BS also informed Committee members of work that is taking place around creating a workforce which is a combined Health and Social Care role which will enable resource to be allocated to the most appropriate and challenged areas. Work is also taking place around international recruitment for social care and health. RD noted the need to investigate prevention of hospital admissions in particular falls prevention, dehydration, dehydration and UTIs and exacerbation of COPD, all are areas in which increased resource could help in the prevention of hospital admissions. RW referred to the 5 Year Plan and his wish to see specifics around the allocation of resources and how the system will take a different approach. CW also voiced his vision for winter 2023 of 300 virtual beds with 50% bed occupancy for patients who would normally be within an acute setting. BD asked if the work on discharge and outflow is being heard at the Population Health and Strategic Commissioning Committee(PHSCC) as he felt that it would be the most appropriate meeting for it to be shared. CC explained that the 5 Year Plan will be presented at the PHSCC in February 2023. CC acknowledged the need for the 5 Year Plan to include details on how money is allocated, workforce, clinical models, and the design of the health economy.	

	BD asked if the presentation has been shared elsewhere, DW confirmed that Quality and Performance Committee is the only committee where it has been presented and was happy with the suggestion that it was discussed at the PHSCC. **The Committee noted the contents of the presentation.**	
Q&P/2223 /079	**Developing the BAF and Strategic Risk Management** LH and UN of 360 Assurance gave a presentation to the Committee which explained the Committees role and responsibilities for the Board Assurance Framework (BAF) . The System BAF has been populated from the strategic risks which were agreed at the ICB Board meeting in November 2022. Two strategic risks were assigned to the Quality and Performance Committee. UN took one of the risks as an example to show the Committee how the strategic risk can be broken down into individual threats to include further detail if required. The BAF requires Committees to agree an overall assurance level which is informed by sources of assurance that the Committee receives over a period of time . The Committee is also required to agree a tolerable level which can be higher than the target level. The Committee is required to review the levels at each Committee meeting. Referring to the section on system sources of assurance, UN explained this section should include a summary of the assurances which come to the Quality and Performance Committee and mitigations that are in place. Any gaps in control which are identified should be documented. **The Committee provided feedback which was acknowledged by 360 Assurance and will be used to develop the Board Assurance Framework further.**	
Q&P/2223 /080	**Strategic Risk / Draft Board Assurance Framework** BS explained to Committee members that the paper outlined how the two strategic risks assigned to the Quality and Performance Committee were discussed, agreed, and subsequently presented to the ICB Board in January 2023. Strategic Risk 1 - *There is a risk that increasing need for healthcare intervention is not met in the most appropriate and timely way and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to delivery consistently safe services with appropriate levels of care.* Strategic Risk 2 - *There is a risk that short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.*	

	RW referred to Strategic Risk 2 and suggested a triangulated activity / workforce / finance plan which covers the immediate and long term is reflected in the risk. BS explained that once the Quality and Performance Committee have accepted the two risks and they have been approved at the ICB Board meeting in March the risks will sit with the System Quality Group who will review, monitor, and agree actions. The Quality and Performance Committee are recommended to **DISCUSS** and **AGREE** the draft Board Assurance Framework Strategic Risks 1 and 2. **The Quality and Performance Committee APPROVED Strategic Risks 1 and 2.**	
Q&P/2223 /081	**Integrated Performance Report (IPR)** The paper was taken as read. CC highlighted there has been focus on the UEC pathway and the report provides a more current position around bed occupancy and discharge pathway. BD asked that Remedial Action Plans (RAP) for 31 day/ 62 day/ 128-day cancer waits, Children and Young Peoples eating disorders and 78 week waits for electives are brought to the Quality and Performance Committee meeting on 23rd February 2023 so that Committee members can scrutinise and be assured around the recovery of these performance metrics. RW raised concerns around the readmission data. CC echoed the concerns and noted the multifactorial drivers associated with the readmissions. The issues have been raised at the Urgent Care Delivery Board and its members have been tasked with identifying any issues. BD agreed with the suggestion from RW for CC to provide an update in 6 months' time. RD asked if the patients who are being readmitted have been reviewed to identify what other support could be offered to prevent readmission. CF reminded members that the Quality and Performance is an assurance Committee and asked for the IPR to be written in that light, in particular the exception report to highlight the key points and draw out the assurance. **The Committee noted the contents of the IPR Report.**	
Q&P/2223 /082	**Risk Stratification and Harm Review Update** The purpose of this paper is to present the System Quality and Performance Committee with Quarter 2 (Q2) report in relation to Standard QS13 of the Quality Schedule: Risk Stratification and Harm in long waiters.	

