NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC AGENDA

Thursday, 19th January 2023 at 9am to 10.45am

Via MST

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

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

Time	Reference	Item	Presenter	Delivery
9.00	**Introductory Items**			
	ICB/2223/062	Welcome, introductions and apologies • Keith Griffiths	John MacDonald	Verbal
	ICB/2223/063	Confirmation of quoracy	John MacDonald	Verbal
	ICB/2223/064	Declarations of Interest • Register of Interests • Summary register for recording interests during the meeting • Glossary	John MacDonald	Paper
	ICB/2223/065	Questions received from members of the public	John MacDonald	Verbal
9.05	**Strategy and Leadership**			
	ICB/2223/066	Chair's Report	John MacDonald	Paper
	ICB/2223/067	Chief Executive Officer's Report	Chris Clayton	Paper
9.15	**Items for Decision**			
	ICB/2223/068	Clinical and Care Professional Leadership Developments: Progress and Forward Plan	Dr Avi Bhatia	Paper
9.25	**Items for Discussion**			
	ICB/2223/069	Making the most of the Voluntary, Community and Social Enterprise sector contribution as a partner in the Integrated Care System	Wynne Garnett	Presentation

9.45	**Corporate Assurance**			
	ICB/2223/070	Integrated Assurance and Performance Report • Quality • Performance • Workforce • Finance	Chris Clayton Brigid Stacey Zara Jones Amanda Rawlings Darran Green	Paper
	ICB/2223/071	Month 8 System Financial Position	Darran Green	Verbal
	ICB/2223/072	Audit and Governance Committee Assurance Report – November to December	Sue Sunderland	Paper
	ICB/2223/073	Derbyshire Public Partnership Committee Assurance Report – November	Julian Corner	Verbal
	ICB/2223/074	People and Culture Committee Assurance Report – September to December	Margaret Gildea	Paper
	ICB/2223/075	Quality and Performance Committee Assurance Report – November to December	Dr Buk Dhadda	Paper
	ICB/2223/076	Population Health and Strategic Commissioning Committee Assurance Report – December to January	Julian Corner	Paper
	ICB/2223/077	Draft Board Assurance Framework 2022/23	Helen Dillistone	Paper
	ICB/2223/078	ICB Corporate Risk Register Report – December 2022	Helen Dillistone	Paper
10.25	**Items for Information**			
	The following items are for information and will not be individually presented			
	ICB/2223/079	ICB Constitution Update	Helen Dillistone	Paper
	ICB/2223/080	Joint Forward Plan and 2023/24 Planning Guidance	Zara Jones	Paper
	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	John MacDonald	Paper

		• Quality & Performance Committee – 27.10.22 and 24.11.22		
10.35	**Minutes and Matters Arising**			
	ICB/2223/082	Minutes from the meeting held on 17.11.2022	John MacDonald	Paper
	ICB/2223/083	Action Log – November 2022	John MacDonald	Paper
10.40	**Closing Items**			
	ICB/2223/084	Forward Planner	John MacDonald	Paper
	ICB/2223/085	Any Other Business	John MacDonald	Verbal
Date and time of next meeting: **Date:** Thursday, 16th March 2023 **Time:** 9am to 10.45am **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	Tracey	Partner Member - DCHS	Primary & Community Collaborative Delivery Board Integrated Place Executive Meeting	CEO of Derbyshire Community Healthcare 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 01/07/222 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
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 Apr 2018 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-Jun-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	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	Audit and Governance Committee 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 Place Executive Meeting	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 A&E Delivery Board	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
Majid*	Ifti	Partner Member - DHcFT	People & Culture Committee Population Health & Strategic Commissioning Committee	CEO of Derbyshire Healthcare NHS Foundation Trust Co-Chair of NHS Confederation BME leaders Network Chair of the NHS Confederation Mental Health Network Trustee of the NHS Confederation Spouse is Managing Director (North) Priory Healthcare	✓	 ✓ ✓ ✓		 ✓	01/07/22 01/07/22 01/07/22 01/07/22 01/07/22	Ongoing Ongoing 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

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	
Mott	Andrew	GP, ICB Partner Board Member	Joint Area Prescribing Committee	GP Partner of Jessop Medical Practice	✓				01/07/22	Ongoing	Declare interests if relevant
			Derbyshire Prescribing Group Clinical Policy Advisory Group System Quality Group	Clinical Director, ARCH Primary Care Network	✓				01/07/22	Ongoing	
			ICB Board	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	Quality & Performance Committee System Quality Group CRHFT Contract Management Board CRHFT Clinical Quality Review Group UHDB Contract Management Board UHDB Clinical Quality Review Group EMAS Quality Assurance Group Maternity Transformation Board (Chair)	Nil							No action required
Sunderland	Sue	Non-Executive Member - Audit & Governance	Audit and Governance Committee	Audit Chair NED, Nottinghamshire Healthcare Trust		✓			01/07/22	Ongoing	The interest should be kept under review and specific actions determined as required
			Finance and Estates Committee Public Partnerships Committee Population Health & Strategic Commissioning Committee	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	
			IFR Panels CFI Panels	Finance NED Inclusion Healthcare Social Enterprise CIC		✓			01/07/22	30/08/22	
				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
Wallace*	Dean	Partner Member - Derbyshire Local Authority	Integrated Place Executive Meeting A&E Delivery Board	Director of Public Health, Derbyshire County Council	✓				01/07/22	31/08/22	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Chief Operating Officer, Derbyshire Community Health Services NHS Foundation Trust	✓				01/09/22	Ongoing	
Weiner	Chris	Executive Medical Director	Quality & Performance Committee Population Health & Strategic Commissioning Committee	Nil							No action required
Wright	Richard	Non-Executive Member - Finance & Estates	Audit and Governance 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
			Finance and Estates Committee Quality and Performance Committee Population Health & Strategic Commissioning Committee Remuneration Committee	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

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

19th January 2023

Item: 066

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
Recognising the work of system health and care staff The pressure being faced by the NHS and our partners in social care is well-publicised at a local and national level, and reports elsewhere on the ICB Board agenda reflect the detail that lies behind that with Derby and Derbyshire. What is more difficult to reflect is the significant effort that our staff across health and care continue to make to ensure our citizens receive the best possible care at this time. As well as being employees of health or care organisations, our staff are also often patients themselves, or carers of family members or friends who use our services, and members of the public in the broadest sense. We mustn't forget that our staff are human, have limits to their endeavours the same as everyone in society, and are affected by the same illnesses and challenges of life that affect us all. It is in this context that it is all-the-more necessary to thank everyone who continues to work across our system to support our citizens, whilst at the same time juggling the challenges of everyday life. The efforts are fully recognised, we are very grateful and we must continue to ensure we look after our teams through this prolonged period of challenge for the health and care system.

Integrated Care Strategy - Framework

Integrated Care Systems are required by law to develop a strategy that details how the health and care needs of residents of Derby and Derbyshire will be met either by the NHS or local authorities. The strategy will consider how NHS bodies and local authorities will work together to meet these needs. It must involve Healthwatch and people who live or work in our area and must identify how health-related services can be more closely integrated with arrangements for the provision of social care. The purpose of the Integrated Care Strategy is to set out how Local Authority, NHS, Healthwatch, and Voluntary Community and Social Enterprise (VCSE) sector organisations will work together to improve the health of Derby and Derbyshire citizens, and further the change needed to tackle system health and care challenges.

In December, the Derby and Derbyshire Integrated Care Partnership (ICP) approved a framework document which set out the strategic aims and population outcomes we are seeking to achieve. The four strategic aims for the development of integrated care 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; and
- improve connectivity and alignment across Derby and Derbyshire, to ensure people experience joined up care, and to create a sustainable health and care system.

If the population was 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.

We will shortly be publishing a summary of the framework document on the Joined Up Care Derbyshire website. It sets out our priority health indicators, which include specific indicators around known, priority inequality areas.

Hewitt Review

The government has announced through the Chancellor's autumn statement that a new independent review into oversight of Integrated Care Systems (ICSs) to reduce disparities and improve health outcomes across the country, will be completed. The review will be led by former Health Secretary the Rt Hon Patricia Hewitt who is currently Chair of NHS Norfolk & Waveney Integrated Care Board, and will explore how to empower local leaders to focus on improving outcomes for their populations.

The review will 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.

In particular it will consider and make recommendations on:

- how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending
- the scope and options for a significantly smaller number of national targets for which NHS ICBs should be both held accountable for and supported to improve by NHS England and other national bodies, alongside local priorities reflecting the particular needs of communities
- how the role of the Care Quality Commission (CQC) can be enhanced in system oversight

There is currently a call for evidence, which the ICB has responded to, including using some outputs from the Derby and Derbyshire Together process in setting our strategic framework. The review will report to the Secretary of State for Health and Social Care, with interim findings by 16 December 2022, a first draft by 31 January 2023 and a final report by no later than 15 March 2023.

East Midlands Devolution Deal Consultation

Derbyshire County Council, Nottinghamshire County Council, Derby City Council and Nottingham City Council have agreed to a £1.14 billion devolution deal by the government. The deal would create the first ever East Midlands Combined County Authority (EMCCA) and would see an extra £38 million a year coming to the region from 2024, addressing years of historically low investment in our area. It would mean funding and powers move from a national level to a regional level to help the 2.2 million people who live in the region. Existing local authorities would remain.

The vision of the combined authority is for the people who live and work here to be better connected, more competitive, and more prosperous within an inclusive Combined County Authority area at the heart of the country. Share objectives are about:

- boosting productivity, pay, jobs and living standards;
- spreading opportunities and improving public services;
- restoring a sense of community, local pride and belonging;
- empowering local leaders and communities

The consultation is open to partners and residents alike, and the ICB Board has submitted its formal response. The ICB and Integrated Care Partnership (ICP) have a statutory key role on improving health outcomes for the population of Derby & Derbyshire and therefore the ICB has welcomed the development of the EMCCA given the importance of socioeconomic regeneration on the wider determinants of health. Given the Anchor Institution role that the NHS plays in our area, the NHS would be keen to work in partnership with the EMCCA on the Adult Training and Education devolved area given our local ambition to create a "One workforce" approach with local authorities and other partners.

The ICB has asked for clarification in a number of areas, including assurance on additional running costs of a new authority and mitigation of risks associated with the creation of an additional layer of local government, and noted that the NHS would desire to be considered as a member of the EMCCA given its economic, employment and educational scale.

Addressing inequalities in mental health care

Two population groups have been identified by the Mental Health, Learning Disability and Autism Delivery Board for focus of local efforts to reduce inequalities in mental health care. This includes people who are Deaf and those from a Black background, given the multiple barriers and poorer outcomes faced by people in these communities. The Delivery Board has discussed plans to undertake a Health Needs Assessment (HNA) to better understand the mental health needs of Black and Deaf communities in Derby and Derbyshire. This work will also seek to access a range of data and information relating to the population of Derby and Derbyshire and their access to, use of and outcomes from community and mental health services. This will

include whether there are differences in access, use and outcomes in Black and Deaf communities.

The HNA will also engage with people in these communities to understand views and experiences relating to mental health and mental health care. This will include drawing on the expertise of local community and voluntary services. The intention is for the process to result in tangible recommendations for change, the delivery of which will reduce inequalities in mental health in these priority populations. This will build on the event held with the Deaf community this summer to understand issues and challenges.

Working Together to Reduce Ambulance Delays
East Midlands Ambulance Service (EMAS) in collaboration with Derby and Derbyshire Integrated Care Board (DDICB), University Hospitals of Derby and Burton (UHDB), Derbyshire Health United (DHU), Derbyshire Community Health Services (DCHS) and Derby and Derbyshire Adult Social Care joined forces recently to take part in a 'Rapid Improvement Fortnight', to explore whether a 'Single Point of Contact' could assist with reducing ambulance delays.

The aim was to reduce ambulance conveyances to A&E where an better alternative was available. Alternatives would include hospital wards and services such as Medical Assessment Units (MAU), Surgical Assessment Units (SAU), Same Day Emergency Care (SDEC), on site and community Urgent Treatment Centres (UTC), Nursing and Occupational Therapy Teams and Primary Care, among others. The initiative involved setting up a Single Point of Contact for any clinician to call to get support in finding alternative locations for conveyance.

It was found that during this period, despite EMAS dealing with a similar number of incidents as normal, and the number of calls being assessed for conveyance being similar, handover delays reduced by up to 50% and lost hours, i.e., the hours ambulances wait with patients waiting for handover to an Emergency Department (ED), went from being between 200-400 hours to between 18-45 hours, indicating that the Single Point of Contact had a huge impact.

In addition, the Single Point of Contact team found that with the support of different teams across Derbyshire, it was possible to greatly improve the chance of positive outcomes for patients over 70 – who make up 56% of normal ambulance conveyances to ED - by ensuring they were put on a more appropriate pathway than ending up at the ED.

More information on this project is available in the January edition of the Joined Up Care Derbyshire newsletter**,** which contains a wide range of information about other partnership initiatives taking place across Derby and Derbyshire.

Case Study
One case saw an 81-year-old male, with vascular dementia and bipolar, who was generally verbally agitated due to possible delirium, and was experiencing a rapid deterioration in mental health over the past four weeks. The ambulance crew contacted the Single Point of Contact to discuss the patient's own medication and his support needs. An MDT discussion with the GP practice resulted in a home visit being arranged, and the Nursing Therapy Team also arranged a support review. This resulted in the gentleman receiving the care he needed at home, with primary and urgent care reviewing his medication and reluctance to accept care from external sources. Plans were put in place to provide respite for his wife by agreeing a short-term care package for the patient.

Glossop Lung Health checks for smokers
Local NHS teams in Glossop are inviting smokers past and present to get a lung health check in a drive to improve earlier diagnosis of lung cancer and save lives. GPs will be sending letters to households as part of the new screening project, which includes in-person appointments and CT scans. The letters will go to eligible people aged 55-74, inviting them for an initial lung health

check with a specially trained healthcare professional. More than 65% are then expected to be eligible for the low-dose CT scans. Over two years, across the 23 pilot projects in England, the programme is expected to identify an estimated 6,000 cases of lung cancer earlier than would have been possible. Glossop has one of the highest mortality rates for lung cancer in England and is one of 23 places across the country running the Targeted Lung Health Check (TLHC) programme.

Youth-Led Citizen Research

MH:2K is a powerful, youth-led model for engaging young people in conversations about mental health and emotional wellbeing in their local area. First piloted in Oldham in 2016/17, their early success saw them expand into new areas. MH:2K is now well embedded in Derbyshire and Nottinghamshire and running into its fourth year.

The youth led model empowers 14–25-year-olds to become 'Citizen Researchers' to:

- identify the mental health issues that they see as most important;
- engage other young people in discussing and exploring these topics;
- work with key local decision-makers and researchers to make recommendations for change. They achieve this through:
    - end-to-end youth leadership: MH:2K's youthled approach means it is grounded in the reality of young people's lives. Young people decide its focus, co-lead its events, and determine its findings and recommendations;
    - peer-to-peer engagement: By empowering young people to reach out to their peers, MH:2K creates a safe and engaging space for participants; and
    - close collaboration with key decision-makers and researchers: By involving key figures in the project from its start, MH:2K builds trust, enthusiasm, and commitment for MH:2K, and the implementation of its recommendations.

Last year, MH:2K worked in partnership with Derbyshire County Council, Derby City Council, and the then NHS Derby and Derbyshire CCG to engage with 221 young people across the city and county. Through interviews, workshops, and surveys, they were able to outline youth-informed priorities and recommendations for change across five key areas. These were:

- Hidden Impacts of the Pandemic
- The Crisis Response Pathway
- Specialist Community Support
- Access and Communications
- The Digital Offer

More information on the approach is available in the report 'A Youth-Led Approach to Exploring Mental Health'

Health and Wellbeing Board Guidance

The Department of Health and Social Care has published its final guidance on the role of health and wellbeing boards following the introduction of the Health and Care Act 2022. This updated version replaces the previous draft guidance. The non-statutory guidance sets out the roles and duties of health and wellbeing boards (HWBs) and clarifies their purpose within the new system architecture introduced by the 2022 Act.

This guidance incorporates feedback from across the health and care system received by the Department of Health and Social Care. The guidance also includes case studies that illustrate how HWBs are adapting to the changes introduced by the 2022 Act and using their influence as leaders at place. The guidance is in line with arrangements we have made locally in setting the roles and remits of our HWBs and our ICP to ensure we are clear on their complimentary roles and delivery of priorities.

Health Index for England
The Office for National Statistics (ONS) has published the Health Index 2020, giving a rich insight into how the nation's health has changed at national, regional and local levels. The data allows users to understand aspects that affect the health of people, places and communities, and whether these are getting better or worse. This is an invaluable tool for population health planning and is feeding into our strategic planning processes.

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 ICB BOARD

MEETING IN PUBLIC

19th January 2023

Item: 067

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
I take every opportunity to reiterate that while we must work on the immediate challenges facing the system and to maintain high quality healthcare for local people, we must also have a continued and increased focus on the future, where we have a vision to see improvement in local health outcomes and important factors such as increased life expectancy and reduced health inequalities. These remain our long-term objectives. I am pleased to report that colleagues in the ICB have started work on the development of our NHS Joint Working Plan. This is the five year plan that is a statutory requirement for Integrated Care Boards (ICB) to produce, highlighting the strategic priorities of the NHS in Derby and Derbyshire for the next five years and beyond. It is to reflect on and respond to the health priorities set out in our Integrated Care Strategy (see Chair's Report for further information), and we are required to have competed the work during June 2023. Within this, there will need to be a dual focus; our one year operational plan will describe some of the immediate tasks in managing our financial position, stabilising our urgent care system, continuing our recovery of elective waiting times and cancer pathways, but will 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.

The two months since the last ICB Board meeting have seen a continuation of the significant pressure faced by our services, with two periods where we have declared system critical incidents through our Gold command structure. Both incidents have continued to be driven by challenges in patients being able to progress through their care pathway, with a lack of capacity to meet demand in our community teams. This has had a well-publicised impact on ambulance handovers at the front door of our hospitals, the admission of patients from our emergency departments into our hospital wards, and the ability to discharge patients to the required next place of care once they are deemed to be medically fit. Overlayed onto these challenges have been a sharp increase in admissions of patients with Covid-19 and influenza during December and into January, a corelated increase in staff absence due to these and other conditions and the system's management of industrial action by healthcare staff who are members of Unison and the GMB Union.

We are continuing to implement our agreed winter plan, to understand the impact this is having on capacity and to review where we would expect to be at this stage of the winter against the plan. By some activity measures we are above plan, for example in our utilisation of bed stock and the volume of calls into our GP out of hours and 111 services; in other areas we are below plan, for example the number of 999 calls received by our ambulance service is in fact lower than this time last year. However the individual statistics alone do not reflect the whole, in which ambulances being held outside of Emergency Departments due to reduced patient flow offset the reduction in calls, and the utilisation of bed stock being driven by a deficit between the number patients being discharged compared to those admitted to our hospitals.

Our Operation Control Centre (OCC) was established on 1 December 2022 and is currently staffed with colleagues from our urgent care commissioning team. It is establishing the processes and data flows that will enable the system to monitor and manage live information to support proactive and pre-emptive decision-making, with the input of clinicians in that process. We continue to recruit for additional staff to support the OCC, but it is already proving invaluable in deepening our understanding about our activity data and managing the interface between all system partners and our regulators. Proactive management of emerging hot spots of pressure and the necessity to understand the changing landscape of demand and activity to support future planning is a live example of how we must manage today's work and also plan for future improvements.

A further element of our work for the future is setting the strategic vision and framework for the ICB. Having clarity on our role in the context of an NHS family and health and care system, and in our relationship with NHS England is crucial in setting priorities and having proper processes to support delivery. Our 'Derby and Derbyshire Together' engagement exercise ran during November and December with ICB staff, with over 300 staff getting involved in some form. The Executive Team took receipt of the analysis from that engagement last week and are reviewing the outputs. The next stage will be to test this with leadership across our broader NHS and ICP partners at the end of January before concluding the exercise in February and agreeing our strategic framework with the ICB Board and NHS Executive Team.

I would like to record my gratitude to everyone who has played a part in our efforts to manage and maintain the care we have provided for patients during 2022, and in particular during the recent Christmas and New Year period. It has been a challenging period for our frontline teams in seeking to find the right solutions to ensure our population continues to receive high quality healthcare, and despite significant pressure, clinical teams have found further resilience in providing care. The ICB has played a significant part in supporting that effort and I am grateful to colleagues who were involved in the strategic and tactical response during our critical incidents before and during the Christmas and New Year period.

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 England 2023/24 priorities and operational planning guidance

NHS England's 2023/24 priorities and operation planning guidance reconfirms the ongoing need to recover core services and improve productivity, make progress in delivering the key Long Term Plan ambitions and continue to transform the NHS for the future. Further technical guidance and templates are expected soon and we are reviewing the detail to inform the system's response. Below are links to the other items shared alongside the planning guidance:

- Commissioning for quality and innovation: 2023/24 guidance
- NHS Payment Scheme consultation (closes Friday 27 January)
- NHS Standard Contract 2023/24 consultation (closes Friday 27 January).

See also: NHS Confederation analysis of NHS England's operational planning guidance and priorities

Industrial action winter 2023

A number of NHS trade unions in England have balloted their NHS members to take part in industrial action. As a result, members of the GMB and UNISON (ambulance staff) took part in industrial action on 11 January 2023, members of the Royal College of Nursing on 18 and 19 January 2023, and members of UNISON (ambulance staff) on 23 January 2023. The system has continued to make fully collaborative preparations for the periods of industrial action.

The first days of statutory integrated care systems

The King's Fund have published a long read on the first months of ICS as statutory bodies. The King's Fund has been following the development of integrated care systems since 2017. Over this time, they have conducted several pieces of research including interviews with senior system leaders as the concept has developed. To continue this work, over the summer and early autumn of 2022, they spoke to 25 chairs and chief executives of ICBs and chairs of ICPs, asking them to reflect on the creation of the new bodies, and their very earliest days as statutory entities.

Integrated workforce thinking across systems

Improved outcomes in population health and healthcare is one of the fundamental purposes of integrated care systems (ICSs). To achieve this, partners from across both health and social care must come together to plan and develop a workforce that integrates and connects across all parts of the system to deliver personal, person-centred care to their local populations now and in the future. This is a new way of working for some in health and social care and so NHS Employers, which is part of the NHS Confederation, has worked in partnership with Skills for Care and the Local Government Association to produce a guide to help systems consider what is needed to successfully integrate their workforce thinking.

A record year for people receiving NHS cancer treatment

Thousands more people started vital treatment for cancer over the last year compared to before the pandemic. Over 320,000 people received treatment for cancer over the last year (Nov 2021 – Oct 2022) – the highest year on record, and up by more than 8,000 on the same period pre-pandemic.

Nine in ten patients positive about NHS community pharmacies
New polling shows that around than nine in ten people surveyed positively rated the advice they received from their local pharmacies. As pharmacies play a greater role in looking after peoples' health, the results from Ipsos found that the vast majority of patients (91%) who had used a community pharmacy in the previous year for advice about medicines, a health problem or injury, or what health service they should use said they received good advice.

NHS set to eliminate Hepatitis C ahead of rest of the world
The NHS is on track to eliminate Hepatitis C by 2025 thanks to a pioneering drug deal and a concerted effort to find people at risk, which is helping dramatically cut deaths five years ahead of global targets.

NHS launches new dementia diagnosis drive
Hundreds more people will be checked for dementia thanks to a new specialist service being trialled across the country,

NHS answers near record 111 calls
Amid levels of demand not seen since the start of the COVID pandemic, NHS 111 answered the second highest number of calls ever in a week, with 410,618 calls answered in the first week of January, up from 365,258 the previous week.

Flu and COVID-19
Patients encourage public to get flu jabs as hospital cases soar – 9 January 2023
Flu pressure rises with hospital cases up sevenfold in a month – 30 December 2022
Two thirds increase in hospital flu cases amid rising staff absences – 22 December 2022
NHS visits every care home to offer life-saving jabs ahead of Christmas – 17 December 2022
NHS sees significant 111 demand as flu cases in hospitals continue to rise – 15 December 2022
Hundreds of beds taken up by flu patients every day ahead of winter – 24 November 2022

Also of interest

NHS makes progress on long waits despite winter pressures surge – 8 December 2022
NHS expands mental health crisis services this winter – 8 December 2022
Thousands of beds taken up every day as NHS contends with 'perfect storm' of winter pressures – 1 December 2022
NHS delivers on winter plan as system control centres go live – 1 December 2022
NHS launches NHS 111 online campaign ahead of winter – 24 November 2022
NHS cuts 18-month waits as staff contend with busiest October ever – 10 November 2022
NHS catching more cancers earlier than ever before – 10 November 2022

Local developments

Provider Collaborative Update
Testing out new ways of working
The Provider Collaborative Leadership Board has agreed to focus on two clinical areas as immediate improvement priorities, testing out new ways of working within the ICS such as providers taking on some delegated functions that were previously done by commissioning

organisations. The selected priorities are; musculo-skeletal (MSK) services including management of acute orthopaedic outpatient referrals and children's speech and language therapy, focusing on joint working between providers to improve resilience and reduce waiting times. More work will now be done to develop project plans for these two areas, which will be led by project teams drawn from across the system including provider clinical leadership.

Whilst the collaborative strives to achieve some rapid and tangible improvements in these two areas, the collaborative will also be leading a wider process of engagement and intelligence gathering to identify future areas for collaboration where there may be more significant or strategic impact on system and patient outcomes or efficiencies. This work will be supported by the system Clinical and Professional Leadership Group and will have a focus on fragile or clinically unsustainable services and improving access.

System delivery and transformation

The Provider Collaborative is taking responsibility for the system delivery and transformation function, which includes system Delivery and Programme Boards. Recent developments include work to align the way that programme groups work and to develop consistent programme reporting and escalation processes. All areas and providers are now starting to use the same electronic programme management tool which will simplify and streamline the way that system improvement projects are reported on.

Finance sub-group

A finance sub-group of the provider collaborative has been set up and is currently being chaired by Simon Crowther, Chief Finance Officer of University Hospitals of Derby and Burton (UHDB). The finance sub-group will support the system Delivery Boards and transformation work by aligning financial reporting and decision-making to system improvement programmes of work. There is an increasing focus on plans to improve efficiency and productivity across all system programmes as well as within individual providers.

People Services Collaborative

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. There has been a lot of work to develop shared approaches, resulting in changes such as enabling the 'passporting' staff to allow them to work more flexibly in different providers within Derby and Derbyshire and work on shared training and induction, which has created a single induction programme for all new starters within Derbyshire providers. In line with the national focus on providers working together at scale, further proposals for shared working will be developed in the coming months.

Industrial action winter 2023

As stated in the national updates section, a number of NHS trade unions in England have balloted their NHS members to take part in industrial action. In Derby and Derbyshire members of the GMB trade union (ambulance staff) went on strike on 11 January 2023. Details of how EMAS, along with system partners, prepared for and managed the industrial action are available on their website at www.emas.nhs.uk. At the time of writing, negotiation is still ongoing around derogations at the provider trusts ahead of members of the Royal College of Nursing striking on 18 and 19 January 2023.

Using communications to support people to make the right choices this winter

Much of our campaign efforts from late November and during December were focused on

preparing people for the Christmas and New Year holidays; encouraging them to order any repeat prescriptions they may need over the festive period, booking in to see the dentist if they had a niggling tooth or gum problem and getting their flu and COVID vaccinations.

As we got closer to Christmas, many of our communications messages were aimed at helping people to understand how best to access NHS services over the Christmas and New Year period. We also heavily promoted Urgent Treatment Centres alongside messages encouraging people to:

• Ensure their medicines cabinet was well stocked with over-the-counter medicines, especially cough, cold and flu remedies

• Utilise NHS 111 online if they had a medical problem which wasn't an emergency, but they didn't know what to do

• Get their blood pressure checked to catch hypertension early and reduce the risk of heart attack and stroke

• Support any relatives they may have in hospital who are ready to go home

In addition, we encouraged people not to store up care needs against the background of industrial action and critical incidents being declared.

Use of NHS 111, especially the online service, is central to our strategy to managing many of the pressures caused by winter.

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 ICB BOARD

MEETING IN PUBLIC

19th January 2023

Item: 068

Report Title	Clinical and Care Professional Leadership Developments: Progress and Forward Plan							
Author	Sukhi Mahil, JUCD Assistant Director – Workforce Strategy, Planning and Transformation							
Sponsor (Executive Director)	Chris Weiner, Chief Medical Officer							
Presenter	Avi Bhatia, Joined Up Care Derbyshire Clinical and Professional Leadership Group Chair							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix A – CPLG Development Progress Summary Appendix B – CPLG Terms of Reference Review Appendix C – JUCD CPLG Chair Job Description Appendix D – CCPL NHSE Support Offer - JUCD Comms							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	CPLG – 20th December 2022 NHS Executive – 6th January 2023							

Recommendations
The ICB Board are requested to: • **NOTE** the Clinical and Care Professional Leadership Developments – Progress and Forward Plan (Appendix A); • **APPROVE** the new Joined Up Care Derbyshire Clinical and Professional Leadership Group (CPLG) Terms of Reference and **NOTE** the approved clinical pathways development process embedded within the Terms of Reference (Appendix B); and • **APPROVE** the CPLG Chair Job Description and proposed appointment process (Appendix C); • **SUPPORT** the NHSE offer and **ENCOURAGE** target group/strategic leader participation (Appendix D); • **SUPPORT** the direction of travel for GP Clinical Leads resourcing; • **NOTE** the status of the discussions with Social Care colleagues.
Purpose
The purpose of this paper is to provide the ICB Board with a progress update on recent Clinical and Care Professional Leadership developments and in that context seek approval in relation to specific aspects, as set out in the report.
Background
The Joined Up Care Derbyshire Clinical and Professional Leadership Group (CPLG) began strengthening the positioning of the group in the summer of 2021, this resulted in a step change

from the previous Clinical and Professional Reference Group (CPRG) to the Clinical and Professional Leadership Group.

These developments were undertaken ahead of the national guidance 'ICS implementation guidance on effective clinical and care professional leadership' (2 September 2021). The guidance set out 5 principles which all ICS's must evidence in the respective Clinical and Care Professional Leadership (CCPL) model. We built out from the initial development work through CPLG and wider engagement, to create our distributed CCPL model and framework. The framework was submitted as part of the ICB Readiness to Operate Statement (ROS) in May 2022 and was considered nationally as one of the strongest system frameworks.
Since this time, significant progress has been made to take forward the areas identified in our agreed framework. Details these developments along with the key priorities for the next 6 months are provided in the supplementary information attached (Appendix A). In summary these include:

- the Integrated Care Board (ICB) and Integrated Care Partnership (ICP) and associated governance committees have formal participation/membership from CPLG in these system level decision making groups;
- initial phase ToR developed supported by interim Chair arrangements until the end of March 2023 (approved by the Shadow ICB Board in May 2022) supported by 3 Vice Chairs sought through expressions of interest from CPLG members. CPLG also agreed to retain a 'placeholder' for a Local Authority Vice-Chair as these arrangements evolve to ensure CPLG maintains a rounded ICS view;
- established a CPLG Senior Leadership Team (SLT) which now meets fortnightly (extended formal CPLG meetings taking place monthly);
- reviewed CPLG meeting structure into 3 facets: ICB/NHS – (Provider Collaboratives), ICP (Place Partnerships) and CCPL Developments, to create stronger alignment with the wider ICS;
- 2 extremely positive and well received system level engagement sessions (May 2022 and October 2022); each with circa 100-150 attendees from across all partner organisations (including Social Care) and with a broad range of clinical and professional leaders.
  13 volunteers from the last event put their names forward to work with the Programme Director, People Services Collaborative to design an applied leadership offer for the system; and
- agreed a Clinical Pathways Development Proposal to enable better utilisation of CPLG in the system decision making processes; the proposal was approved by the Population Health and Strategic Commissioning Committee on 10 November 2022 and the Provider Collaborative Leadership Board on 30th November 2022.

It is important to note that whilst the systems and processes are evolving and taking shape, the cultural shift required to build and connect genuine distributed CCPL leadership in JUCD is complex and iterative. We have commenced on a positive footing, but it is recognised this will be an ongoing journey to ensure CCPL is truly embedded at all levels in the system.

Report Summary

The supplementary slides attached to this report provide further details to support our developments and identify the priority areas of focus for the next six months. We now require system support and endorsement for the areas described below to move certain developments to the next stage.

This update and proposals were considered by the NHS Executive at its meeting on 6 January and were broadly supported with a mandate to continue progressing with the developments. Where appropriate, any areas of concern are summarized below and will be considered in the next stage of the developments.

Strengthening the positioning of CPLG: Terms of Reference (Appendix B)

Based on CPLG and broader CCPL developments the attached ToR have been reviewed and further developed to reflect our new way of working. The key developments relate to:

- redefined purpose based on development work undertaken;
- strengthened remit categorised into the 3 facts - ICB/NHS – (Provider Collaboratives), ICP (Place Partnerships) and CCPL Developments;
- the specific CPLG Chair and Vice Chair areas of responsibility, aligned to each of the 3 facets;
- delegated authority to reflect the clinical pathways development process approved by the PHSCC and PCLB (now embedded within the ToR)*;
- membership review with noted areas of further development to reflect the evolutionary nature required, depending on the ongoing needs of the system, and of the CCPL community.

*The NHS Executive highlighted the importance of the clinical pathways development process not adding another potential layer, which could result in delayed decision making and/or duplication. Assurance was provided that the next phase of the developments with the Expert Advisory Forums (EAFs)/other multi-disciplinary clinical and professional groups, will recognise the value of those groups by ensuring strong clinical and professional input is strengthened in the first instance. There is a balance that is needed so that the process and CPLGs role is enabling. CPLG will not be looking to unpick the work of the specialists in those forums but will be in position to provide a more strategic view by considering any wider system implications, where necessary, in order to endorse proposals. The key aspect is about ensuring there is strong clinical and professional involvement at the outset to minimize duplication and ensure that everyone is aware of and understands the agreed process.

The ICB Board are asked to approve the new CPLG ToR and note the approved clinical pathways development process embedded within the ToR.

Leadership Roles: Substantive Chair (Appendix C)

The shadow ICB Board agreed in May 2022 to continue with 'interim' Chair arrangements until March 2023. The resource requirement for this role is allocated through an area of ICB programme spend for 2 days/week. The role and wider CPLG is also supported by a management lead and project/admin support. This decision was taken on the premiss that a review of the arrangements be undertaken in December, to develop proposals beyond March 2023.

The rationale for this decision was to provide continuity and momentum with the CCPL movement. The ICB has been deliberate in having separate functions around clinical leadership vs executive leadership. Therefore, this role is in addition to the ICB Chief Nurse, Chief Medical Officer, Chief Pharmacist, and others who remain important contributors CPLG and the wider CCPL developments.

The Shadow ICB Board, when approving the interim Chair arrangements in May 2022 set out the following areas which would need to be addressed when considering the future arrangements. The table below aims to demonstrate how each of these aspects have been addressed:

Shadow ICB discussion key points (May 22)	**How has this been addressed?**
Do the revised ToR and Chair JD take CPLG to the next level and push transformation?	The job description and ToR for CPLG have been expanded to reflect this, with the inclusion of the clinical pathways' development process and the roles/ responsibilities which have been defined for the CPLG SLT. It is noted however, that further development

	discussions are required to progress the strategic relationship with social care to create a more rounded ICS approach.
How is relationship with the ICB Medical Director intended to work as there appeared similar objectives for the Medical Director and this role?	The updated job description has been reviewed alongside the CMO job description to ensure clear differentiation with the CPLG Chair taking the lead on all CCPL developments and effective functioning of CPLG itself. The ICB CMO is a member of the CPLG SLT as a senior executive clinical advisor so is embedded as part of the development work taking place.
Helpful to have some evaluation of the Chair role to help the ICB Board take a view in December	A review of the agreed CCPL framework has been undertaken to demonstrate progress made. A stocktake of the CPLG meeting discussions has also been undertaken which demonstrates that the discussions are more meaningful and aligned to system developments than before. Details can be found in Appendix A.
Concerns about timescale/waiting a year to hard wire it in/ how these roles will coordinate /lead thousands across the system, plus the visibility of non-medical leadership	We have strengthened the positioning of AHPs (AHP Council Chair is also a vice chair of CPLG) and broadened the CPLG membership e.g. to include social worker (DHcFT) clinical psychologist, LDC representation. The revised ToR also look to expand membership further to include LPC, LOC. This is subject to further discussions to ensure CPLG attendance is meaningful and adds value for all participants (similar to ongoing discussions with Local Authority colleagues with regards to Social Care). This relates to CPLG itself, but it is important to note that distributed Clinical and Care Professional Leadership is already happening in the system (e.g. Local Place Alliances) and CPLG is facilitating wider recognition, connectivity and embedding of our distributed model.

The revised job description aims to address the key points raised by the Shadow ICB Board previously and reflects the new ways of working as set out in the strengthened ToR. This is a key role to ensure the agreed distributed leadership model and framework is embedded and enacted in the system, the individual will do this by actively working with partners and system development leads. The Chair will also ensure effective functioning and stronger positioning of the CPLG itself; acting as the expert group that is recognised and utilised by the system to provide assurance and advice, as the strategic level clinical and care professional conscience for the system; making recommendations to the ICB and ICP and other strategic groups as appropriate.