	LF informed Committee members that the risk stratification work around long waits is now part of business as usual and is incorporated into the Quality Schedule. Assurance is sought at the monthly CQRG meetings. The report highlights the progress in Quarter 2. The Provider report is submitted to DDICB on a quarterly basis, this is the second report (Quarter 2 (Q2)). All Providers have submitted their Q2 report. Provider compliance against Key Performance Indictors (KPI) is rated Red, Amber, or Green (RAG). Every Provider is rated Green or Amber for one or more Key Performance Indicator (KPI). No indicator is rated Red. Common themes that need exploring in future tracking is continued establishment of processes for Risk Stratification, Root Cause Analysis (RCA) and Harm Review and Equal Access to All. Ongoing compliance against QS13 will be monitored at Clinical Quality Review Groups (CQRG). Providers have been working with their Communication Teams to provide information in relation to waiting to include expectations and information relating to waiting well. Service-specific letters, FAQ, and waiting well leaflets have been developed by Providers for patient information. All providers are compliant with both indicators and provided evidence in the form of current Waiting Well policies and procedures. UHDB, CRHFT, DCHS and DHcFT report ongoing progress using risk stratification / prioritisation systems, in addition acute providers are undertaking validation of the lists, providing additional opportunity to re- prioritise patients. Assurance has been provided by all Providers around standard processes in-place for RCA and harm reviews, and the providers are ensuring harm is identified, reported, and investigated under the Patient Safety Incident Response Framework (PSIRF). UHDB, CRHFT, DHcFT and DCHS data suggests that processes are in place to identify disadvantaged groups, and to ensure they are not further disadvantaged. They are rated amber as all acknowledge that work is ongoing to analyse data on health inequalities and deprivation and how to extend outreach to disadvantaged groups. In Q2 all Trusts remain on plan to track and report incidents of identified harm. Further analysis of all Providers will be presented in Q3 as more data becomes available. In terms of patient feedback, both DCHS and DHcFT share common themes for complaints and concerns. Namely, waiting times and availability of services. These Trusts continue to monitor waiting times and respond to complaints in line with contractual processes.	

	UHDBFT are rated amber due to the 112 documented concerns. No evidence of themes or trends or mitigating actions is documented in their submission. The three business units with highest number of concerns are: o General Surgery and Urology (20) o Trauma and Orthopaedics (15) o Pharmacy (14) No actions or mitigations are given in their submission. DDICB will seek further assurance at the next CQRG. CRHFT reported zero complaints for concerns for Q2. DDICB will seek further assurance at the next CQRG. It has been acknowledged that full assurance in relation to the framework is difficult due to the volume of patients waiting, and ongoing system and service pressures. There has however been progress in relation Communication and Waiting Well whilst RCA and Harm Review and Equality of Access remain challenging. BS asked the Committee the note that the risk stratification work has been in place for some time and Derby and Derbyshire ICB are recognised regionally as a system that is more progressed in this area of work. BS stated to Committee members that whilst the risk stratification work is manged through the System Quality Group with escalations coming to Quality and Performance Committee it would be good practice for an update to be presented to this Committee in six months' time. **The Committee noted the contents of the report and there were no questions raised by the Committee.**	
Q&P/2223/083	**System Quality Group Assurance Report** The paper was taken as read. BS referred to an action from the meeting on 22nd December 2022 to invite Quality and Performance Committee members to one of the System Quality Group meetings and confirmed that an invite has been extended to members for the 7th February 2023. **The Committee noted the contents of the report and there were no questions raised by the Committee.**	
Q&P/2223/084	**Any Other Business** BS informed the Committee that this was the last meeting for Dr. Buk Dhadda. BS gave thanks on behalf of the Derby and Derbyshire system for his work and input over the past 13 years at Southern Derbyshire CCG, Derby and Derbyshire CCG and latterly Derby and Derbyshire ICB.	

	BS went on to say that the ICB are in the process of appointing an interim Chair and members will be notified of the arrangements in due course.	
MINUTES AND MATTERS ARISING		
Q&P/2223/085	**Minutes from the meeting held on 22nd December 2022** The minutes from the meeting held on 22nd December 2022 were agreed as a true and accurate record.	
Q&P/2223/086	**Action Log from the meeting held on 22nd December 2022** The action log was reviewed and updated as necessary.	
	Assurance Questions • Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? • Were papers that have already been reported on at another committee presented to you in a summary form? • Was the content of the papers suitable and appropriate for the public domain? • Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? • Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? • What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting?	
DATE AND TIME OF NEXT MEETING		
Date: 23rd February 2023		
Time: 9:00am to 10:30am		
Venue: Florence Nightingale Room, Cardinal Square, DE1 3QT		

Time Commenced: 13:00pm
Time Finished: 15.00pm

Health and Wellbeing Board
10 November 2022

Present:

Statutory Members Chair: Councillor Webb (Chair) Robyn Dewis (Director of Public Health), James Moore (Derby Healthwatch),

Elected members: Councillors Martin and Lonsdale

Appointees of other organisations: Amjad Ashraf (Community Action Derby), Lucy Cocker (Derbyshire Community Healthcare Services), Gino Distefano (Derby Hospitals NHS Foundation Trust), Ian Fullagar, (Head of Strategic Housing, City Development and Growth DCC), James Joyce, Head of Housing Options and Homelessness Michael Kay (Head of Environment Protection, Housing Standards, Licensing and Emergency Planning DCC), Bridget Stacey (Derby & Derbyshire ICB), Clive Stanbrook (Derbyshire Fire and Rescue Service)

Non board members in attendance: Stuart Batchelor, Active Partners Trust, Duncan Cowie, Head of Parks and Active Living, Marie Cowie, Senior Public Health Manager, Tamsin Hooton, Programme Director, Provider Collaborative, Siobhan Horsley, Consultant in Public Health, Kirsty McMillan, Director Integration and Direct Services Adults, Alison Wynn, Assistant Director Public Health

23/22 Appointment of Chair

Councillor Roy Webb was elected as the Chair of the HWB for the remaining meetings of the municipal year 2022/2023.

24/22 Apologies for Absence

Apologies were received from: Councillors Poulter, Lind, Whitby and Williams, Chris Clayton (Chief Executive Officer Derby & Derbyshire ICB), Buk Dhadda, (Non Executive Director Derby & Derbyshire ICB), Fran Fuller (University of Derby), Claire Mehrbani (Director of Housing Services, Derby Homes Ltd), Stephen Posey, (Chief Executive University Hospitals of Derby and Burton NHS Foundation Trust), Perveez Sadiq (Director Adult Social Care DCC), Steve Studham (Chair Derby Healthwatch), Andy Smith (Strategic Director of People Services DCC).