The proposal is now to secure a substantive Chair working 2 days/week. The CPLG chair will be accountable to the ICB Chair to maintain pseudo independence and will report to both the ICB and ICP. This role will require funding through the existing ICB programme arrangements; the rationale being that there is more strategic alignment work to do with Local Authorities over the coming year to 18 months and as such, we are seeking continued support for CPLG through the NHS principally on a recurrent basis until this is further developed. The term of office for the Chair will therefore be for 2 years to enable the strategic alignment with the Local Authorities to inform the requirements for the future.

It is recommended that the appointment process is undertaken by seeking Expressions of Interests from CPLG members. 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 CPLG which are inclusive of all system partners;

- 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.

The ICB Board are asked to approve the new CPLG Chair Job Description and the proposed appointment process.

Embedding CPLG Developments: National Support Offer (Appendix D)

We have recently been approached by the NHSE national team with regards to a CCPL support offer. The offer is for a facilitated workshop delivered virtually for a morning or afternoon slot. The workshop will be facilitated by the National Clinical Advisor and National Care Advisor and would bring stakeholders together from across system to:

1. Understand what CCPL is and why it is important
2. Understand and engage with the vision set out in in our local CCPL framework
3. Map what exists already that aligns with the vision
4. Identify priority actions to progress CCPL locally

Based on further discussions with the national team, it is felt that the session would be best utilised to explore the relationships and interactions between senior clinical and professional leaders and Executive/ senior managers (inc. Board and sub-Committees). We are already reaching out to the wider CCPL community through the engagement events and newsletters and 'launched' our CCPL framework. We have therefore considered the ways in which this offer would complement our ongoing work. The rationale for the approach we are taking for this particular support offer, is to genuinely embed CPLG and distributed CCPL in strategic system thinking and decision making. We are deliberately inviting both Clinical and Care Professional strategic leaders and Executives/ senior leaders to this session so that we can influence and shape a shared understanding and in turn agree specific actions for further development.

The offer must be utilised within this financial year, so the date for this workshop has been set to take place on the afternoon of **Thursday, 16th February,** this will allow for any subsequent support to be provided before 31 March. In order to provide colleagues with sufficient notice, communication has been sent out (see Appendix D) and we are seeking support from strategic system leaders to actively participate in this important workshop.

We will be working with the national team in the coming weeks to co-create the session outputs and plan; this will be done through the CPLG SLT, including others as necessary.

The ICB Board are asked to support the NHSE offer and to encourage target group/strategic leader participation.

Other Developments/ Next Steps

GP Clinical Leads Resourcing

There is a need to align the current GP clinical leads to the transformation programmes and priority areas for system developments. The clinical pathways development process goes some way in moving this forward but there is further work to be undertaken in relation to the allocation of this resource.

The direction of travel is for the statutory ICB clinical leads (e.g. safeguarding) to be retained by the ICB CMO and it is proposed that responsibility for the other GP clinical leads (e.g. Local Place Alliances and EAFs) be devolved to CPLG to oversee and manage. CPLG will need to work with the provider collaboratives and place partnerships to ensure these developments are considered

as part of the wider leadership models overall. This transition would be supported by a review of the clinical skill set required to maximise this capacity to best effect, how the roles are prioritised to support delivery, with clearly defined roles, consistent objectives and accountability developed.

The ICB Board are asked to support this direction of travel.

Strengthening the Local Authority strategic links with CPLG

We also had the opportunity for further bespoke support from NHSE specifically focusing on health and social care developments. This offer would be provided by Sir David Pearson to hold a smaller more focussed session to arrive at a shared language and purpose (linking with the Integrated Care Strategy), shared understanding of the work to be done/how it might be approached together and creating a better understanding the differing operating models between health and social care etc. The aim would be to develop a foundation upon which we might then build the wider system conversations and involvement. A meeting took place with our Local Authority colleagues (Helen Jones and Andy Smith) on 15 December, and it was considered whether this additional bespoke offer may facilitate moving the strategic CCPL developments forward to create a more rounded ICS CPLG. It was felt that there was a timing issue, and this offer may be better utilised at a later date, once the Integrated Care Strategy is developed. On that basis, we will explore the potential for this offer to be made available to the system in the next financial year.

Irrespective of the support offer, we have agreed to reconvene with LA colleagues in April. We will use the integrated care strategy to frame the strategic leadership needs and objectives to ensure value is added with minimal duplication. In the meantime, whilst we recognise that there is more to do to bring health and care strategic clinical and care professional leadership together in the CPLG space, it is also important to note that distributed health and care leadership is already happening in Place e.g. through Team Up and CPLG is connected into the ICP through Avi Bhatia (CPLG Chair) and Penny Blackwell (Place Clinical Lead and CPLG Vice Chair). This development is about working through the additional benefits of strengthening the strategic approach through CPLG itself and to ensure we are creating the same leadership opportunities in both health and care and so that the voice of wider care professionals are reflected in anything that CPLG does from a wider ICS perspective.

The ICB Board are asked to note the status of the discussions with Social Care colleagues.

Noting that there is further work to be undertaken in relation to the strategic alignment with social care, this report will also be shared with the ICS Executive and ICP Board, for information.

Identification of Key Risks				
Not applicable.				
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.				
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.

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

Details/Findings
Not applicable.

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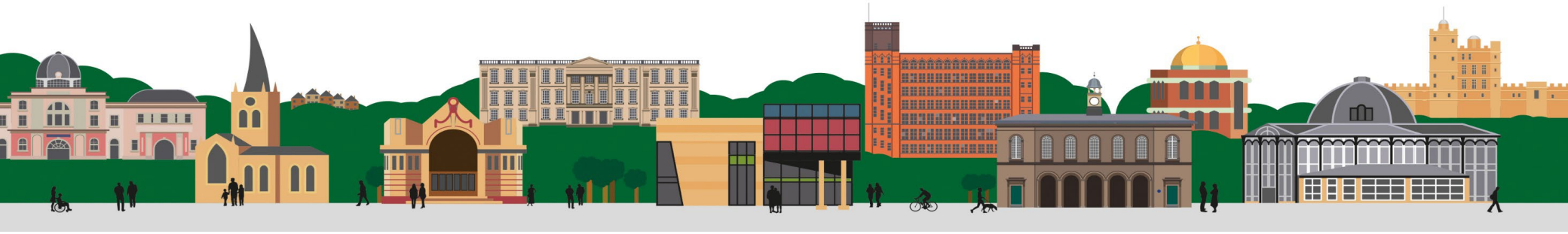
Appendix A: Supplementary Information: Clinical and Care Professional Leadership (CCPL) Developments - Progress and Forward Plan

1 December 2022



NHS | The Derbyshire VCSE sector Alliance | Derby City Council | Derbyshire County Council

Progress against our CCPL Framework (summary) April 2022 to November 2022

Joined Up Care Derbyshire

The following tables provide a summary of the CCPL framework development themes which emerged through discussions with CPLG and the focus group sessions. These areas were agreed as the key development areas at the CPLG meeting on 5 April 2022. The 5 principles and alignment to the full framework can be found in Appendix 1.

Development Theme	What will be different?	What have we achieved?	Priorities for the next 6 months
Model/ Narrative	We have a clear model and narrative that resonates and is applicable at all levels; enabling a cultural shift towards a collective vision/set of priorities which informs decision making	• Co-produce our CCPL framework in response to the national guidance, which includes the vision and model for distributed clinical and care professional leadership for JUCD and the role of CPLG within that. We have done this through various forums (inc. Shadow Provider Collaborative Leadership Board, Integrated Community Place Board, Place Development Sub-Committee, People and Culture Board, GP Provider Board and the Alliance for Clinical Transformation (ACT); all feedback incorporated into our model and framework and further informed by our launch event in May 2022. • Considered to be one of the strongest system CCPL frameworks. • Launch event in May with circa 150 attendees, key messages informed the design of the October event	• Continue to review language being used to ensure it is inclusive, relevant and applicable across the system - including Local Authorities and the voluntary sector – build a consistent understanding of what is meant by distributed CCPL • Consider how the model speaks to/represents operational leaders – continue to socialise and test further
Distributed leadership	• Clinical and care professional voices are heard and listened to, enabling dialogue across professions and developments with the ability to influence wider JUCD priorities • Interdependencies and synergies across the system are recognised, including how we connect, support people and the roles of individual organisations	• We have strengthened the role of CPLG as the 'glue' that binds distributed leadership together (this is not about having everyone around the CPLG table but how that system leadership group facilitates beyond the group itself); recognising that distributed leadership already happening in the system space and the approach is to connect and recognise this more effectively where appropriate • Undertaken an initial mapping exercise to understand what is already established and where clinical and professional leaders are driving forward developments • 2nd Engagement event held in October with circa 100 attendees to further develop consistent understanding of what good distributed leadership looks like by using positive experiences/ leadership in action • Key message from the May event was that people needed greater emphasis on practical tools/methods to recognise their distributed leadership roles – the session was designed initiate the coproduction of an applied leadership offer	• Build trusted, open relationships with wider networks; by tapping into existing networks and ICS developments (including Place and Provider Collaboratives); further develop mapping exercise and look at opportunities for alignment and refinement • Continue to facilitate broader clinical and professional leadership which is connected and representative • Provide the necessary tools to support individuals to step into the leadership space. 13 individuals volunteered to develop the offer at the Oct event. 2 focus groups have been arranged for the end of Nov and early Dec to test out content and delivery, with the aim to get offer ready from April.

Progress against our CCPL Framework (summary) April 2022 to November 2022

Joined Up Care Derbyshire

The following tables provide a summary of the CCPL framework development themes which emerged through discussions with CPLG and the focus group sessions. These areas were agreed as the key development areas at the CPLG meeting on 5 April 2022. The 5 principles and alignment to the full framework can be found in Appendix 1.

Development Theme	What will be different?	What have we achieved?	Priorities for the next 6 months
Diversity & Inclusivity	• Mechanisms are in place to ensure the broadest engagement across the system, including Local Authorities and the voluntary sector to have an impact on the wider determinates of health • Subsequent feedback from NHS Elect colleagues to note national emphasis being place not only on diversity and inclusivity from a broad range of professional leaders but also leaders reflective of all protected characteristics. Our leaders will reflect EDI	• Reviewed CPLG membership to include a broader range of professionals	Work through the People Service Collaborative to embed the CCPL distributed leadership model and ensure that it is connected with the 7X5 EDI workstream
Leadership Roles	• We will have defined clinical and care professional roles, responsibilities and representation at the heart of decision making throughout ICS developments • Leaders will act as ambassadors connected to CPLG	• Chair of CPLG is a member of both the ICB and ICP • Reviewed membership of CPLG to ensure broader range of professionals • Agreed 3 vice chairs with defined areas of responsibility (placeholder for LA vice chair to ensure all aspects of the ICS are covered in the future and not solely NHS) • Aligned CPLG senior leadership (Chair and Vice Chairs) with component parts of the system e.g. members of PCLB, Integrated Place Executive, Population Health and Strategic Commissioning Committee, Workforce Advisory Group, System Quality Group • Mapping undertaken to create better understanding of CPLG connectivity and visibility across system governance and developments (see appendix 2)	• Work with Local Authority colleagues to form a plan to create a stronger social care leadership voice in the CPLG space (with clear objectives and shared purpose aligned to the Integrated Care strategy) • Work with clinical pathway groups e.g. EAFs to create clarity about the mandate, objectives, resources and support for leadership roles

Progress against our CCPL Framework (summary) April 2022 to November 2022

Joined Up Care Derbyshire

The following tables provide a summary of the CCPL framework development themes which emerged through discussions with CPLG and the focus group sessions. These areas were agreed as the key development areas at the CPLG meeting on 5 April 2022. The 5 principles and alignment to the full framework can be found in Appendix 1.

Development Theme	What will be different?	What have we achieved?	Priorities for the next 6 months
Leadership Development	Working with the Workforce Advisory Group we will: • Ensure new leaders are identified and nurtured by providing broader system leadership opportunities • Ensure leadership capabilities and behaviours relevant to all leaders are embedded consistently • Create an environment and culture which gives leaders a voice and freedom to act beyond the constraints of organisational boundaries • Ensure every professional group has some population health understanding	• Through the CCPL engagement events we have started to shape a better understanding of leadership needs and established a working group to develop a system applied leadership offer. The offer will build on what is already in place (e.g. mentorship and coaching) • Agreed a CCPL leadership behaviours framework to help clinical and professional leaders at all levels (not just those in formal leadership roles) to think and lead differently (see appendix 3)	• Develop stronger links with system OD so CCPL leadership development is considered part of the whole and not as a separate entity • Promote and utilise initiatives/development opportunities already happening in the system (e.g. Clinical Directors forums to be opened up to other clinical and professional colleagues including primary care and PALM in Place Partnerships) • CPLG development to be included as part of wider system OD
Support	Leaders are provided with the necessary time and resource (including aligned management support)		• Confirm resourcing of strategic leaders • Review what we have now to determine resource available, identify gaps and realign to new ways of working/ priorities • Develop plans to devolve leadership oversight and resource (namely GP Clinical Leads currently aligned to EAFs) to CPLG • Create learning networks and peer support forums

Progress against our CCPL Framework (summary) April 2022 to November 2022

Joined Up Care Derbyshire

The following tables provide a summary of the CCPL framework development themes which emerged through discussions with CPLG and the focus group sessions. These areas were agreed as the key development areas at the CPLG meeting on 5 April 2022. The 5 principles and alignment to the full framework can be found in Appendix 1.

Development Theme	What will be different?	What have we achieved?	Priorities for the next 6 months
Comms & Engagement	• Knowledge and understanding of the ICS, its vision and priorities are clearly articulated to give leaders confidence in the new arrangements and the value their contributions add to the system • Greater visibility, engagement and awareness between clinicians, professionals, managers and the public • Simplified processes with better connectivity between developments taking place at different levels to reduce duplication and complexity	• 2 system wide engagement events held to shape our direction of travel/ framework, engage and seek views on key issues to inform future developments and to share information in relation to CCPL le in the context of the wider ICS for example). Extremely positive feedback received with a desire for the events to continue regularly • CPLG updates now included regularly in JUCD newsletters	• Develop a communication and engagement strategy/approach to create consistent messages across the system and broaden understanding of the ICS • Consider other ways to support clinical and care professionals to have a better understanding of the system and think 'system first' • Actively seek the views of frontline colleagues, for example through regular engagement exercises and annual pulse checks • Develop NHS Futures as a platform for sharing information
CPLG Role	In the context of our agreed model and the development discussions, the role and positioning of CPLG will be strengthened to genuinely act as the 'glue' that binds the distributed CCPL developments together and acts as a strategic system group to advise the wider ICS	• Strengthened the role of CPLG and how it fits within future governance arrangements (including the ICB, ICP, place-based partnerships, Provider collaboratives and Delivery Boards) and any sub-committees; being clear about what we do and what others do and how we all connect • Developed a clinical pathways development process which has been approved by the PHSCC and PCLB to provide consistency, with recommendations made by CPLG accepted and recognised in decision making	• Seek approval of revised TOR (separate paper) • Substantive Chair to be in place from 1 April 2023 (separate paper) • Continue to review and develop role and functioning of CPLG within the wider ICS developments • Seek system support to undertake NHSE Support offer in February, focusing on strategic decision makers with the aim of embedding CPLG positioning in the system • Develop plan with the Local Authority for Senior Social Care representative and input to CPLG by considering merit of potential support offer from NHSE delivered by Sir David Pearson

Strengthened CPLG approach: Summary of considerations (Aug 22 – Nov 22)

Joined Up Care Derbyshire

From August onwards the CPLG agenda was aligned to ICS developments, to reflect 3 facets:

1. ICB (NHS)
2. ICP
3. CCPL Developments

The purpose of this change is to differentiate agenda items where there would be greater benefit for Social Care colleagues to be part of the discussions in a more meaningful way. We also established the CPLG Senior Leadership Team which now meets fortnightly and changed the formal CPLG meetings to monthly with extended timings (previously met for 1hour each fortnight).