25/22 Late Items

There were none.

26/22 Declarations of Interest

There were none.

27/22 Minutes of the meeting held on 8 September 2022

The minutes of the meeting on 8 September 2022 were proposed, seconded and agreed.

Item 19/22 - The Assistant Director of Public Health confirmed that the updated Terms of Reference for the HWB had been approved by Council and the constitution of the Council has been updated in alignment.

All the references to the CCG in the Minutes should be amended to ICB.

28/22 Better Care Fund (BCF) Update

The Board received a report and presentation from the Strategic Director of People Services.

The Director of Integration and Direct Services presented the report for approval. The HWB is the governing body for the BCF, which is a joint fund between NHS and Local Authorities to drive forward on a number of integration priorities. The HWB has previously received and approved all the previous submissions as well as various monitoring reports. The latest planning round had concluded and the proposal for DCC has been submitted. It was very similar in part to the proposal for Derbyshire as there was one integrated system. In particular the narrative plan was very similar as the care system which was Derby and Derbyshire wide could not be separated. The document had been submitted in accordance with the timeline as yet there has been no formal confirmation that the plan was assured but confirmation was expected in the near future.

The officer highlighted the national conditions that must be satisfied so that BCF plans are assured, areas must set out how health and social care will work together using BCF funding to improve outcomes for overall policy objectives. The national conditions for the BCF in 2022 to 2023 are:

- That BCF plans are agreed jointly by local health and social care commissioners supported and signed off by HWB
- That the NHS contribution to adult social care at HWB level be maintained in line with the uplift to NHS minimum contribution
- That there is an investment in NHS commissioned out-of-hospital services
- That there is a commitment to implementing the BCF policy objectives

The officer highlighted that Appendix 1 was a summary of what had been submitted. A Narrative Plan, Appendix 2, had also been submitted with some key lines of enquiry about what needed to be covered. The Board were asked to note that it was a combination of the planning submission which has the finance and performance set out as well as the Narrative Plan which described how work would be done in terms of integration of health and care across Derby and Derbyshire, the two should be read together to understand how the BCF supports all of that. The Narrative Plan sets out that in our system the BCF was not seen to be separate and disparate from existing arrangements but was supporting them.

The Chair asked if there were any questions about spending on the BCF, there were no questions. He explained that the BCF has helped with collaboration over the years between Social Care and Health.

The Board resolved to approve the proposed spend and performance objectives for the Better Care Fund for 2022/23 in line with the national expectations for the programme set by the Department of Health and Social Care (DHSC)

29A/22 Joined Up Care Derbyshire Update – Provider Collaborative

The Board received a report and presentation from the Chief Executive, Derbyshire Healthcare NHS Foundation Trust which was presented by the Programme Director, Provider Collaborative, JUCD. The report gave an update on the development of the provider collaborative within the JUCD Integrated Care System.

Provider Collaboratives are partnership arrangements involving at least two trusts, working at scale across multiple places, with a shared purpose and effective decision making arrangements. It was expected that all acute and mental health trusts would be in at least one collaborative by April 2021.

The benefits of collaboratives are:

- Delivering benefits of working at scale
- Creating effective shared decision making structures
- Aligning providers within a shared purpose
- Reducing duplication and variation
- Supporting resilience
- Joined up workforce planning
- Addressing health inequalities

Derby and Derbyshire NHS providers have worked in partnership for some time. However, a more formal approach was developed over the past 18 months being part of a move to the new statutory Integrated Care System (ICS).

A Provider Collaborative Leadership Board was formed which initially met in shadow form before the changes to the ICS structure in July 2022.

The Joined Up Care Derbyshire (JUCD) provider collaborative Leadership Board membership consists of local Health Trusts and services including Chesterfield Royal Hospital NHS Foundation Trust, Derbyshire Community Health Services NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust, Derbyshire Health United, East Midlands Ambulance Service, University Hospitals of Derby and Burton NHS Foundation Trust.

GP Practices are represented by the Derby and Derbyshire GP Provider Board. Derby City Council and Derbyshire County Council were also invited to attend meetings, but their focus currently was on the JUCD Integrated Place Executive.

There was a rotating Chair for the Board currently it was the Chief Executive of Derbyshire Healthcare Foundation Trust but would pass to the Chief Executive of University Hospitals of

Derby and Burton NHS Foundation Trust by the end of November.

The Provider Collaborative Leadership Board meets quarterly with NHS provider Chairs, it sets the direction for the Provider Collaborative, the first year will be a developmental year moving into a delivery mode.

Further information was provided to the Board in a presentation which explained the development of the JUCD provider collaboration, it's purpose, strategic aims, current position and future plans.

A councillor sought clarification on the type of organisation the JUCD Collaborative was. The officer explained that the JUCD was the Integrated Care System (ICS) and included partners such as the Local Authority and Voluntary Sector. The Provider Collaborative was a sub-set of this and would deliver strategy and intent, multiple provider collaboratives could exist, there was no brand name for this collaborative currently.

Resolved to note the update from the JUCD provider collaborative.

29B/22 Joined Up Care Derbyshire Update – Provider Integrated Care Strategy

The Board received a report from the Director of Public Health which gave an update from JUCD Derby and Derbyshire's Integrated Care System. The report was presented by the Assistant Director of Public Health.

The update on progress was provided to formally establish the Integrated Care Partnership (ICP) and the development of an Integrated Care Strategy (ICS).

Integrated Care Systems (ICS) are partnerships of organisations that come together to plan and deliver joined up health and care services. Each ICS comprises of an Integrated Care Partnership and an Integrated Care Board.

Joined Up Care Derbyshire (JUCD) co-ordinates health and social care across Derby and Derbyshire. There are 42 ICS across England and they bring together NHS bodies, local authorities and voluntary sector organisations to deliver better care for the community.

Derby and Derbyshire ICP currently operates in shadow form. A process was ongoing to establish formal joint arrangements between Derby and Derbyshire ICB, DCC and Derbyshire County Council. Approval has been sought from both Council Cabinets and also will be sought from the ICB Board at their meeting in November. The ICP should be operating as a formally established joint committee from February 2023. It was planned that DCC will host the ICP so it will follow DCC committee procedure rules. The ICP will be chaired by the Chairs of DCC and Derbyshire CC on a rotating basis. The Vice Chair will be the Chair of the ICB.

The ICP has a statutory responsibility to develop an Integrated Care Strategy to address the health, social care and public health needs of the local area, it was hoped to have an initial version of the Strategy by December 2022. This would be a "framework" document that would include high level ambitions, identified care gaps and the work needed to close them. The ICB and local authorities must bear in mind the Integrated Care Strategy in their planning and

decision making and it will be reviewed by the HWB. Also the HWB should review its HWB strategy and consider if it needs updating in response to the Integrated Care Strategy.

Resolved to note the update from JUCD

30/22 Derby Health Inequalities Partnership

The Board received a report from the Director of Public Health to introduce Health and Wellbeing Board Members to the Derby Health Inequalities Partnership (DHIP) its role, purpose and scope. The report was presented by representatives of the Derby Health Inequalities Partnership (DHIP).

The DHIP was started in response to the COVID 19 Pandemic which highlighted the inequalities in the city and demonstrated the good work and potential of communities to respond to the challenge.

The COVID 19 Resilience Forum Health and Welfare Cell identified a gap for the city in community led health planning. Initial DHIP meetings recognised a need for community consultation to understand the most important health issues in the communities. The aim was to capture the human experience behind the inequalities data in Derby.

The DHIP was a co-led and a joint initiative between DCC Public Health and Community Action Derby. They work together with community organisations and leaders to help achieve better outcomes in the city.

An initial consultation to understand local people's experience of health in Derby has been completed. This work provided some insight into people's lived experience and the challenges for the health system.

The DHIP has identified 3 themes of development work:

- Community consultation and engagement to understand what health issues are most important within our communities: the human experience behind the inequalities data
- Health promotion/ education: supporting the development of knowledge, skills and confidence in health issues
- An advisory function to health services and providers to improve the offer for our communities and holding to account for actions following that advice.

The current policy context were explained including: Health and Wellbeing Board and JUCD priorities; Proportionate Universalism - resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need; NHS Core 20+ which asks us to focus on the 20% most deprived population who have the highest health needs, poorest outcomes, and experience disparities in access to health and related services. Seven themes were identified from analysis of the report: health issues, community issues, Health service, service issues, health behaviours, information, need for action.

The learning and reflections from the consultation were highlighted and included the following:

- The importance of building trust and relationships
- An acknowledgement that meaningful co-production and engagement takes time

- The importance of clear communication
- That this was an ongoing learning process

Some of the recommendations from the consultation were also highlighted:

- Bridging the knowledge gap between healthcare professionals and communities, ensuring that information is widely accessible and that individuals can make informed decisions about their health.
- Transitioning away from top-down initiatives which do not consider the opinions and experiences of the communities being engaged with, instead NHS and Local Authority to build in the role of community participation

The next steps were outlined:

- The consultation report has been completed to final draft form. The aim of the report was to understand and begin to articulate the health and wellbeing concerns of communities
- The report findings and recommendations have been shared with and endorsed by the DHIP.
- A task group would be formed to review recommendations and findings, and create a DHIP action plan to address the concerns which link with HWB and ICS priorities
- Consultation and engagement would continue to develop the 2-way dialogue and inform planning and actions

A councillor felt that this was public health with a heart, data can be collated but it was how that data was used that was most important. The video shown today which voiced what people were experiencing in real life was extremely powerful, it was something we all see. Health inequalities were not down to communities but to how they are treated within the health and social care system. It's our job to help improve that. He hoped that Health Inequalities Partnership will continue to move this forward.

Another councillor felt it was one of the best reports received by the Board and accorded with councillors knowledge of wards and what residents are saying to them, but it was concerning that the situation was worsening. The councillor looked forward to hearing what could be done as there was a need for change but communities need to be fully engaged.

Several other Board members echoed these comments, and raised further concerns around the current situation with life expectancy in Derby falling, rising hospital admissions, possible health and safety concerns with people using candles for light and heat in their homes, poor private sector housing conditions in the city and the impact of this on peoples health. A councillor asked if education charities in the city were being used to transmit this information for NHS training purposes, and offered contact details for charities in the city to ensure it was. Several Board members also offered to work together with the DHIP and requested a copy of the report and contact details. A councillor stated that this was an example of co-production with all working together for a common aim, if there was a continuation of this collaborative working then issues could be picked up across the city.

The representatives from the DHIP explained the membership was being looked at with a view to extending it to more providers across the city and they were open now to new members joining.

The Board resolved

1. **to note the content and recommendations of the community consultation findings and the role of community voice in addressing health inequalities**

2. **to ratify the role and function of the DHIP in achieving health and wellbeing priorities for the City.**

31/22 Strategic Value of Physical Activity

The Board received a report of the Director of Public Health which gave an update on physical activity in Derby and the progress of Move More Derby. The report was presented by Active Partners Trust and the Head of Parks and Active Living.