Date	Item:	Agenda 'facet'	Presenter:	Overview:	CPLG Recommendations:
15 November 2022	Provider Collaborative Leadership Board Priorities	ICB (NHS)	Tamsin Hooton, Programme Director	An overview of the potential PCLB priority areas and initial thinking in relation to fragile services and how they inform prioritisation	CPLG agreed it would be beneficial to hold a wider workshop discussion in relation to fragile services early in the new year and would support the development of that.
15 November 2022	Cancer Referral Optimisation	ICB (NHS)	Monica McAlindon, Head of Cancer	To enable clinical and professional discussion regarding Cancer Referral Optimisation with regards to FIT uptake in particular	CPLG agreed priority audits needed to be undertaken to facilitate peer to peer discussions in referral practices and to explore the options for primary/secondary care joint education focusing on cancer referrals
20 September 2002	CPLG Terms of Reference	CCPL Development	Sukhi Mahil - JUCD Assistant Director	Revised CPLG Terms of Reference shared with members for comment and approval. CPLG connectivity to system governance also shared to aid understanding of where CPLG now fits.	CPLG **approved** the amended Terms of Reference, with the inclusion dental, pharmacy and ophthalmology colleagues and ensure representation at CPLG to future proof ahead of March 2023, and noted the connectivity within the wider system governance
20 September 2022	Headache Pathway	ICB (NHS)	Dom Moore, Deputy Chief Pharmacist (UHDB)	Amendments made to pathway since initially being presented to CPLG in February 2022	CPLG noted the pathways but further development was required re: engagement with primary care and CRH before full support could be given
2 August 2022	GP with Extended Roles Proposal	CCPL Development	Kath Bagshaw, Deputy Medical Director DDICB and GP in Erewash	Feedback sought on pilot roles proposal - 3 x roles at CRH and 3 x roles at UHDB. The pilot aims to improve GP retention, particularly for mid-career GPs, and also aims to improve the primary and secondary interface and quality of referrals	CPLG **supported** the pilot, noting that if the only outcome is improved GP retention, that is a great positive. If the pilot supports knowledge/skill sets coming back into community, that's an even better result. KB will feedback outcomes of pilot at a future CPLG
2 August 2022	Primary & Secondary Care Interface	CCPL Development	Andy Mott, GP and Interim Chair of GP Provider Board	Document developed by Alliance for Clinical Transformation (ACT) aiming to improve interface between primary and secondary care. The document details guiding principles on behaviours all professionals should be undertaking to improve communication and keep the patient at the centre of decision making	CPLG **supported** the document, noting its relevance to the wider system. CPLG members took away actions to socialise the model with colleagues across the system
2 August 2022	CPLG Terms of Reference	CCPL Development	Sukhi Mahil - JUCD Assistant Director	Revised CPLG Terms of Reference shared with members for comment and approval; incorporating the Vice Chair roles and responsibilities	CPLG members approved the Vice Chair roles/responsibilities and were happy for these to be embedded into the revised CPLG Terms of Reference

Strengthened CPLG approach: Summary of considerations (Aug 22 – Nov 22)

Joined Up Care Derbyshire

Date	Item:	Presenter:	Overview:	CPLG Recommendations:
28 June 2022	Dental Services for the ICS	Rami Khatib, Chair of the Derbyshire County Local Dental Committee	RK shared updates on how dentistry sits in the ICS and to share insight into the pressures dentistry is currently facing, and the wider role dentistry has in the populations overall health	CPLG **noted** the presentation and reflected on the challenges shared across the system
14 June 2022	Clinical Governance Model	Avi Bhatia - CPLG Chair	Discussion around the development of a clinical governance model to ensure appropriate and system-wide engagement before pathway changes are implemented.	**Agreement** by CPLG for the development of a clinical governance model that avoids duplication, has some input into finance and other key considerations, and has a clear route of where recommendations feed into and how to escalate.
17 May 2022	Dermatology Advice & Guidance	Hal Spencer, Interim Chief Executive (CRH)	Test case for clinical governance and decision making processes across the ICS - ensuring appropriate clinical engagement across the system	It was agreed that the dermatology advice and guidance pathway would be reviewed again later in the year. Further discussions would be had around increasing the GP workload as a result of the pathway change. This case triggered the development of the Clinical Pathway Development Process which has since been approved by the PHSCC.
17 May 2022	JUCD Quality Strategy	Helen Hipkiss, Director of Quality (DDICB)	Draft JUCD quality strategy shared with colleagues for comment and support	CPLG provided feedback and **support** of the strategy. HH took away an action to collate comments to inform a further version of the draft strategy before re-circulating for final comment virtually, ahead of the final version being taken to the Shadow ICB Board in June 2022
3 May 2022	CCPL Framework Development	Sukhi Mahil - JUCD Assistant Director	Vice Chair arrangements to be confirmed in context of wider CCPL leadership requirements and system developments	CPLG **confirmed** preference towards option 2 (2x Vice Chairs – I NHS facing and 1x ICP facing) CPLG members were asked to put forward their expressions of interest in the roles.
3 May 2022	Post-Covid Service	Steve Lloyd: Executive Medical Director (DDCCG)	CPLG were updated on the new Post-Covid Service pathway, which now encompasses rehabilitation as well as assessment	CPLG **supported** the approach being taken
5 April 2022	CCPL Framework Development	Sukhi Mahil - JUCD Assistant Director	An overview of the CCPL framework development was provided and plans for launch event on 10 May to socialise and develop further were discussed. Chair arrangements were considered	CPLG **approved** the CCPL framework, direction of travel and proposals for the Chair arrangements. CPLG members encouraged to continue endorsing and promoting CCPL.
5 April 2022	Virtual Wards	Reeve Palmer, Commissioning Manager (DDCCG)	Virtual ward proposal was shared for comment/support	Feedback provided around staffing, clear lines of clinical accountability and consideration of digital exclusion in the development of virtual wards. Feedback was also given around the need to build on existing programmes, such as Team Up, and to ensure appropriate system-wide engagement
22 March 2022	Liberty Protection Safeguards	Michelle Grant, Designated Nurse Safeguarding Adults/MCA Lead	CPLG were informed of the transition from the Deprivation of Liberty Safeguards Framework to the Liberty Protection Safeguards - implications for clinical and care professional colleagues were discussed	CPLG colleagues **noted** the update
22 March 2022	Strategic Clinical Planning	James Crampton, Interim Executive Medical Director (UHDB)	CPLG were asked to support with the UHDB review of strategic clinical planning	CPLG **supported** the UHDB Clinical Strategy refresh and agreed there was a need for wider clinical and professional input to be included (e.g. primary care); this was considered a great opportunity to see how the system works together across partner organisations. It was noted that in the future there was a need to consolidate organisational clinical strategy developments.
8 March 2022	CCPL Framework Development	Avi Bhatia - CPLG Chair & Sukhi Mahil - JUCD Assistant Director	CPLG were asked to provide feedback on the agreed narrative following socialisation within respective groups, discuss the role of CPLG, and agree next steps	**Support** was given for the CCPL Model and Framework, and the direction of travel
8 February 2022	Headache Pathway	Dom Moore, Deputy Chief Pharmacist (UHDB)	CPLG were asked to receive and review the proposed headache pathway. Clinical agreement was sought to publish through JUCD	CPLG were **unable to support** the pathway in its current state - DM was asked to refine the tool based on CPLG feedback and return to CPLG once developed further.
8 February 2022	SEC Ethics Request	William Jones, Chief Operating Officer (DCHS) & Kirsty McMillan, Director of Integration and Direct Services (Derby City Council)	CPLG were asked to consider increasing the risk appetite for delayed discharges.	There was an appetite from CPLG members to look at potential solutions to address the challenges highlighted - CPLG members were happy to **support** a task and finish approach to progress this work.
11 January 2022	Current System Pressures	Ben Pearson, Executive Medical Director (DCHS)	CPLG were asked to consider and support difficult decisions needing to be enacted due to the current system pressures	CPLG **supported** the measures proposed, noting the need to continue to work collaboratively as a system to address these issues. Letter of support sent out to all organisations from CPLG.

APPENDIX 1: 5 Principles: ICS implementation guidance on effective clinical and care professional leadership

Joined Up Care Derbyshire

Principle 1: Ensure that the full range of clinical and professional leaders from diverse backgrounds are integrated into system decision-making at all levels, supporting this with a flow of communications and opportunities for dialogue.

- Fully inclusive multiprofessional clinical and care professional leadership (including general practice, other primary care and community service partners) is central to designing and delivering integrated care and meeting the complex needs of people, rather than just treating their individual conditions.
- This includes allied health professionals, pharmacists, doctors, nurses, social workers/practitioners, psychologists, healthcare scientists, physician associates, midwives, dentists, optometrists, orthoptists and public health professionals, among others.
- Work equally with local government, social care and other partners.

Principle 2: Creating a culture that systematically embraces shared learning, supporting clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities.

- Be systematic in assessment of current arrangements.

Principle 3: Support clinical and care professional leaders throughout the system to be involved and invested in ICS planning and delivery, with appropriate protected time, support and infrastructure to carry out this work

- Ensure clinical and care professional leaders are fully integrated into decision-making on all aspects of ICS functions and governance at every level of the system and create an environment in which distributed leadership can thrive.
- Make tangible improvements to the way clinical and care professionals are integrated into system decision-making and to support them in their system roles and in their development as system leaders (links to principles 4 & 5)

Principle 4: Create a support offer for clinical and care professional leaders at all levels of the system, one which enables them to learn and develop alongside non-clinical leaders (e.g. managers and other non-clinical professionals in local government and the VCSE sector), and provides training and development opportunities that recognise the different kind of leadership skills required when working effectively across organisational and professional boundaries and at the different levels of the system (particularly at place).

Principle 5: Adopt a transparent approach to identifying and recruiting leaders which promotes equity of opportunity and creates a professionally and demographically diverse talent pipeline that reflects the community served and ensures that appointments are based on ability and skillset to perform the intended function.

APPENDIX 1: JUCD Clinical and Care Professional Leadership Framework

**This framework is based on the outputs of the focus group discussions to date and will be further developed to address any gaps. Our development themes in some case cut across multiple principles, as set out in the guidance on 'effective clinical and care professional leadership' (Sept21) ; the table below aims to demonstrates those principles which would predominantly be addressed through the specific areas.*

Joined Up Care Derbyshire

Development Themes - What will be different?	What do we need to do to get there?	Principles supported * 1	2	3	4	5
Model/ Narrative • We have a clear model and narrative that resonates and is applicable at all levels • A cultural shift towards a collective vision/set of priorities which informs decision making	• Use language that is inclusive, relevant and applicable across the system - including Local Authorities and the voluntary sector • Further define what is meant by CPL (multidisciplinary/ multiagency) – build consistent understanding • Consider how the model speaks to/represents operational leaders – socialise and test further					
Distributed leadership • Distributed leadership is key; it is not about having everyone around the CPLG table but how that system leadership group facilitates beyond the group itself • Clinical and professional voices are heard and listened to, enabling dialogue across professions and developments, with the ability to influence wider JUCD priorities • Interdependencies and synergies across the system are recognised, including how we connect, support people and the roles of individual organisations	• Facilitate broader clinical and professional leadership which is connected and representative • Build trusted, open relationships with wider networks; by tapping into existing networks (mapping exercise) and ICS developments (including Place and Provider Collaboratives) • Develop roles as strategic leaders and ambassadors					
Diversity & Inclusivity • Mechanisms are in place to ensure the broadest engagement across system, including Local Authorities and the voluntary sector to have an impact on the wider determinates of health	• Consider how the model links with the ICP through Place and CPLG					
Leadership Roles • Defined clinical and professional roles, responsibilities and representation at the heart of decision making throughout the ICS developments • Ambassadors at Place, with leads connected to CPLG	• Create clarity about the mandate, resources and support for leadership roles across the system • Inspire confidence and establish credibility across organisational and professional boundaries so clinicians are able to work with peers and facilitate conversations to bring the right people together, galvanise support and deal with naysayers • Develop the understanding of what happens where to enhance connectivity and visibility connectivity (e.g. Place and Local Place Alliances) • Influence and support the identification of professionals to sit within various groups, committees and boards, ensuring clear lines of sight between forums and how they link in together • Build on the experience of Primary Care and Place-based development					
Leadership Development • New leaders identified, and nurtured by providing broader system leadership opportunities • Leadership capabilities and behaviours relevant to all leaders are embedded consistently • An environment and culture which gives leaders a voice beyond the constraints of boundaries • Every professional group has some population health understanding	• Develop a common framework of knowledge, skills and behaviours clinical and professional leaders at all levels should enact • Build a strong development offer to support collaborative behaviours and working as system leaders; not just those with a formal system leadership role • Build on what is already in place and works well, e.g. mentorship and coaching - build upwards and outwards to provide an equitable development provision • Recognise different stages of maturity and target developments to address needs • Make stronger links with system OD so a consistent support offer for clinical and care professional leaders at all levels is created which enables learning and development opportunities alongside non-clinical leaders • Promote and utilise initiatives/development opportunities already happening in the system (e.g. Clinical Directors forums to be opened up to other clinical and professional colleagues including primary care and PALM in Place Partnerships) • Promote the personalisation agenda (i.e. person at the centre of decisions) to drive improvements					
Support • Leaders are provided with the necessary time and resource (including aligned management support)	• Consider CPL resourcing (not solely through dedicated funding but also through wraparound support/infrastructure) • Review what we have now, identify gaps and realign to new ways of working • Create learning networks and peer support forums					
Comms & Engagement • Knowledge and understanding of the ICS, its vision and priorities are clearly articulated to give leaders confidence in the new arrangements and the value their contributions adds to the system • Greater visibility, engagement and awareness between clinicians, professionals, managers and the public • Simplified processes with better connectivity between developments taking place at different levels to reduce duplication and complexity	• Develop a communication and engagement strategy/approach to create consistent messages across the system and broaden understanding of the ICS • Actively seek the views of frontline colleagues, for example through regular engagement exercises and annual pulse checks • Build a library of evidence/learning and 'good news stories' of working together • Consider other ways to support clinical and care professionals to have a better understanding of the system					
CPLG Role • Defined distributed leadership model with the group acting as the glue to ensure all aspects brought together and embedded • Recognised, utilised and connected in decision making at all levels as the Strategic Clinical and Professional Leadership Group in the ICS • Informs and is involved in the ICS strategic agenda (inc. ICP Strategy) by providing high quality advice and shared learning/best practice • Acts as the clinical and professional conscience for the system (senate approach) • Develops and oversees Clinical and Professional Leadership by facilitating structures, people and relationships across the system at all levels • System developments are aligned to a consistent framework/principles • Leads and facilitates cultural change • Provides an 'open door' to resolve difficult system problems and has a role in holding partnerships/organisations to account • Responsible for building and connecting networks for anyone with a contribution	• Consider how best to connect other professionals and engage with more isolated groups (e.g. housing, environmental health, social prescribing leads) • Review Clinical & Professional mapping exercise to identify gaps and initiate discussions to consider opportunities for alignment/bringing people/groups together • Inform the development of an evidence based HI strategy (led through Strategic Intent) • Development of a system decision making framework aligned to the Quadruple Aim to provide consistency for decision making all levels; aligned to system priorities, evidence based, and addressing population health needs – recommendations made by CPLG to be accepted by the ICB and wider system • Develop mechanisms so that CPLG is routinely utilised and sighted on key ICS developments with mechanisms to enable feedback by exception where CPLG advice is required over and above/ adding value • Clarity, recognition and utilisation of Senate Advisory Role and how to influence decisions in that capacity • Tap into existing groups/networks and better connect Primary Care • Strengthen the role of CPLG and how it fits within future governance arrangements (including the ICB, ICP, place-based partnerships, Provider collaboratives and Delivery Boards) and any sub-committees; being clear about what we do and what others do and how we all connect • Ensuring broader clinical and professional leadership (beyond CPLG) is represented on all key decision making groups responsible for progressing the design and delivery of integrated care and are connected to CPLG • CPLG act as ambassadors to support consistent implementation of system-wide, best practice approaches (e.g. quality framework developed through SQG)					

APPENDIX 2: CPLG Connectivity to ICS Functions & Decision Making

NOTE THIS IS AT A POINT IN TIME AND MAY BE SUBJECT TO CHANGE

*** The Executive Groups are shown on this diagram for information only at this stage as they are still forming and the CPLG representation may change in light of the developments as necessary.**

Joined Up Care Derbyshire

Derby and Derbyshire Integrated Care Board (see following slides)
Chair: ICB Chair
Lead Exec: ICB CEO
CPLG SLT eps: Avi Bhatia
Accountabilities:
- Statutory organisation leading integration across the NHS. to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place.
- Ensure compliance with legal and statutory duties and obligations including quality, provider selection regime, the People Plan, public involvement and data and digital priorities, emergencies.
- Develop a plan and allocate resource to meet the health and healthcare needs of the population including provision, contracting etc.
- Establish joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.
- Establish governance arrangements to support collective accountability for whole-system delivery and performance.
- Publish an Annual Report setting out how duties were discharged in the previous year.

Decisions:
- Agree and publish a constitution and annual report.
- Agree and publish a plan setting out how it will discharge its duties including the strategies of the HWBBs and strategic objectives and risks.
- Receive assurance from its committees as to the satisfactory discharge of statutory functions and duties or agree remedial actions as appropriate.
- Agree allocation of resources in line with financial regulations and strategic priorities.
- Agree process for assuming delegated responsibilities from NHSEI and for joint working on specialised services.

Health & Wellbeing Boards
Derbyshire County H&W Boar & Derby City H&W Board
Accountabilities:
- Sets the vision and high-level outcomes and priorities for their areas.
- Conducts Joint Strategic Needs Assessments for their areas and for setting the high-level priorities and outcomes in the Joint Health and Wellbeing Strategies.
- Encourages integrated working between health, care, police and other public services in order to improve wellbeing outcomes for the local population.

Decisions:
- Agree priorities and the co-ordination of plans for the integration of health and social care services to improve health and wellbeing of the population and reduce inequalities
- Agree content for contribution to the ICB's Annual Report.

Derby and Derbyshire Integrated Care Partnership
Chair: Rotating City/County HWB and JUCD ICB Chairs
Lead Exec: Strategic Directors of LAs/ICB CEO
CPLG SLT Reps: Avi Bhatia/ Penny Blackwell
Accountabilities:
- Statutory forum where political, clinical, professional and community leaders from across the care and health system come together
- Provide leadership and advise to improve the health and wellbeing of their local population and reduce health inequalities
- Duty to prepare and publish a Joint Strategic Needs Assessment (JSNA) of current and future health and social care needs in relation to the population of the local authority.
- Prepare and publish a Pharmaceutical Needs Assessment (PNA) to assess the need for pharmaceutical services in Derby.
- Prepare and publish a Health and Wellbeing Strategy – a strategy for meeting the needs identified within the JSNA which sets the vision and high-level outcomes and priorities for their areas.
- Duty to encourage integrated working - to advance the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.
- Provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006
- Work collaboratively across local authority area to improve health and wider population outcomes inc. work with Place and Derby Partnership Board

Decisions:
- Support HWB outcomes & priorities and the co-ordination of plans for the integration of health and social care services to improve health and wellbeing of the population and reduce inequalities
- Agree content for contribution to the ICB's Annual Report.
- Drive greater use of resources in prevention (but financial decisions reserved to SFEC)

NHS Executive
Chair: Chair: ICB CEO
CPLG SLT Reps: Chris Weiner/ Amanda Rawlings
The primary purpose of the Joined Up Care Derbyshire (JUCD) NHS Executive is to retain executive level oversight of the NHS delivery, performance (operational, quality, finance) and transformation. The NHS Executive would therefore incorporate the current role undertaken by the regionally led system review meetings (SRMs), providing executive level assurance to inform assurance provided to the Integrated Care Board (ICB).
Remit:
- Overseeing NHS strategic, tactical and operational system planning and delivery
- Overseeing NHS performance improvement and transformation
- Overseeing system performance of the NHS Oversight Framework (Quality of Care, access and outcomes; preventing ill health and reducing inequalities; finance and use of resources; people; leadership and capability; local strategic priorities)
- Managing the system's process of operational control and escalation to the ICB
- Supporting the delivery of assurance against NHS Finance including capital and system efficiency, Quality, People & Culture, Estates and the management of system Risk and Governance
- Ensuring that NHS delivery supports improvements in Derby & Derbyshire populations' Life Expectancy (LE) and Healthy Life Expectancy (HLE) as well as reductions in the Health Inequalities

ICS Executive (NHS and LA)
Chair: Rotating Chief Officers
CPLG Reps: Avi Bhatia (see note above)
The primary purpose of the Joined Up Care Derbyshire (JUCD) System Leadership Team (System SLT) is to be the most senior executive forum for the JUCD health and social care system. The System SLT provides an executive connection to inform the Integrated Care Partnership (ICP). Its primary focus will be collective opportunities and actions to address health inequalities, improve life expectancy and healthy life expectancy, including anchor institution developments, to enable delivery of the Joined Up Care Derbyshire ambitions. Remit:
- ICS development
- Health and social care interface
- Place partnership development and delivery
- Health inequalities: population need and outcomes
- Wider determinants
- Anchor Institutions
- Clinical and professional leadership
- ICP/HWBB strategic intent and development