Derby has a background of above national average inactivity rates with 1 in 4 adults (16yrs+) being inactive, achieving less than 30 minutes of moderate intensity movement a week. The Board heard that demographic factors influence physical activity behaviour, there are higher rates of inactivity in groups with the most to gain in terms of reducing risk including those with long-term health conditions. As well as females, people in lower socio-economic groups, people with a disability, people from some black and minority ethnic groups and older people are more likely to be less physically active.

Move More Derby (MMD), a physical activity and support strategy 2018-23 was adopted in March 2018. It was developed from a collaboration with the University of Derby, the work sought to develop an approach to reducing physical inactivity. The focus was to move physical activity from a venue based strategy to a community based strategy where activity happens everywhere. Before MMD, Derby only had a Leisure Facilities Strategy, facilities satisfy around 15% of the population although this was significant there was a need to get lots of people becoming active themselves.

An understanding of physical activity behaviour and how to change it was undertaken in three communities (Dewent, Sinfin and Alvaston). There were positive developments in Derby in relation to work around physical activity as a result. The development of Move More Derby as a whole-systems-approach led to the delivery of place-based approaches and locality working like the “Beat the Street” programme, work on Derby Active through Football and Derby PlayZones.

Outside of the strategy actions there has been progress in other areas like increased spaces, connectivity, networks, physical activity advocates and champions coming together to share, learn and collaborate such as the Move More Derby Ambassadors network.

The MMD strategy review was highlighted, the environment and context for MMD has changed since it was adopted giving an opportunity to review the strategy which is at the midway point and also because of COVID-19. The message has not changed but there was a need to focus more on a universal approach fixed deeply with people working in this area day-to-day and across the system. The approach should build on the culture and learning to date and sit within the context of the environment and priorities for Derby. More people need to own the inactivity problem and challenge. The health of communities will be determined by

how effective the whole physical activity system works together to raise the value of physical activity into society consciousness.

DCC and Active Derbyshire together have supported the engagement work of the refresh and a new Active Derbyshire strategy, heading in the same direction to build a movement and working with people and partners at a local and level to align strategic thinking, policy, practice and ensure what was being done worked for all and recognising that what works in one place may not work elsewhere. The key learning for this work and all of the place-based work was that a local approach to improve the conditions for the people of Derby was a priority focus. Physical activity has a place in the conversation both by direct intervention and in support of other agendas.

Councillors noted the ongoing collaboration work between partners and organisations such as Derby Fire and Rescue and the Livewell Programme. A councillor was interested to know how much take up of activities there was by girls. The officer explained the aim was to develop communities to take ownership themselves and develop opportunities that are gender inclusive and for all ages, but there was a focus on under represented groups for example children of 7 to 8 years. Another councillor was concerned about physical activity for young children in schools. The officer explained there were opportunities in the system to influence school communities. Liaison had taken place with the Holiday Activities and Food Programme (HAF) Co-ordinator to fund after-school activities and inform schools about building physical activity.

Resolved

1. **That members of the Health and Wellbeing Board consider the contents of this report.**

2. **The Health and Wellbeing Board members engage with the Move More Derby refresh process and explore how physical activity and movement might be used more strategically to help tackle inequalities, particularly health inequalities.**

3. **That the Health and Wellbeing Board ask for an update report in 5 month's time, setting out progress made and the learning from the work that has taken place.**

32/22 Healthwatch Derby – Chronic Pain Experiences Report 2022

The Board received a report of the Chair of Healthwatch Derby, the purpose of the report was to provide the Health and Wellbeing Board with an overview of Healthwatch Derby – Chronic Plan Experiences Report 2022. The report was presented by the CEO, Healthwatch Derby.

The Board heard that chronic or persistent pain lasts longer than 12 weeks and affects a patient constantly or intermittently despite receiving treatment or medication. The Health Survey for England (NHS Digital 2017) found that 34% of the UK population are affected by chronic pain, 28 million, and accounts for up to 5 million GP appointments per year. It affects peoples quality of life and limits their ability to carry out regular daily activity, leading to an increase in mental health issues and possible job loss. The situation affects more women than men and increases with age.

In 2022 Healthwatch Derby designed a survey to discover what support was available for these patients, how they cope with pain daily and if any improvements can be made. The survey took place between 5th April and 12th July 2022 and there were 309 responses.

The Board heard that the report was well received across the local and national system and will help shape outcomes. Since the report was written a further 6 workshops had taken place. The report seems to have started the conversation on a national scale and the survey could be rolled out nationally to get more data.

The Chair thanked HealthWatch for the well put together report, there are some points that need to be considered around pain management and how we deal with it collectively. The Board were being asked to note the report and he considered that it was a very valuable report.

A Board member queried the the report in terms of the ethnicity of respondents who were predominently white british, and asked if this was because of access. The officer stated the report was online and Healthwatch had attended a lot areas where people go for pain management, it was just the breakdown of people who attended on the days. This was a general survey and usually more white british come forward. Ethnicity was a point to be noted.

Another member echoed these comments as she found when working in Derby City there were difficulties in engaging the BAME population, this could be partly cultural in terms of how people perceive pain. The report was interesting as it reflected what she recognised in the health service that there was a lot more medicalised treatment rather than psychologist support and self care or self management approach towards supporting those people. It was a good report but she recognised the imbalance between people accessing the service, it would be interesting to have population data on people using the pain management service.

Resolved to note the contents of the report.

Items for Information

33/22 COVID Outbreak Engagement Board and Health Protection Board Update

The Board received a report of the Director of Public Health which provided an update and overview of the key discussions and messages from the COVID Outbreak Engagement Board and Derbyshire Health Protection Board.

The Derby Outbreak Engagement Board has been paused as the country was learning to live with safely with COVID. A meeting has been scheduled to review the Local Outbreak Management Plan and to consider plans for winter.

The Derbyshire Health Protection Board met on 21st October, key points of note for the information of the HWB were:

- Infection Prevention and Control Services in the Community – a local review underway of what the service needs looks like and where the gaps, including challenges around

capacity of services and of recruitment of specialist staff was underway, a report was due at the Health Protection Board in a few months.

- Screening – all local services have recovered their activity levels from restriction during the Pandemic, and the age extension of the bowel cancer pathway was being implemented, Aortic Aneurysm programme has the 4th best performance nationally.

- Immunisation – NHS England are providing more support for the delivery of vaccinations in the pregnancy programme. There's a national MMR catch up programme as there has been a decrease in Children's MMR vaccinations over the last few years. The Flu campaign was underway, there are concerns nationally about the uptake of the nasal flu vaccine for 2 to 3 year olds, this was reflected nationally. Uptake has been reduced this year and there has been an increase in flu cases nationally and of young children being admitted to hospital also. Work was ongoing to reduce inequality in vaccination uptake and consideration of the best communication channels for promotion was being done.

- Responsibility for commissioning the national immunisation and screening programmes was planned to transfer to Derby and Derbyshire ICB from NHS England before March 2024

- A full update on the local status of the national immunisation programme will be scheduled for for consideration at the next HWB.

A Councillor asked about herd immunity of communicable diseases. The DoPH indicated the main area of concern was MMR where there was need for a high level of vaccination to control measles transmission, this was a national issue, locally the 2 doses update by the age of five was 82% which was below the national average of just under 87%. There was a national catch up programme and work being undertaken locally to try and improve uptake.

Another Councillor was concerned how much of an impact was the misinformation going around about vaccination, was that the reason why MMR and other vacinnes are dropping off. The Board discussed the question and felt it did have some impact, the nasal spray vaccine for young children was not suitable for muslims due to the porcine element. Also people were struggling to get GP appointments. A councillor felt it might be necessary to have a different strategy for the vaccine programme to improve uptake. An officer felt a lot of the issues came down to peoples perception of vaccinations and to their trust and understanding of what the offer was and the risk of not taking up the vaccinations.

Another officer stated there was a lot of concern about the levels of flu this winter, previously during the Pandemic there were almost no admissions to hospital, this was because of peoples behaviour as they they were taking more precautions such as handwashing. The DoPH highlighted that there was particular concern about 2 to 3 year olds as they had not been exposed to the flu virus before and also had no vaccine protection.

Resolved to note the report.

34/22 Derby and Derbyshire Drug and Alcohol Strategic Partnership

The Board received a report of the Director of Public Health and Strategic Director of People Services. The report was to inform the Board about the government's New Drug Strategy – Harm to Hope, and the requirement to form a local dedicated Drug and Alcohol Strategic Partnership.

The Board were informed of the key national policy and work in the city and wider county to combat the impact of drugs.

The report gave an update on development of Derby and Derbyshire Drug Strategic Partnership, there was new government strategic policy "harm to hope" requirement for local areas to develop these partnerships, clear guidance was given around priorities and associated funding.

The key strategic priorities were:

- breaking drug supply chains
- delivering a world class treatment and recovery system
- achieving a generational shift in demand for drugs

The partnerships were being established between Local Authorities and Police, Probation Services and ICB. The purpose was to have a senior responsible officer, DoPH was taking up this role in the interim, who would be assured of all the activity around drug and alocohol actions across Derby and Derbyshire and to be the link into national government and to bring the partnership together to ensure actions taken and improvements were made. Under the partnership there would be a Derby city and Derby County Group to look at operational detail and the commissioning of services. The partnership had been established as a sub group of both the City and County Councils.

The representatives from Community Action and DF4T Alliance asked to join the Partnership. The DoPH confirmed that she would contact them to discuss options as it may be more appropriate for them to be a part of the City based operational group.

Resolved to note the national drug strategy Harm to Hope and establishment of a county-wide strategic partnership to tackle drug and alcohol related harm.

35/22 Publication of the Pharmaceutical Needs Assessment

The Board received a report of the Director of Public Health which gave an update on progress of the requirement to prepare and publish a revised Pharmaceutical Needs Assessment (PNA) by 1 October 2022.

The HWB were informed that the approved version of the PNA was published by 1 October as per statutory responsibility and can be accessed by the link below:

https://www.derby.gov.uk/media/derbycitycouncil/contentassets/documents/healthandsocialcare/jsna/publications/pharmaceutical-needs-assessment-2022.pdf.

Resolved to note the publication of the Derby and Derbyshire Pharmaceutical Needs Assessment 2022-2025 by 1 October 2022.

Private Items

None submitted.

MINUTES END

PUBLIC

MINUTES of a meeting of **HEALTH AND WELLBEING BOARD** held on Thursday, 6 October 2022 at Committee Room 1, County Hall, Matlock, DE4 3AG.

PRESENT

Councillor C Hart (in the Chair)

Councillors H Froggatt (Derbyshire Dales District Council), A McKeown (High Peak Borough Council), P Maginnis (Erewash Borough Council) J Patten (Derbyshire County Council) , T Spencer (Amber Valley Borough Council), and C Clayton (Derbyshire ICB), H Henderson-Spoors (Healthwatch Derbyshire).