PROVIDER COLLABORATIVES AT SCALE: System Providers: Provider Collaborative Leadership Board
Chair: Ifti Majid
Lead Exec: TBC
CPLG SLT Reps: Avi Bhatia
Accountabilities:
- The mandate for integrating care
- Provide joint system leadership to transform and address provider quality and efficiency, working together at scale with a shared purpose and effective decision-making arrangements.
- Operational Delivery, Performance & Quality including Silver Escalation
- Plan, deliver and transform services, address unwarranted variation and inequality in access, experience and outcomes across wider populations, improve resilience and ensuring that specialisation and consolidation occur where this will provide better outcomes Increasing efficiency & effectiveness (value)

Decisions:
- Identify and agree opportunities and priorities for collaboration in line with strategic objectives
- Agree on deployment of local assets and resources for service recovery, restoration and transformation
- Agree management of risks and mitigations of each provider partner
- Agree strategic plan collaboration for recommendation to ICB Board

Clinical and Professional Leadership Group (CPLG)
Chair: Dr Avi Bhatia
Objectives:
- To provide advice and assurance to the ICB on matters specifically relating to the NHS and Provider Collaboratives:
- To influence the work of the ICP and Place Partnerships:
- To develop and embed system wide clinical and professional distributed leadership arrangements

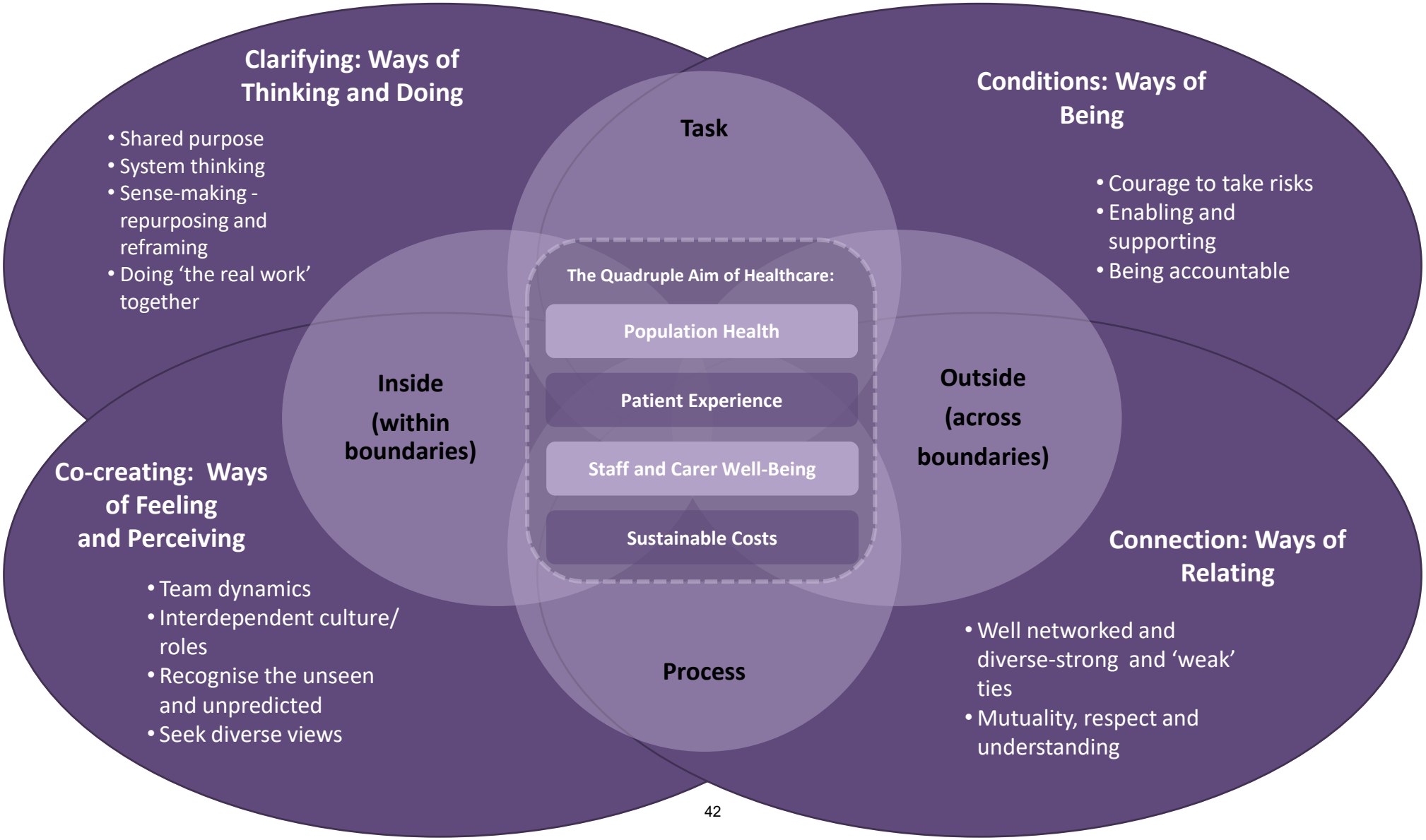
Place Partnerships X2 Place Partnership Boards (City and County) and PCNs INTEGRATED PLACE EXECUTIVE
Chair: Dr Penny Blackwell
Lead Exec: Tracy Allen (NHS) and Helen Jones (LA)
CPLG SLT Reps: Penny Blackwell
Accountabilities:
- One Integrated Place Executive (IPE) to co-ordinate and deliver the set of activities that are best done once. These include for example:
- Identifying Place priorities from system strategic plans (e.g., ICB NHS plan, ICP Integrated Care Strategy)
- 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 board output to determine implications for place based provision.
- Hold delegated resources/accountability from ICB (via NHS Lead Provider in first instance).
- Identifying and addressing system / inter-agency barriers to integrated care.

Decisions:
- Agree the operating model for place based working
- Agree on deployment of local assets and resources to support health, social and economic development, including procurement
- Agree integrated and responsive services
- Agree transition plans and support for Glossop

Care Derbyshire: Developing Clinical and

APPENDIX 3: Our agreed Distributed Clinical and Care Professional System Leadership Behaviour Framework

Joined Up Care Derbyshire



Joined Up Care Derbyshire
Clinical and Professional Leadership Group (CPLG)
Final DRAFT Terms of Reference
December 2022

1.0 Purpose

The Joined Up Care Derbyshire vision is to improve Life Expectancy and Healthy Life Expectancy for the people and communities we serve AND reduce the Health Inequalities driving these differences. CPLG as an agnostic group provides clinical and professional leadership which directs the system in achieving this vision and in doing so, drives achievement of the Quadruple Aim of improving patient outcomes, improving patients' experience of care, improving staff experience of delivering care and to reduce the per capita cost of health care.

The primary purpose of the CPLG is to act as the clinical and professional conscience for the Integrated Care System (ICS) by providing collective direction, impetus and guidance, which enables the system to achieve its strategic priorities to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money, and
- Help the NHS support broader social and economic development

CPLG has a central role in the development of wider system Clinical and Professional Leadership and have agreed a Clinical and Professional Leadership Model (see Appendix 1) which underpins everything the group does. The vision for CPLG is:

"The Clinical and Professional Leadership Group (CPLG) will facilitate, strengthen and build clinical & professional leadership within the Joined Up Care Derbyshire ICS so that the best outcomes for the population are achieved collectively. We will do this by ensuring clinicians and professionals are ***involved, informed,*** *have the* ***ability*** *and* ***opportunity*** *to* ***influence*** *and* ***lead*** *decision making at all levels; supported by trusted and connected leadership".*

CPLG will:

- Be driven by the interests of the people and communities we serve; ensuring health and care services are designed to meet the needs and wants of the people who use them, not the organisations who provide them
- Be recognised, utilised and connected in decision making at all levels as the strategic Clinical and Professional Leadership Group in the ICS by influencing and informing the ICS strategic agenda through high quality advice and shared learning
- Ensure system developments and transformation are aligned to consistent frameworks/principles; seeking to ensure shared learning, innovation and following evidence-based practice
- Act as the clinical and professional conscience for the system; making recommendations to the ICB, ICP and other strategic groups
- Provide an 'open door' to resolve difficult system problems with a role in holding partnerships/organisations to account
- Ensuring there are mechanisms for strong clinical and care professional involvement in service redesign proposals

- Define clinical and professional roles, responsibilities and representation at the heart of decision making throughout ICS developments; ensuring leadership is resourced (funding, support and infrastructure)
- Reduce duplication and add value, with everyone working towards the same vision (making the system less complex)
- Develop and oversee Clinical and Care Professional Leadership by facilitating relationships and structures across the system at all levels
- Avoid duplication by ensuring distributed leadership is embedded in the right place and time with CPLG as a group providing the strategic umbrella

2.0 Remit

The CPLG will ensure delivery of its purpose through 3 strategic areas, aligned to wider ICS development and delivery:

i. To provide advice and assurance to the **ICB** on matters specifically relating to the **NHS and Provider Collaboratives:**
   a. Undertake clinical pathway and transformation reviews, ensuring strong clinical and professional involvement is evident as developments are progressed
   b. Support the work of the Provider Collaborative Leadership Board (PCLB) to ensure strong connections with collaboration at scale and underpinning structures such as the Delivery Boards
   c. Develop and ensure rollout of the Clinical Pathways Development Process (appendix 3) to ensure CPLG is utilised effectively in pathway developments and can make recommendations to the Population Health and Strategic Commissioning Committee and/or other groups as necessary

ii. To influence the work of the **ICP** and **Place Partnerships**:
   a. Influence the Integrated care strategy development by utilising CPLG effectively
   b. Support the work of the Integrated Place Executive to ensure strong clinical and professional distributed leadership is embedded consistently in our Place Partnerships, Local Place Alliances (inc. Social Care) and PCNs
   c. Ensure the ICP infrastructure is aware of the Clinical Pathways Development Process (appendix 3) and utilises the CPLG as set out where necessary/ appropriate
   d. Provide assurance to the ICP of strong CCP leadership and involvement in developments, ensuring broader health and care perspectives are taken into account

iii. To develop and embed system wide **Clinical and Care Professional distributed leadership** arrangements
   a. Responsible for delivery of the CCPL framework and associated action plan to ensure progress is being made
   b. Strengthen the distributed leadership model with the group acting as the glue to ensure all aspects brought together and embedded
   c. Facilitate strengthening of the strategic relationships and connectivity between CPLG and both Local Authorities, which has a shared purpose and is aligned to the integrated care strategy objectives
   d. Work with the Workforce Advisory Group to provide direction and facilitate the required cultural change

3.0 Roles and Responsibilities

The specific CPLG Chair and Vice Chair areas of responsibility can be found at Appendix 2.

All CPLG members are responsible for:

- Contributing to delivery of the overarching objectives as set out in these ToR

- Ensuring clinical and care professional ownership of changes and supporting leadership behaviours across the system
- Acting as ambassadors for JUCD; ensuring there are clinical and care professional advocates and involvement in service redesign proposals
- Ensuring that wider system clinical and care professional colleagues are kept informed and are engaged in developments as appropriate
- Providing the necessary intelligence and information to support the undertaking of accurate analysis to inform decision making

4.0 Delegated Authority

The scheme of delegation set out in the agreed clinical pathway development process will be followed for all clinical pathway and transformation proposals (see Appendix 3). The process defines the thresholds which CPLG can sign-off directly and what needs escalating to other ICS groups. CPLG will discusses the proposal in its meeting, and will provide one of the following recommendations:

a) Fully Supported – with comments and considerations
b) Partially supported – with recommendations and suggestions for further development
c) Not currently supported – Further additional work needs to be undertaken prior to CPLG being in a position to provide a considered view and make recommendations.

CPLG does not have the ability to make decisions which commit resources, however CPLG will make firm recommendations to relevant groups to inform decision making.

CPLG will make decisions on behalf of the system in relation to the clinical and professional leadership developments, working with other groups and committees as appropriate.

5.0 Accountability

CPLG is accountable to the Derby and Derbyshire Integrated Care Board (ICB) and the Derby and Derbyshire Integrated Care Partnership (ICP), through the CPLG Chair as a partner member on the respective Boards.

The Chair of CPLG will provide regular updates to highlight key considerations, recommendations and escalations to the ICB and ICP.

The Chair is responsible for proactively notifying the Chair of the ICB and ICP of any matters which need to be on the agenda of Board meetings, which are pertinent to the business of CPLG.

In addition, an annual report from CPLG will be developed to include progress and effectiveness in relation to system clinical leadership and engagement.

6.0 Membership and Attendance

The membership of CPLG will be kept under continual review to ensure it is evolutionary, depending on the ongoing needs of the system, and of the CCPL community. This will ensure the membership remains inclusive and representative, whilst balancing the value added both in the meetings and in enabling stronger connections with the wider ICS.

6.1 Membership

CPLG Chair
CPLG Vice Chairs (1)
CPLG Management Lead
AHP Council representative
Chief/Director of Pharmacy

Directors of Nursing from CRH, DCHS, DDICB, DHCFT, DHU, EMAS (2), UHDB
Medical Directors from CRH, DCHS, DDICB, DHCFT, DHU, EMAS (2), UHDB
General Practice Provider Board representative
LMC representative
Public Health representative (s)
Senior Social Care representative (s) (3)
Integrated Place Executive Clinical Lead
Local Dentistry Committee representative (4)
Psychological Therapies Representative (4)
Social Work Representative (4)

Notes:

(1) Vice Chairs may be members of CPLG in another capacity from the wider membership
(2) Recognising the scale of the service provider and necessity to connect with multiple ICSs and/or the nature of the discussion, EMAS members will be invited and included in the membership, but it is noted that they may not be able to consistently attend the meetings. Where there are pertinent agenda items for discussion then endeavours will be made to ensure representation
(3) Senior social care representatives are considered vital and important in ensuring a holistic view across the ICS and influencing the developments beyond the NHS in isolation. It is noted that this relationship is evolving to ensure value is added in the contributions. Representatives will remain as members of CPLG, but it is recognised that further clarity and confirmation will evolve.
(4) Members are included to provide a broader and more inclusive view and connectivity into wider clinical and care professional leadership developments. Developments are taking place to engage Local Pharmacy Committee and Local Optical Committees to recognise NHSE delegated function with effect from 1 March 2023/22

At this point in time, connectivity to the Provider Collaborative Leadership Board (PLCB) will be through the CPLG Chair attendance at the PLCB to create the strategic link, there is no request for a specific PLCB clinical lead in addition to this. Clinical and/or professional leads for the Delivery Boards reporting to the PCLB will be invited to CPLG subject to the agenda.

Where members are unable to attend a meeting, an appropriate deputy should be identified to attend in their absence.

By invitation:

- Programme Leads as required
- Delivery Board/ Programme Clinical Leads as required
- Any other representatives from across the system as required

All members will be required to provide organisationally agnostic clinical and care professional views in discussions.

6.2 Attendance

Members will be expected to attend 70% of the planned meetings.

It is recognised that, for a forum of this nature, there may be difficulties in attendance due to clinical commitments, therefore the Chair must be satisfied that there are enough representatives in the room to give a good cross-system balanced opinion for a firm recommendation to be made.

7.0 Meeting Arrangements and Frequency

Meetings will be held monthly for duration of 1.5-2 hours; extraordinary meetings may be arranged if required to consider matters in a timely manner.

All meetings will be held via MS Teams to facilitate attendance, except for development sessions which will be held face-to-face on occasion.

Where necessary members will be required to respond to ‘virtual’ electronic communications owing to timescales.

The Chair and Vice Chairs will be responsible for jointly agreeing the agenda; ensuring matters discussed meet the objectives as set out in these ToR.

Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing.

Papers will be circulated at least 4 working days prior to the meeting; meetings will be clearly minuted and circulated promptly following the meeting to all members.

There will be a standing agenda item at the end of each meeting to check the objectives have been met and review effectiveness of the discussions.

8.0 Quoracy

Quoracy will be at least one representative, as a minimum, from each of the sectors below:
Acute
Community services
Mental health
Primary Care
Commissioners
CPLG Management Lead
Local Authority - Public Health/ Social Care (depending on the subject matter)

9.0 Behaviours and Decision Making

9.1 Behaviours

CPLG members will:

- Model collective leadership by acting as system ambassadors to ensure the common purpose of ICS is delivered
- Facilitate broader clinical and professional leadership, which is recognisable, connected, representative and diverse
- Value everyone's contributions; actively listening and enabling people to be heard and having trust that their opinions and decision making will make a difference for the mutual benefit of our population
- Act as facilitators to engage respective organisations in the direction of travel
- Support each other to address barriers to system integrated care transformation
- Be inclusive and engaging with all levels of the system
- Demonstrate consistent and effective messaging and communication
- Be fair, open and transparent
- Make proactive and positive contributions

9.2 Decision-Making

The CPLG has no powers other than those included in the ToR

The group will seek to reach consensus in deciding recommendations. Where consensus cannot be reached, views which oppose the majority view will be recorded and presented with the report to the relevant committee to ensure transparency.

Members are expected to act as facilitators, providing effective communication for the programme to engage their respective organisations in the developments, modelling collective leadership.

Members are expected to provide information as necessary to support the undertaking of accurate analysis to inform developments.

9.2.1 Urgent Decisions

The CPLG may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting.

Where an urgent decision is required, a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via video conference or communicate by email to take an urgent decision. The quorum, as described above, must be adhered to for urgent decisions.

In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting for formal ratification.

10.0 Equality and Diversity

Members must demonstrably consider the equality and diversity implications of ant decisions and recommendations made.

11.0 Managing Conflicts of Interest

Members of ICS governance groups shall adopt the following approach:

Members must ensure that they continue to comply with relevant organisational policies / governance framework for probity and decision making.

a register of interests will be recorded and maintained. This will be reviewed annually to ensure accuracy, in the intervening periods members should declare any unregistered interests pertinent to the agenda on an on-going basis. Members will be responsible for notifying of any changes to their respective declarations as and when they occur.

In advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals.

The Chair will take overall responsibility for managing conflicts of interest pertinent to agenda items as they arise; any such declarations will be formally recorded in the minutes of the meeting.

The Chair will determine how declared interests should be managed, which is likely to involve one the following actions:

a. Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions.
b. Allowing the individual to participate in the discussion, but not the decision-making process.
c. Allowing full participation in discussion and the decision- making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

12.0 Secretariat and Administration

The CPLG shall be supported with a secretariat function which will include ensuring that:

Attendance of those invited to each meeting is monitored

Records of members' appointments and renewal dates are maintained so that the Board is prompted to renew membership and identify new members where necessary.

Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

The Chair is supported to prepare and deliver reports to the Board.

CPLG is updated on pertinent issues/ areas of interest/ policy developments.

Action points are taken forward between meetings and progress against those actions is monitored.

13.0 REVIEW

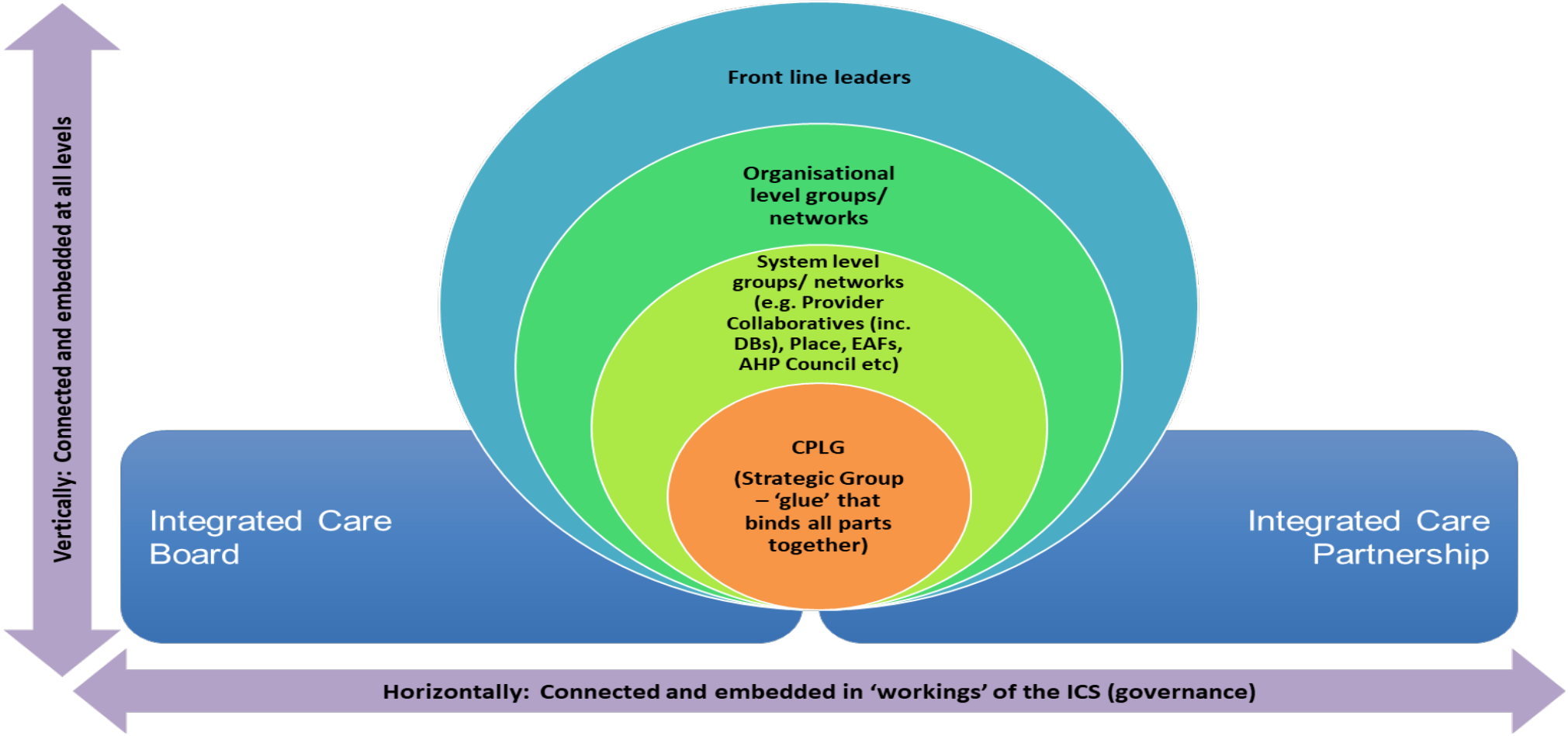
These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board and ICP Board for approval.

To facilitate continual learning and development, a 6-monthly review will take place to ensure that CPLG continues to be effective in discharge of its functions.

Reviewed:	CPLG	20 December 2022
Approved:	NHS Executive	[Insert Date]
	ICB Board	[Insert Date]
	ICP Board	[Insert Date]
Review Date:		[Insert Date]

APPENDIX 1

Our Agreed Clinical and Care Professional Leadership Model - distributed clinical and Professional Leadership which is connected at all levels in JUCD



APPENDIX 2

CPLG Roles and Responsibilities: Agreed at CPLG SLT 12 July 2022 and CPLG 2 August 2022

The overarching CPLG objectives (previous slide) have been distributed amongst the leadership team. These areas of responsibility have been aligned to the future agenda structure; noting that there will be an inevitable element of cross over. **Wider CPLG leadership will be responsible for supporting the Chair and Vice Chairs in delivery of the overarching objectives.**

Chair/ Vice Chair	Areas of responsibility
Chair: Avi Bhatia	• Convenor of CPLG with responsibility for effective functioning and development of the group • Making recommendations and providing assurance to the ICB and ICP; ensuring the CPLG considerations are taken into account as necessary • Influencing the Integrated care strategy development by utilising CPLG • Facilitate strengthening of the strategic relationships and connectivity between CPLG and both Local Authorities, which has a shared purpose and is aligned to the integrated care strategy objectives • CPLG link to Strategic Population Health & Commissioning Committee, ensuring recommendations made by CPLG are taken into account in commissioning decisions
1 Vice Chair: (NHS) Provider Collaborative Link – Ben Pearson	• Deputy for the Chair on the ICB Board as required • Leading on clinical pathway and transformation reviews and strong clinical and professional involvement is evident as developments are progressed • Support the work of the Provider Collaborative Leadership Board (PCLB) to ensure strong connections with collaboration at scale and underpinning structures such as the Delivery Boards • Develop and ensure rollout of the Clinical Pathways Development Process to ensure CPLG is utilised effectively in pathway developments and can make recommendations to the Population Health and Strategic Commissioning Committee and/or other groups as necessary • Supporting leadership developments through the CPLG Leadership Team – connecting to relevant system groups (e.g. Place, Provider collaboration, People and Culture)
1 Vice Chair: ICP & Place link – Penny Blackwell	• Deputy for the Chair on the ICP Board as required • Acting as the conduit with the ICP to ensure CPLG is connected to and influencing the ICP Integrated Care Strategy developments • Support the work of the Integrated Place Executive to ensure strong clinical and professional distributed leadership is embedded consistently in our Place Partnerships, Local Place Alliances (inc. Social Care) and PCNs • Ensure the ICP infrastructure is aware of the Clinical Pathways Development Process and utilises the CPLG as set out where necessary/ appropriate • Working with the Chair to provide assurance to the ICP of strong CCP leadership and involvement in developments, ensuring broader health and care perspectives are taken into account • Supporting leadership developments through the CPLG Leadership Team – connecting to relevant system groups (e.g. Place, Provider collaboration, People and Culture)
1 Vice Chair: CCPL Development – Lucy Smith	• Leading the leadership developments through the CPLG Senior Leadership Team – connecting to relevant system groups (e.g. Place, Provider collaboration, People and Culture) • Ensuring all aspects of delivery of the CCPL framework and associated action plan to ensure progress is being made • Strengthen the distributed leadership model with the group acting as the glue to ensure all aspects brought together and embedded • Work with the Workforce Advisory Group to provide direction and facilitate the required cultural change
1 Vice Chair: Integrated Care Local Authority - Vacant	To be developed to maintain a rounded, ICS-view

APPENDIX 3

Clinical Pathways Development Process

(Approved by the Population Health & Strategic Commissioning Committee: 10 November 2022 and the Provider Collaborative Leadership Board: 30 November 2022)

1. Purpose

This paper seeks to clarify the JUCD clinical pathways development process, following recent discussions at Clinical and Professional Leadership Group (CPLG) regarding approval of Expert Advisory Forums (EAF) proposals, and proposes a clear, streamlined route for approval and enactment of proposals generated at specialty/pathway level.

It is important to note that this paper does not aim to define the wider system governance arrangements, which are still evolving. The focus of the approach set out below is to define a specific element regarding pathway developments that are an important part of the whole. CPLGs role in both the approach described in this paper and with the wider ICS governance will be crucial and therefore for context Appendix A describes a wider view of CPLG's developing relationship with other JUCD system elements. In this context, this paper will be reviewed after 12 months, as the wider ICS system governance evolves further.

2. Background – Case for Change

Expert Advisory Forums (EAFs) are one of a series of specialty/pathway level groups that exist within the JUCD governance. EAFs specifically are intended as forums where primary, community and secondary clinicians can come together to develop service improvements within a particular specialty. There are steering groups in a number of other pathways (e.g., LTCs, MSK) which perform a similar function to EAFs.

The governance route through which EAFs' recommendations is enacted is not clear. Nominally, EAFs report to the Outpatient Delivery Board, although their work often extends well beyond outpatient services. Other comparable groups report through different Delivery Boards.

A recent issue has highlighted this lack of clarity – the Dermatology EAF proposed the adoption of an Advice & Guidance model in both CRH and UHDB, however this led to concern from elements within the wider GP community who felt that there could be significant impacts upon primary care services, and that adequate engagement had not taken place.

Discussion therefore took place at the May and June 2022 CPLG meetings (and in a supporting pre-meeting) to determine what an appropriate model could be, which would incorporate adequate engagement for clinical, operational and financial matters; not place undue bureaucracy or delays in the way of proposed developments; and be both streamlined and link into current known wider system governance. These discussions, with senior primary, community and secondary care representation, form the basis of this proposal. Following the initial development through CPLG, the proposal has been considered by other system leads to seek their feedback and inform any subsequent refinement.

Additionally, there is scope alongside the main proposal for CPLG to influence the groups which feed into the model. System priorities, based upon population health data, should influence the range of EAFs and equivalent groups in the system. At the same time, there are instances of potential duplication, with multiple system-level groups for some individual specialties – as an example, ENT clinicians have supported a proposal to concentrate all system ENT work through the EAF. There is scope to create greater simplicity and consistency in these groups. CPLG should be in a position to support this drive to reduce duplication, and to be proactive in system design.

3. Proposed Model

It is intended that the proposed model:

- Offers a streamlined and simplified governance route providing a clear clinical and professional view
- Supports collaboration and co-production
- Ensures communication and consultation with stakeholders across the system, including patient engagement
- Offers the ability to make recommendations to the system from a clinical and care professional perspective
- Enables the individuals in CPLG to work with their own organisations to aid enactment and transformation

Description:

A **Scheme of Delegation** should be in place, to determine what CPLG can sign-off directly and what needs escalating. CPLG should be able to immediately sign off lower risk initiatives or those with little or no cost, or little or no shift or allocation of resource. The Scheme should determine the exact thresholds. This will aid delivery, enactment and ownership as well as aiding transformation in stakeholder groups.

Appendix B sets out the high-level checklist of considerations which underpin the steps defined below; this is based on the scheme of delegation thresholds.

Step 1: It is proposed that EAFs and other comparable groups (having sought appropriate expert input) send their output to CPLG for ratification. The EAF / equivalent needs to have consulted relevant subject matter experts (e.g., finance, workforce, digital, estates) and stakeholders from across the system (incl. patients) before presenting to CPLG. This is to include discussions among all relevant professional groups (such as General Practice, Allied Health Professionals and social care) to evidence that alternative models of service delivery have been considered where appropriate and any wider impacts beyond the immediate scope have also been considered. A clear process for seeking of relevant input, and for recording this to assist CPLG with their decision making, will be communicated to EAFs and equivalents, and it would be expected that this is adhered to, in order to secure CPLG sign-off.

The seeking of expert input should incorporate e.g., reasonable engagement on primary and secondary care opinions although this does not need to be through a formal group (e.g., LMC or GP Provider Board). The development of a standard process / template is recommended, to ensure that EAFs and equivalent groups can demonstrate the engagement and rationale behind their proposals in a clear and structured way. This is important to ensure any advice and/or concerns raised during the development of proposals is evidenced and addressed.

Within this step and prior to seeking formal CPLG support, if necessary, the CPLG can also be utilised to gain a broader system clinical and professional objective view to test any conceptual ideas. However, that would not preclude the need to then undertaken the specific engagement set out above.

Step 2: CPLG then discusses the proposal in its meeting, and then will provide one of the following recommendations:

d) Fully Supported – with comments and considerations
e) Partially supported – with recommendations and suggestions for further development
f) Not currently supported – Further additional work needs to be undertaken prior to CPLG being in a position to provide a considered view and make recommendations.

Step 3: For proposals where there are no commissioning decisions required (i.e. no resource implications, wider system impacts/risks), CPLG will be in a position to support implementation. For all other proposals where initiatives require a shift in allocation of resource, and / or with wider system implications, and / or carrying higher risk, the appropriate commissioning forum will make the necessary decisions. This will be informed by CPLG's recommendations having undertaken an initial review of the proposal; noting CPLG would not be able to consider any

financial implications and would therefore consider the merits from a model of care perspective only and would provide that view to the necessary commissioning decision making group.

One sign-off route from CPLG would be to the JUCD Provider Collaborative (i.e., the Provider Collaborative Leadership Board, PCLB, or its immediate operational sub-committee). The Provider Collaborative will have delegated authority for significant amounts of the commissioning function previously carried out by CCGs and is likely to be resourced to enable this. Additionally, the Provider Collaborative will have prime delivery responsibility for the system and will be able to ensure that EAF initiatives will help to meet that delivery.

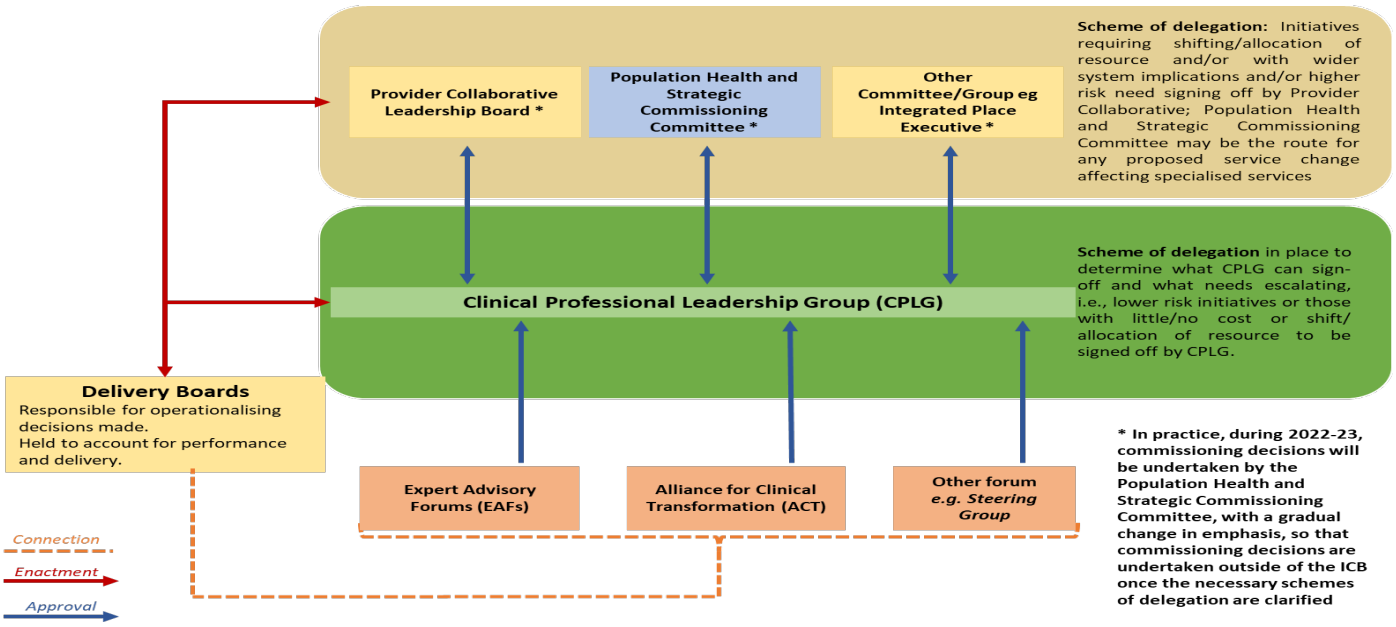
In other cases, Population Health and Strategic Commissioning Committee may be the route for any proposed service change, e.g., anything affecting specialised services or if there are particularly wide-reaching system implications – the Scheme of Delegation should cover this. Alternative routes may develop as the ICS matures.

In practice, during 2022-23, it is likely that commissioning decisions will be undertaken by the Population Health and Strategic Commissioning Committee. It is expected that there will be a gradual change in emphasis over time, so that 'traditional' commissioning routes are undertaken outside of the ICB (e.g., provider collaboratives) once the necessary schemes of delegation are clarified. Therefore, as the broader arrangements develop, so too will the extent to which there is an ability to commit resource to CPLG recommended schemes.

It is important to note that the focus of these proposals relate more specifically to the NHS specialty level pathways and therefore are more closely aligned to the provider collaboratives as described in the diagram below. It is recognised that the other commissioning routes, as they develop will include Place Partnerships but at this time that is not within the scope of this proposal. It will however be necessary to understand such delegation as it evolves so that end to end pathways which are closely related to Place Partnerships delivery are enabled and supported through CPLG with a similar/consistent approach.

Step 4: Delivery / enactment of initiatives will normally sit with the relevant JUCD Delivery Board, likely to be within the Provider Collaborative and therefore with clear accountability for system performance and delivery. This paper does not cover the Delivery Board Terms and composition, but it is noted that a greater and appropriate clinical and professional presence on the Delivery Boards may help to ensure greater alignment with CPLG.