Also in attendance was A Appleton, C Cammiss, H Denness, E Houlston, H Jones, E Langton, I Little, and R Sinclair (Derbyshire County Council), T Broad (Derbyshire Dales District Council), M Holford (South Derbyshire District Council), K Monk (Amber Valley Borough Council), G Smith (Erewash Borough Council), and I Waller (Chesterfield Borough Council).

Apologies for absence were submitted for Councillors M Dooley (Bolsover District Council), and J Mannion-Brunt (Chesterfield Borough Council), H Barnett (Derbyshire Police), and K Hanson (Bolsover District Council).

26/22 DECLARATIONS OF INTEREST

There were no declarations of interest.

27/22 MINUTES

RESOLVED that the minutes of the meeting of the Board held on 07 July 2022 be confirmed as a correct record.

28/22 HEALTH AND WELLBEING BOARD TERMS OF REFERENCE AND MEMBERSHIP

The Health and Wellbeing Board had been asked to agree the Health and Wellbeing Board membership and terms of reference following consultation, and note the revised draft terms of reference, which would be adopted by Derbyshire County Council.

Health and Wellbeing Boards were established under the Health and Social Care Act 2012 and had both set functions and a core membership. The statutory requirements of the Board had been outlined in the terms of reference.

RESOLVED to:

1) Agree the Health and Wellbeing Board Membership and Terms of Reference following consultation, attached as appendix 2;

2) Note the revised draft Terms of Reference, which would be adopted by Derbyshire County Council.

29/22 COMBATTING DRUGS

The Health and Wellbeing Board had been provided with an update to give an overview of the current national context and local drivers in relation to substance misuse as well as an overview of local plans to reduce harmful alcohol and drug consumption.

RESOLVED to:

1) Note the drivers and strategic direction of travel in planning to reduce drug and alcohol-related harm in Derbyshire;

2) Note the plans for using new grant investment to deliver improvements to treatment and recovery services in Derbyshire; and

3) Agree to receive an annual update on this shared partnership agenda.

30/22 HEALTH PROTECTION BOARD UPDATE

The Health and Wellbeing Board were provided with an update of the key messages arising from the Derbyshire Health Protection Board from its meeting on 12 August 2022.

RESOLVED to:

1) Note the update report from the Health Protection Board.

31/22 PUBLIC QUESTION

Question received from Mr Dobbs:

I note that in section 2.5 of the Health Protection Board Update, Mr Little states that “Four Air Quality Management Areas and accompanying action plans are in place in the County.” In fact for one of those AQMAs, in Ashbourne, the Action Plan is NOT yet in place. Also the draft action plan, largely based on suggestions from County Highways, is widely regarded as unlikely to achieve any reduction in NOx levels in the next four years. Qn. What input, if any, have those that report to this board had in shaping this draft plan? If there has been no input why is this, when air quality is the second highest priority for this Board?

Assistant Director - Health Improvement & Public Health, Iain Little,

responded as follows:

The processes for establishing an Air Quality Management Area and associated requirements are set out in legislation, and in County Council areas it is the responsibility of the relevant district or borough council to follow the process as outlined by the Department for Environment, Food and Rural Affairs. Officers from Derbyshire Dales District Council have confirmed that a draft Air Quality Action Plan has been developed for the Air Quality Management Area in Ashbourne, and that it is currently subject to initial consultation with key stakeholders, prior to wider public consultation. The draft Action Plan is the product of technical expertise, feasibility considerations and partner input. Further details on the status of the Action Plan relating to the Air Quality Management Area in Ashbourne should be directed towards Derbyshire Dales District Council, via envhealth@derbyshiredales.gov.uk with Air Quality included in the subject line.

The Air Quality Working Group is a sub-group of the Derbyshire County Health and Wellbeing Board, established to support delivery of the Air Quality priority of the County Health and Wellbeing Strategy. For information, the priorities included in the strategy are not presented in ranking order, and therefore air quality is one of 5 priorities, rather than the second highest priority for the Health and Wellbeing Board. The Air Quality Working Group does not have a statutory role in relation to Air Quality Management Areas. Members of the Group will provide advice and technical expertise where required to inform and advise on the establishment of an Air Quality Management Area, development of an accompanying Air Quality Action Plan, and revocation of an Air Quality Management Area. Air quality levels in Air Quality Management Areas will be considered by the Air Quality Working Group as part of wider consideration of air quality across all monitoring sites in Derbyshire. The purpose of the Air Quality Working Group is to bring together partners from across Derbyshire to identify and implement collective action that can be taken to improve air quality across the county. As outlined in the priorities and deliverables of the Air Quality Strategy for Derby and Derbyshire, this is broader in scope than the elements of air quality subject to legislation, and includes actions relating to facilitating travel behaviour change, reducing sources of air pollution and mitigating against the health impacts of air pollution.

32/22 AIR QUALITY STRATEGY

The Health and Wellbeing Board were provided with information on air quality and the Air Quality Strategy 2020 2030.

The presentation gave an overview on what air pollution is, the sources of pollutants and how air pollution impacts on health, the roles of each District and Borough as well as what was next for the Strategy.

The Health and Wellbeing Board partners were asked to:

- Ensure Health and Wellbeing Board partners were represented at the AQWG, and implemented the strategy;
- Contribute to a refresh of the Strategy in 2023/24;
- Influence planning, housing, transport, County Deal;
- Address health inequalities and vulnerable populations;
- Support clean air campaigns;
- Role model / exemplar / assurance / secure funding; and
- Influence Government policy

33/22 UPDATE REPORT ON WORK OF THE SHADOW DERBY AND DERBYSHIRE INTEGRATED CARE PARTNERSHIP

The Health and Wellbeing Board were provided with an update on activity in the last quarter from the Derby and Derbyshire Integrated Care Partnership that was relevant to the Derbyshire Health and Wellbeing Board, it's development and strategy implementation.