Schematic: The diagram below illustrates the proposed model, per the above description:

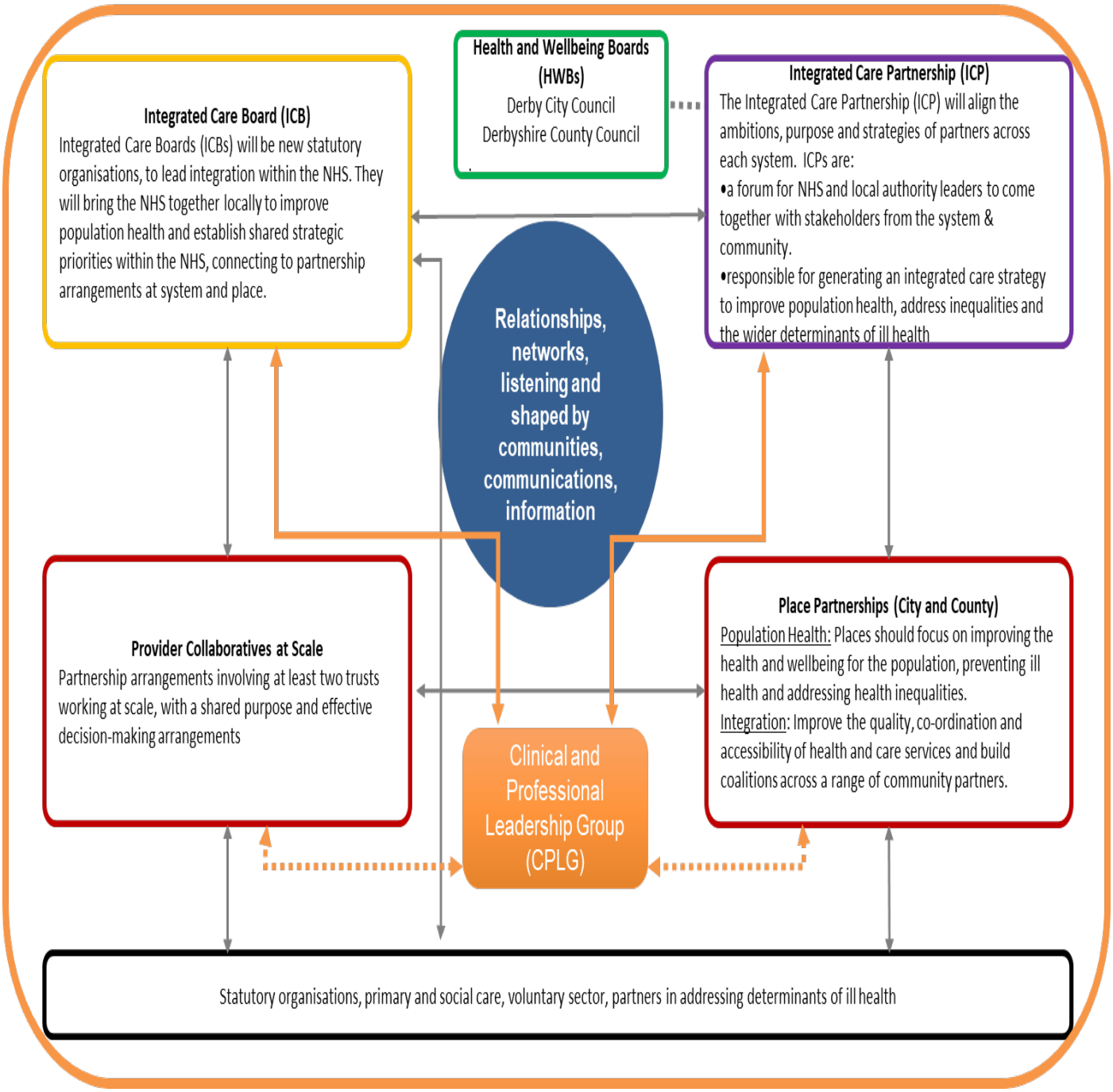


Clinical Pathways Development Process: Appendix A

The diagram below (adapted from the JUCD ICS System Development Plan refresh, May 2022) shows a wider view of CPLG's developing relationship with other JUCD system elements. This is presented for context and does not directly impact the proposals above. It is recognised that JUCD system governance is work in progress.

Component parts of the JUCD ICS: CPLG Relationship

The diagram below aims to demonstrate the CPLG's interface and positioning within the wider ICS 'wiring'. Note this is for illustrative purposes only – not formal governance arrangement. The diagram is described at a point in time and may be subject to change.



Clinical Pathways Development Process: Appendix B

Development Thresholds and Checklist of Considerations

Development Thresholds

Threshold 1: Organisation level

Does the proposal stay within the boundaries of one statutory organisation without significant resource implications?
(i.e. does not impact upon patient flow and / or resource usage outside the organisation)

Changes of this nature can usually be enacted without the need to connect with wider system developments and/or seek support from CPLG, unless it is felt that the proposal would benefit from a wider system view to aid implementation and/or other considerations, in which case CPLG would be happy to support

Threshold 2: System level

Does the proposal cross organisational / sector boundaries? *(i.e. impacts upon patient flow between e.g. primary and secondary care)*

Formal patient and public engagement and/or consultation where appropriate, may not usually be required for proposal's falling in this threshold. Refer to the JUCD Engagement Governance Guide

Threshold 3: Large-scale Change

Does the proposal involve large-scale service change?
(e.g. transfer of personnel / significant workforce change, major capital development, crosses ICB footprints)

Patient and public engagement and/or consultation where appropriate, will be required for proposal's falling in this threshold. Refer to the JUCD Engagement Governance Guide (Guide to working with people and communities » Joined Up Care Derbyshire***)***
Contact ddicb.engagement@nhs.net

Checklist of Considerations

These considerations are designed to help you think about the various aspects which would build a strong proposal for CPLG to provide a view on

Have you considered alternative approaches which could provide greater benefits ***and*** would broaden the scope of the proposal? **If yes, consider areas below in the developments**

- Have you thought about how this addresses the JUCD Quadruple aim?
- Have you engaged with and captured the viewpoints and perspectives of a wide range of multi-professional stakeholders from across the system?
- Can you evidence considerations against the 7 pillars of governance (linking this to the System Quality Group Quality & Performance Framework):
  - Involvement of service users (Engagement and health inequalities / EQIA)
  - Staffing and Staff Management (Engagement, workforce planning, Memoranda of Understanding between employing organisations)
  - Evidence based best practice
  - Use of Information and Resources (Data & Digital, Finance, Estate, contracts) *Have you involved subject matter experts (e.g., finance, workforce, digital, estates, medicines management) in the development of the proposals?*
  - Education and Training (Skills and competencies)
  - Risk Management (Linked to system risks) *Are there any significant risks associated with this change/ risks of not doing it?*
  - Audit, Quality Improvement and Learning (Outcomes expected and performance monitoring)
- Is the proposal in line with JUCD Medicines Guidelines (JAPC) and/or Clinical Policies (CPAG) or otherwise this will require further engagement with the ICB Medicines Management and Clinical Policies Team

It is recommended that you consider linking in with the Joined Up Improvement Network for additional support: ddicb.PMOSupport@nhs.net

Joined Up Care Derbyshire (JUCD) Integrated Care System Chair - Clinical and Professional Leadership Group (CPLG)	
Role:	Chair – JUCD Clinical and Professional Leadership Group (CPLG)
Remuneration:	The salary will be commensurate to the profession of the candidate
Hours:	2 days per week
Term:	2 years
Employing Organisation:	NHS Derby & Derbyshire ICB (inc. constituent organisation secondment opportunity where appropriate)
Accountable to:	Independent Chair Derby and Derbyshire Integrated Care Board (ICB)
Reports to:	Chief Executive Officer NHS Derby & Derbyshire ICB
Location:	Contractual base TBC Required to work at any establishment at any time throughout the duration of their contract, normally within the location of the Organisation or Sector, or as set out under the terms of their contract.

Context

There are four core purposes of integrated care systems (ICSs);

- To improve outcomes in population health and healthcare;
- Tackle inequalities in outcomes, experience, and access;
- Enhance productivity and value for money and
- Help the NHS support broader social and economic development.

Integral to delivering these four core purposes are the NHS Integrated Care Boards (ICBs), which will have a fundamental role in facilitating and supporting the development of Integrated Care within the NHS; alongside the Integrated Care Partnership (ICP) wider Public Health, Social Care and Local Authority partners to create broader integrated care.

Fully inclusive multiprofessional Clinical and Care Professional Leadership (CCPL) is central to designing and delivering integrated care which meets the needs of people, rather than just treating their individual conditions. This is why the JUCD ICS has made strong and embedded distributed leadership a priority in decision making from the outset. In addition, the approach to progressing clinical and care professional arrangements will strengthen our response to the national guidance and requirements as set out in '*Building strong integrated care systems everywhere - ICS implementation guidance on effective clinical and care professional leadership' (September 2021).*

As the Joined Up Care Derbyshire ICS matures, the full range of clinical and care professional leaders, from diverse backgrounds, will need to be involved in decision-making at all levels so they can shape and contribute towards a collective ambition for the health and wellbeing of the population. This is a continuous improvement and engagement journey which will require a cultural shift by working alongside and part of the wider ICS developments.

Purpose

This is a key role to ensure the agreed distributed leadership model and framework is developed, embedded, and enacted in the system, the individual will do this by actively working with partners and system development leads. The Chair will also ensure effective functioning and stronger positioning of the CPLG itself; acting as the expert group that is recognised and utilised by the system to provide assurance and advice as the strategic level clinical and care professional conscience for the system (senate approach); making recommendations to the ICB and ICP and other strategic groups as appropriate.

The Chair will have overarching responsibility for this important development journey by continuing to build arrangements and networks which facilitate greater clinical and professional leadership presence and connectivity across the ICS.

In order to maintain momentum and continuity of the CCPL developments as the ICS evolves, it was agreed to maintain the existing Chair arrangements until 31 March 2023. These arrangements have been kept under review and informed by wider CCPL and ICS developments with the recognition that the role will now be made substantive to ensure progress continues to be made.

Key Responsibilities

The Chair of the Clinical and Professional Leadership Group will be a partner member of the ICB's board and where appropriate relevant subcommittees either directly or indirectly by ensuring there is appropriate clinical and or care professional leadership representation on system committees as appropriate.

The Chair will be responsible for the development and delivery of the JUCD ICS Clinical and Care Professional Leadership framework. This will ensure strong distributed clinical and professional leadership is embedded to deliver Derby & Derbyshire's commitments to integrated care by delivering the agreed CPLG vision:

"The Clinical and Professional Leadership Group (CPLG) will facilitate, strengthen and build clinical & professional leadership within the Joined Up Care Derbyshire ICS so that the best outcomes for the population are achieved collectively. We will do this by ensuring clinicians and professionals are involved, informed, have the ability and opportunity to influence and lead decision making at all levels; supported by trusted and connected leadership".

The Chair will be responsible for ensuring the CPLG deliver the following objectives:

- Be driven by the interests of the people and communities we serve; ensuring health and care services are designed to meet the needs and wants of the people who use them, not the organisations who provide them
- Be recognised, utilised and connected in decision making at all levels as the strategic Clinical and Professional Leadership Group in the ICS by influencing and informing the ICS strategic agenda through high quality advice and shared learning
- Ensure system developments and transformation are aligned to consistent frameworks/principles; seeking to ensure shared learning, innovation and following evidence-based practice
- Act as the clinical and professional conscience for the system; making recommendations to the ICB, ICP and other strategic groups
- Provide an 'open door' to resolve difficult system problems with a role in holding partnerships/organisations to account

- Ensuring there are mechanisms for strong clinical and care professional involvement in service redesign proposals
- Define clinical and professional roles, responsibilities and representation at the heart of decision making throughout ICS developments; ensuring leadership is resourced (funding, support and infrastructure)
- Reduce duplication and add value, with everyone working towards the same vision (making the system less complex)
- Develop and oversee Clinical and Care Professional Leadership by facilitating relationships and structures across the system at all levels
- Avoid duplication by ensuring distributed leadership is embedded in the right place and time with CPLG as a group providing the strategic umbrella

Specifically, the Chair will be responsible for ensuring CPLG deliver its purpose through 3 strategic areas, aligned to wider ICS development and delivery:

i. To provide advice and assurance to the ICB on matters specifically relating to the NHS and Provider Collaboratives:
    a. Undertake clinical pathway and transformation reviews, ensuring strong clinical and professional involvement is evident as developments are progressed
    b. Support the work of the Provider Collaborative Leadership Board (PCLB) to ensure strong connections with collaboration at scale and underpinning structures such as the Delivery Boards
    c. Develop and ensure rollout of the Clinical Pathways Development Process to ensure CPLG is utilised effectively in pathway developments and can make recommendations to the Population Health and Strategic Commissioning Committee and/or other groups as necessary

ii. To influence the work of the ICP and Place Partnerships:
    a. Influence the Integrated care strategy development by utilising CPLG effectively
    b. Support the work of the Integrated Place Executive to ensure strong clinical and professional distributed leadership is embedded consistently in our Place Partnerships, Local Place Alliances (inc. Social Care) and PCNs
    c. Ensure the ICP infrastructure is aware of the Clinical Pathways Development Process and utilises the CPLG as set out where necessary/ appropriate
    d. Provide assurance to the ICP of strong CCP leadership and involvement in developments, ensuring broader health and care perspectives are taken into account

iii. To develop and embed system wide clinical and professional distributed leadership arrangements
    a. Responsible for delivery of the CCPL framework and associated action plan to ensure progress is being made
    b. Strengthen the distributed leadership model with the group acting as the glue to ensure all aspects brought together and embedded
    c. Facilitate strengthening of the strategic relationships and connectivity between CPLG and both Local Authorities, which has a shared purpose and is aligned to the integrated care strategy objectives
    d. Work with the Workforce Advisory Group to provide direction and facilitate the required cultural change

Leadership Behaviours

The individual will be expected to exemplify behaviours that promote collaborative ways of working and integrated service delivery with a personal drive to increase the health and wellbeing of our Derbyshire population. The CPLG Chair will ensure the following agreed principles and behaviours are always demonstrated, both as an individual and in developing CPLG as a group and supporting wider CCPL leader developments:

- Model collective leadership by acting as a system ambassador to ensure the common purpose of ICS is delivered
- Demonstrate consistent and effective messaging and communication resulting in meaningful dialogue; ensuring that wider system clinical and care professional colleagues are kept informed and are engaged in developments as appropriate
- Facilitate broader clinical and professional leadership, which is recognisable, connected, representative and diverse
- Value everyone's contributions; actively listening and enabling people to be heard and having trust that their opinions and decision making will make a difference for the mutual benefit of our population
- Act as facilitators to engage respective organisations in the direction of travel
- Support each other to address barriers to system integrated care transformation
- Be inclusive and engaging with all levels of the system
- Be fair, open and transparent

Accountability

Line management for the role will sit within the Integrated Care Board (ICB), however there will be mutual accountability and reporting arrangements to both the ICB and ICP to ensure the broader scope of the clinical and care professional developments is firmly embedded in the wider ICS.

The Chair of the CPLG will play an essential role in this overall system development but will have specific objectives within this, as detailed above.

Key Relationships

- Integrated Care Board (ICB) and appropriate sub-committees/functions; in particular the People and Culture, Population Health and Commissioning and Communications and Engagement
- Integrated Care Partnership (ICP)
- ICS Executive
- NHS Executive
- Partners in the Provider Collaborative Leadership Board
- Partners in the Integrated Place Executive (including the two Derbyshire Place, Local Place Alliances and PCNs)
- Provider Organisations Clinical and Care Professional leads (inc Medical Directors, Directors of Nursing, AHP Council Leads)
- Regional colleagues from NHSE/I

This list is not exhaustive, the Chair will need to ensure strong engagement and liaison with the various ICS developments as they evolve.

SUPPLEMENTARY DUTIES AND RESPONSIBILITIES

OTHER DUTIES

The above is only an outline of the tasks, responsibilities and outcomes required of the role.
The job holder will carry out any other duties as may reasonably be required by the Chief Executive Officer.

The nature of this role is one of continual development and the duties and responsibilities outline above will change from time to time to reflect the emerging legislation.

CODE OF CONDUCT FOR NHS MANAGERS

Managers are required to carry out their duties in a manner which complies with the NHS Code of Conduct for Managers Directions, 2002.

ADDITIONAL INFORMATION

Infection Control
Infection Prevention and Control is everyone's responsibility. All staff, clinical and non-clinical, are required to adhere to the ICBs' Infection Prevention and Control Policies and Procedures and must make every effort to maintain high standards of Infection Prevention and Control at all times, thus minimising the risks associated with healthcare associated infections.
Staff involved with patient care, whether directly or indirectly, have a duty to:

- Clean their hands before and after direct contact with patients and when entering and leaving a clinical area;
- Ensure that patient equipment is cleaned and/or decontaminated appropriately between each patient use;
- Ensure that all environments, where patient care is provided, is clean at all times, maintained to a high standard and appropriate for patient care;
- Provide patients, relatives, and the public with clear and consistent HCAI messages and advice on standard Infection Prevention and Control precautions and key infections (MRSA and Clostridium Difficile).

All staff have a duty to:

- Attend/undertake Infection Prevention and Control training programmes provided by the ICBs;
- Report to Occupational Health any infections that they develop which may be transmissible to patients or colleagues;
- Adhere to the ICBs' Uniform and Non Uniform Dress Code Policies;
- Challenge and address inappropriate Infection Prevention and Control practice;
- Report and take action on areas where Infection Prevention and Control standards are not being met.

Health and Safety at Work
You must not wilfully endanger yourself or others whilst at work. Safe working practices and safety precautions will be adhered to. Protective clothing and equipment must be used where provided. ALL accidents / incidents must be reported to your immediate senior officer, and you are asked to participate in accident prevention by reporting potential hazards and to ensure that appropriate forms are completed.

A copy of the ICB's Health and Safety Policy document will be given to the successful applicant on appointment.

Rehabilitation of Offenders Act
Due to the nature of the work for which you are applying, this post is exempt from the provisions of Section 4 (2) of the Rehabilitation of Offenders Act 1974, by virtue of the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975. Applicants are therefore not entitled to withhold information about convictions which for other purposes are "spent" under the provision of the Act, and, in the event of employment, any failure to disclose such convictions could result in dismissal or disciplinary action by the ICB. Any information given will be completely confidential and will be considered only in relation to an application for positions to which the order applies.

Protection of Children or vulnerable adults
Disclosure of Criminal Background of Those With Access to Children or vulnerable adults whether it be in-direct or direct contact.

Following a report by the Home Office, the Government accepted its recommendations regarding the disclosure of criminal convictions of those with access either direct or non-direct access to children or vulnerable adults. If therefore this post involves substantial access to children or vulnerable adults, a check will be made with the police as to whether you have a criminal record before the appointment can be confirmed.

Data Protection and Information Governance
If you have contact with computerised data systems you are required to obtain, process and/or use information held on a computer or word processor in a fair and lawful way. To hold data only for the specific registered purpose and not to use or disclose it in any way that is incompatible with such purpose and to disclose data only to authorised persons or organisations as instructed.
You must abide by all the conditions laid down within the most recent NHS Information Governance Toolkit.

Access to Health Records
All staff who contribute to patients' health records are expected to be familiar with and adhere to, the Trust's Record Keeping Policy and other related documents. All staff who have access to patients' records have a responsibility to ensure that these are maintained efficiently, and that confidentiality is protected in line with the ICB's policies and related documents.
Staff are also subject to this obligation both on an implied basis and also on the basis that, on accepting their job description, they agree to maintain both patient/client and staff confidentiality.
In addition, all health professionals are advised to compile records on the assumption that they are accessible to patients in line with the Access to Health Records Act 1998.

APPENDIX D

You are invited to an important workshop – Embedding Clinical and Care Professional Leadership (CCPL) in decision making in the Joined Up Care Derbyshire Integrated Care system (ICS)

Thursday 16 February 2023, 1pm to 4pm (MS Teams)

Background

The Joined Up Care Derbyshire Clinical and Professional Leadership Group (CPLG) began strengthening the positioning of the group in the summer of 2021, this resulted in a step change from the previous Clinical and Professional Reference Group (CPRG) to the Clinical and Professional **Leadership** Group.