RESOLVED to:

1) Note the development work of the Integrated Care Partnership and development of the Integrated Care Strategy; and

2) Consider whether there was an opportunity to align the operational delivery work associated with the Health and Wellbeing Strategy priorities with the County Place Partnership so there was a combined 'engine room' working to deliver health, wellbeing, and care priorities for the county.

34/22 COST OF LIVING UPDATE AND CONSIDERATION OF HEALTH IMPACTS

The Health and Wellbeing Board were provided with a summary of the health impacts of the cost-of-living pressures caused by rising inflation and proposed that the Derbyshire Health and Wellbeing Board received quarterly updates on this issue until summer 2023 when the position was reviewed. Health and Wellbeing Board partner agencies were encouraged to actively share intelligence and information on this key issue. This would enable a broad partnership response to mitigate and reduce health impacts.

RESOLVED to:

1) Highlight, monitor and respond to the health impacts of the cost-of-living pressures and proposed that the Derbyshire Health and Wellbeing Board

received quarterly updates on this issue until summer 2023 when the position is reviewed.

2) Agree that Health and Wellbeing Board members actively shared intelligence and information on this key issue to enable a broad partnership response to mitigate and reduce associated health impacts.

35/22 HEALTH AND WELLBEING ROUND UP

The Health and Wellbeing Board were provided with a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda.

RESOLVED to:

1) Note the information contained in the round-up report.

36/22 WORK PROGRAMME 2022/23

The Health and Wellbeing Board were provided with the anticipated work programme for the period 2022/23.

RESOLVED to:

1) Note the anticipated work programme for the period 2022/23.

37/22 PHARMACEUTICAL NEEDS ASSESSMENT - FORMAL RATIFICATION OF FINAL VERSION FOLLOWING VIRTUAL APPROVAL

Health and Wellbeing Boards must publish a revised Pharmaceutical Needs Assessment every three years. Revised assessments were due to be published by April 2021 but due to the Covid 19 pandemic this had been extended and publication must now be by 1 October 2022. Board members were referred to Appendix 3, the report presented to them at the 7 July 2022 meeting, for further information and legislation background. Since 7 July 2022 the statutory consultation had been completed. The responses received were summarised in Appendix 1 to the report.

The updated Pharmaceutical Needs Assessment was circulated to the board and was virtually approved by a majority of the board. Following this approval, the Pharmaceutical Needs Assessment was published by 1 October 2022.

RESOLVED to:

1) Note that on 7 July 2022 the Board agreed that following statutory consultation a final version of the draft, updated, Derby and Derbyshire

Pharmaceutical Needs Assessment (“draft PNA”) would be shared with Board members and, if approved by a majority of Board members, would be published by 1 October 2022;

2) Note the summary of the responses to the consultation at Appendix 1;

3) Note the draft PNA at Appendix 2, prepared in response to the consultation; and

4) Indicate whether they each approved the draft PNA by using the voting buttons on the covering email or emailing director.publichealth@derbyshire.gov.uk by 16 September 2022.

NHS Derby and Derbyshire Integrated Care Board

Meeting in Public Forward Planner 2022/23

Please Note: All reporting timeframes are currently indicative and subject to review and confirmation.

ICB Key Areas	2022/23									2023/24	
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Introductory Items											
Welcome / Apologies and Quoracy	x		x		x		x		x		x
Questions from Members of the Public	x		x		x		x		x		x
Declarations of Interests • Register of Interest • Summary register of interest declared during the meeting • Glossary	x		x		x		x		x		x
Strategy and Leadership											
ICB Chair's Report	x		x		x		x		x		x
ICB Chief Executive Officer's Report	x		x		x		x		x		x
NHS Derby and Derbyshire ICB Annual Report and Accounts			x								
Annual General Meeting (from previous CCG arrangements)			x								

ICB Key Areas		2022/23									2023/24	
		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
	Exec Lead (s)											
ICP New arrangements TORs	HD					x						
Integrated Care Strategy	ZJ							x				x
Planning for Winter (Operational/Care/Finance/Workforce)	ZJ/BS/KG/AR					x						
NHS Joint Forward View, Operational and Financial Plans and priorities for 2023 and beyond	KG/ZJ							x		x		
Workforce and People Plans	AR							x				
Amended Constitution	HD							x				
Update on VCSE Engagement Work	CC/Wynne Garnett									x		
Corporate Assurance												
Integrated Performance								x				x
Audit and Governance Committee Assurance Report		x		x		x		x		x		x
Finance and Estates Committee Assurance Report		x		x		x		x		x		x
People and Culture Committee Assurance Committee						x		x		x		x

ICB Key Areas	2022/23									2023/24	
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Population Health and Strategic Commissioning Committee Assurance Report	x		x		x		x		x		x
Public Partnerships Committee Assurance Committee	x		x		x		x		x		x
Quality and Performance Committee Assurance Report	x		x		x		x		x		x
ICB Corporate Risk Register Report	x		x		x		x		x		x
Strategic Objectives and Strategic Risks					x						x
New Board Assurance Framework and Updates							x				x
Corporate Committees' Annual Reports											x
Update and review of Committee TORs										x	
Derbyshire ICS Green Plan	x										
For Information											
Clinical Pathway Model									x		
Ratified Minutes of ICB Corporate Committees	x		x		x		x		x		x
Minutes of the previous meeting	x		x		x		x		x		x
Action Log	x		x		x		x		x		x
Forward Planner	x		x		x		x		x		x