These developments were undertaken ahead of the publication of the national guidance Clinical and Care Leadership Guidance, in September 2021. The guidance placed emphasis on the need for strong clinical and care professional leadership as being crucial to delivering the improvements in care and population health. NHS England engaged with more than 2,000 clinical and care professionals in the development of the guidance to understand what was and wasn't working with traditional approaches and to agree what effective clinical and care leadership across an Integrated Care System (ICS) should look like.

The guidance set out 5 principles that all ICS's needed to evidence in our respective Clinical and Care Professional Leadership (CCPL) models. We built out from the initial development work through CPLG and undertook wider engagement, to create our distributed CCPL model (see appendix A for information). It is important to note this is underpinned by a more comprehensive framework setting out our key areas of development aligned to the 5 principles.

Since then, we have held two important workshops targeted at front line leaders to begin embedding our model; both sessions have had circa 100-150 attendees from across all partner organisations (including Social Care) and with a broad range of clinical and professional leaders. These sessions have been invaluable in helping to shape our direction of travel. We plan to continue reaching out in this way to further develop and embed our approach. We hope that as strategic system leaders you will continue to support us in this important journey, by empowering your clinical and care professional leaders, irrespective of the level/grade at which they work, to continue being part of this collective movement.

Our specific ask to you as strategic system leaders

We know that there is more to do with regards to our engagement with strategic decision makers (groups and committees at system and organisational level) and we are pleased that we have the opportunity to utilise an NHS England to support offer to help us shape this particular area further. We will therefore be holding a workshop **on Thursday 16 February from 1pm to 4pm; the event will be held virtually to facilitate attendance**. The workshop will be facilitated by the National Clinical Advisor and National Care Advisor.

This workshop is intended to explore the relationships and interactions between senior clinical and professional leaders and Executive/ senior managers (inc. Board and sub-Committees). This is important in order for us to collectively create the shift required and to genuinely embed CCPL in our strategic system thinking and decision-making structures. We are deliberately inviting both Clinical and Care Professional

strategic leaders and Executives/ senior leaders to this session so that we can influence and shape a shared understanding and in turn agree specific actions for further development.

As Chair of the JUCD CPLG, I am therefore inviting you as strategic system leaders to this important workshop and should be grateful if you could commit to this time to help develop our next steps together. A diary invite will be issued shortly, in the meantime please could you **confirm your attendance with Abi Ingram abigail.ingram@nhs.net by Friday 30 December so that we can review attendance and design the event accordingly**. If you require any additional information, then please do not hesitate to contact Sukhi Mahil (System CCPL Management Lead) sukhi.mahil@nhs.net.

If there are other strategic leaders working in health or care in the JUCD ICS that we might have missed, please extend this invite as appropriate.

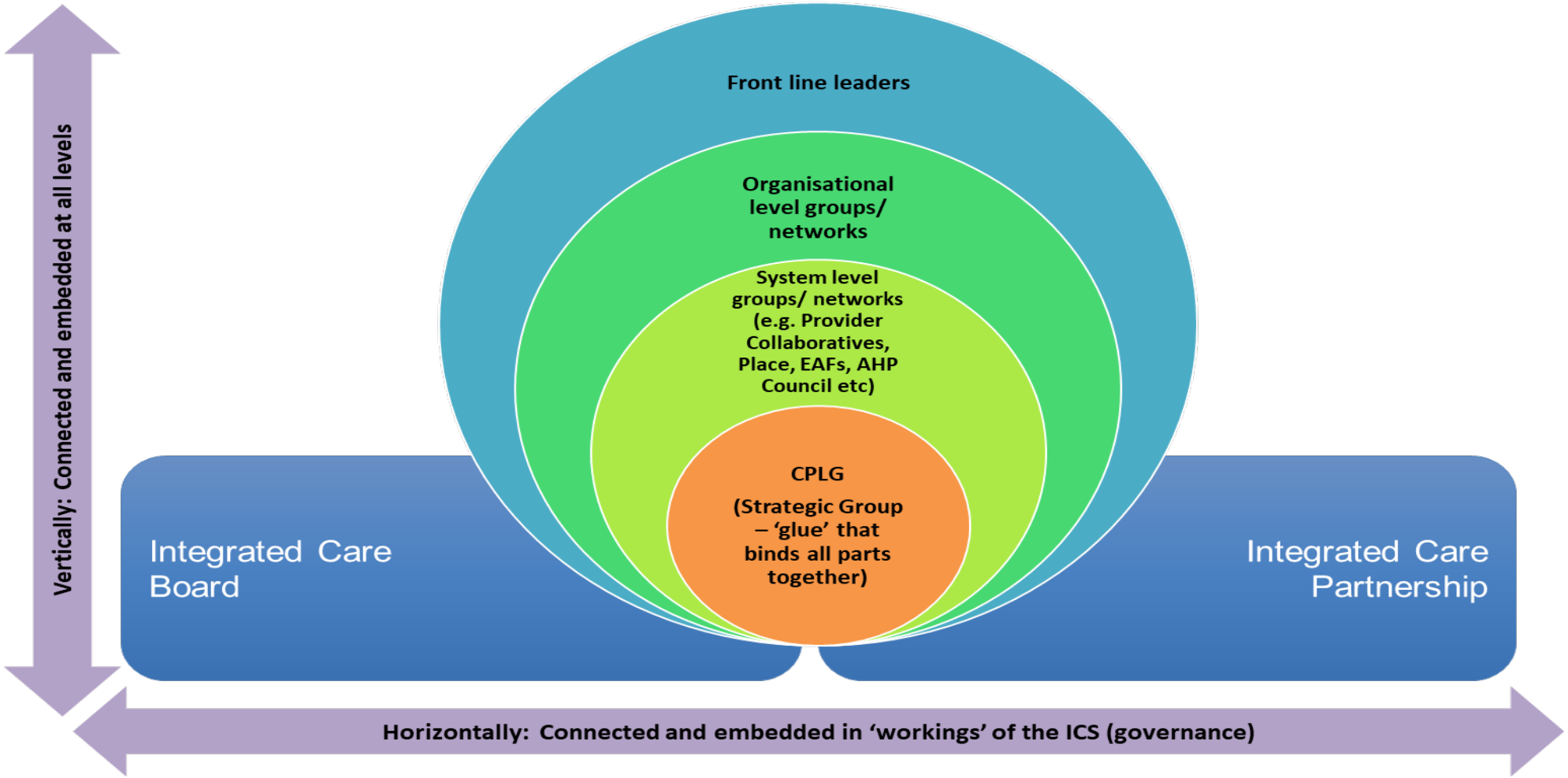
This is a key step to building a more integrated and distributed approach to CCPL in our decision making as a system which will directly support the success of the JUCD ICS, and we look forward to seeing you there.

Many thanks and best wishes,

Dr. Avi Bhatia
Chair, JUCD CPLG

Appendix A

Our Agreed Clinical and Care Professional Leadership Model - distributed clinical and Professional Leadership which is connected at all levels in JUCD



NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

19th January 2023

Item: 069

Report Title	Making the most of the Voluntary, Community and Social Enterprise sector contribution as a partner in the Integrated Care System							
Author	Wynne Garnett, Programme Lead – Embedding the VCSE sector in the Integrated Care System							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Wynne Garnett, Programme Lead – Embedding the VCSE sector in the Integrated Care System							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☐	Information	☒
Appendices	Appendix 1 – Making the most of the Voluntary, Community and Social Enterprise sector contribution as a partner in the Integrated Care System presentation slides Appendix 2 – Engaging VCSE Sector in Derbyshire ICS, progress and future priorities							
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** and **DISCUSS** the presentation for 'making the most of the Voluntary, Community and Social Enterprise (VCSE) sector contribution as a partner in the Integrated Care System (ICS)'.
Purpose
This report provides the Board with assurance on the work being done in regards to the inclusion of the VCSE sector as a partner within the ICS.
Background
ICS Guidance sets out the importance of the Voluntary, Community and Social Enterprise sector as a key strategic partner in shaping and developing services and implementing plans to tackle the wider determinants of health. Through the new VCSE Alliance, work has been done with partners to make this happen and identify opportunities and future priorities. There are particular development areas and opportunities where the VCSE sector can support NHS bodies in the system.
Report Summary
The VCSE sector is a large, diverse sector that makes a substantial contribution to the health and well-being of people living in Derbyshire. It is comprised of over a 1,000 organisations, most of which are volunteer led and employs over 10,000 staff. There is the potential for the VCSE sector to play a bigger role around preventative activity, addressing health inequalities and the

determinants of ill health. It can do this through engaging communities, providing soft intelligence and delivering services in innovative, cost effective and flexible ways.

Making the most of this relationship means looking at how to best engage such a large diverse sector with defined partnership structures and moving away from traditional transactional approaches. It also means looking at new ways of working with and investing in the VCSE sector and making it integral to the thinking of service design and delivery. Supporting the VCSE workforce is another challenge in that it comprises of volunteers as well as paid staff often releasing potential within communities.

Substantial progress has been made in engaging the VCSE sector and redefining the relationship with NHS partners but there remains work to do if we want to maximise its potential. NHSE has advised that our aspirations and how we might achieve this, should be set out in a Memorandum of Understanding to be signed off by the ICB and the VCSE Alliance later in the year.

Identification of Key Risks
None identified.

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.

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.					

Making the most of the Voluntary, Community and Social Enterprise sector contribution as a partner in the Integrated Care System

The Derbyshire VCSE sector Alliance

ICB Presentation

The VCSE Contribution

The Derbyshire VCSE sector Alliance

County alone

- 5000 organisations
- 5.5 million service users
- Combined value of £340 million
- 10,000 FTE paid staff
- 6000 FTE volunteers
- 70% of organisations volunteers only
- Providers, advocates, campaigners, infrastructure, mutual support
- Befriending £800K for £7million of value

- Soft intelligence and data
- Reach and engagement of communities (of place, interest, condition, lived experience)
- Innovative service design
- Delivery, (complementarity, innovation, flexibility and responsiveness)
- Value, (cost effective and access to other resources)
- Release of community potential
- Strong on prevention

Underpin, Shape, Prevent, Complement, Deliver

Hospital Discharge

Supporting maternity services

Improving Mental Health

End of life care

Transport, follow up, support packages

Crisis Cafes, Eating Disorders, Autism etc

Hospice Care

Social prescribing

Keeping people at home

Connected; peer support to perinatal parents

Social prescribers and providers

Befriending services, Falls support etc

VCSE Sector Contribution

Community Dental Services to vulnerable people

Dentistry

Addressing isolation

Community mutual aid, BAMER, Travellers, groups etc

Range of IAPT services

Counselling

Community of place and interest engagement to shape planning, design and delivery

Housing Associations

Alcohol Advice Service

CAB advice in Mental Health Units

Homelessness and Accommodation

Alcohol and substance misuse

Debt and welfare rights advice

Engagement Challenges and how we are responding

Engaging a huge diverse sector with a defined structure	VCSE Alliance, - Topic approach, IC Strategy - System engagement - Virtual Platform - VCSE infrastructure engagement - New, less linear approaches
Moving away from the parent child relationship and becoming less risk averse	Awareness raising, relationship building, engaging at each step of the process, demonstrating success
Investment; Approaches that maximise VCSE assets, rather than exclude	Procurement and commissioning framework Grants, investment at local level
VCSE Workforce; recruitment, retention, development, progression, volunteering	System workforce involvement; leadership and management training, secondments etc

Engagement Challenges and how we are responding

The Derbyshire VCSE sector Alliance

Taking account of the community of place, condition and interest perspective	Community engagement, insight, data interpretation
Embedding in initiatives, (TeamUp, Social Prescribing, Hospital Discharge)	Topic based discussion, relationship building, Hospital Discharge initiatives, Social Prescribing Leading for System Change
Building VCSE capacity to be proactive	Provider Collaborative/ Lead Agency models, skills Governance, standards, impact measurement Infrastructure

The behaviours, structures and approaches we need to work together effectively will be brought together in a MoU between the VCSE Alliance and the ICB (on behalf of the system). Target to sign off by April 2023. Senior cross partner/system group to oversee.

Some ICB Asks

The Derbyshire VCSE sector Alliance

- 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
- Use the MoU as a tool to build and strengthen how we work together

The Derbyshire VCSE sector Alliance

Engaging VCSE Sector in Derbyshire ICS, progress and future priorities

1. Context

Voluntary, community and social enterprise (VCSE) organisations make a significant contribution to the health and well-being of people living in Derbyshire. There are thousands of groups of all sizes providing a variety of roles ranging from service provision to the advocacy and support of communities of place, condition and interest. The Integrated Care System approach seeks to engage the VCSE sector as an equal partner with statutory health and social care bodies to make best use of its strengths including addressing health inequalities and the wider determinants of ill health.

The ICS guidance stresses the need to look at different ways of working and this particularly applies to the engagement of the VCSE sector as maximising the VCSE sector as a partner means moving away from an operational “parent-child” relationship to a strategic equal one. This presents a range of structural, cultural and process challenges. In 2021, funded by NHSE, work began in Derbyshire to look at these challenges and how they might be addressed. Now funded by the ICB but hosted within the VCSE sector, this work has continued in 2022. An analysis follows of where we have got to and where our future priorities might be. There is a lot here (with a lot of inter connections) and making progress requires the commitment of all partners and organisations across the VCSE sector. Maximising the full potential of the VCSE sector is to the whole systems benefit and therefore a whole system challenge.

2. Engagement in ICS Structures

An immediate logistical challenge is how to best engage a sector containing thousands of organisations with a defined structure. This is not just about places at different levels of the partnership structure but also about how such places relate to a wider VCSE constituency.
In December 2021, a Derbyshire VCSE Alliance was established. This was set up as a network open to all VCSE infrastructure organisations and any frontline VCSE organisation. Many VCSE groups will choose to engage through local infrastructure organisations, but others may want to do so directly. This has been particularly true of county based VCSE groups where it is not easy to engage through a number of local bodies. In August 2022, Alliance members reviewed structure and decided to continue as a network rather than a constituted organisation. The Alliance now has its own branding and works closely with the Derby and Derbyshire VCSE Infrastructure Alliance which brings together all of the local VCSE infrastructure organisations which are engaging the local VCSE sector with their Local Place Alliances.

NHSE Voluntary Sector Team guidance promotes VCSE engagement at all parts of ICS structures and processes. This helps to build understanding but also reflects the move away from a more transactional approach. The VCSE sector should be involved at all points of the planning cycle including the gathering and assessment of hard and soft intelligence to determine priorities and the planning design and delivery of services.

The VCSE Alliance has worked on this and has so far developed and filled VCSE places on most parts of the ICS structure, (Local VCSE infrastructure facilitates VCSE sector engagement with Local Place Alliances). This has included places on the Integrated Care Partnership, the Integrated Place Executive and on initiatives such as the Population Health Management programme. It will also fill places on the new County Place Partnership and has responded to an invitation to engage with the Integrated Care Board Population Health and Strategic Commissioning Committee. In doing so, it has aimed successfully to broaden the range of people from the VCSE sector involved to support a more “distributed leadership” approach.

In addition, the Alliance works closely with both local VCSE infrastructure and networks engaging VCSE groups with the Mental Health, Learning Disabilities and Neurodiversity Delivery Board, (which is generating some excellent examples of partnership working). It may be helpful to have some common guidelines around expectations around VCSE engagement at Local Place Alliance level.

Engagement is more than places on partnership structures. It requires engagement in partnership planning processes that support the Integrated Care Strategy. It also means connecting a wide and diverse sector with VCSE delegates in different parts of the structure. One of the key challenges articulated by VCSE groups is knowing where in the ICS to engage with capacity being a real problem. Four initiatives aim to help.

- We have been working with the Communications Team at JUCD and NHSE to explore the potential for the new FutureNHS Platform to act as a VCSE Alliance Virtual Network within a JUCD workspace. This would provide another way for VCSE groups to communicate across the sector and with delegate colleagues.

- The VCSE Alliance is taking a “topic based” approach. This aims to bring out system leads to discuss key issues and developments with VCSE colleagues to explore the potential for greater VCSE sector integration. The first of these topics was hospital discharge and worked very well. Other topics might include TeamUp, the ICS Strategy, Workforce Development etc.

- VCSE Alliance Members have been working closely with JUCD to explore community engagement. This work embraces both communities of place and communities of interest/condition. The challenge is how to build on existing approaches and engage different types of community in the planning, design and delivery of services. This is not only about community engagement but also ensuring that the system will change in response to feedback.

- An engagement event will bring together system leads with the VCSE sector to explore progress in embedding the VCSE sector within the Integrated Care System and this will then be supported by a strategic cross sector group that could be linked into the ICP.

There is much to build on in engaging the VCSE sector as a full partner and maximising its contribution, not least the passion and commitment of people across all sectors. At the same time, as can be seen above, there is still much to do. The aspirations around engagement and what this should mean in practice, will be captured in an agreement that will be signed off by the VCSE Alliance and the Integrated Care Board on behalf of the ICP. This is a requirement of ICS Guidance.

Key Work Areas

Achieved so far	Looking forward
Establishment and development of VCSE Alliance	Continued development of Alliance. Connection with and support for consistent VCSE engagement with Local Place Alliances
Initial drafting of agreement setting out how VCSE sector should be embedded in the ICS and setting out success measurements	Refine with partners, sign off by VCSE Alliance and ICB. Strategic cross sector, system wide annual event to discuss progress
Places for VCSE sector agreed and recruited in most parts of ICS structure, supported at meetings	Explore VCSE sector engagement on other parts of the ICS. Develop new VCSE virtual platform to link delegates with wider sector and provide complementary virtual engagement
Small engagement fund identified and criteria developed	Agreement on criteria and roll out
Initial agreement on VCSE engagement in ICB through Strategic Commissioning Committee	Develop this opportunity and look at further ways of building this relationship
Support for new cross sector Mental Health, Learning Disability and Neurodiversity Alliance with additional recruitment of VCSE Strategic Engagement Manager	Changes to engagement and commissioning approach to facilitate effective VCSE sector engagement
Alliance topic-based approach agreed and piloted successfully with hospital discharge	Further topic-based sessions in areas such as TeamUp, workforce development, ICS Plan and commissioning
Initial engagement in ICS Plan	Support for extensive VCSE engagement through providing intelligence and helping with design
Work with system partners to establish VCSE engagement at all parts of the planning cycle	Promote engagement at earliest stage rather than few steps later
Provision of information to promote engagement opportunities to the VCSE sector	Extension of information flow using Virtual Platform
Work with JUCD to set out an approach to engage communities	Work with partners to put this into practice ensuring communities of place and interest are influencing priorities and service planning

3. <u>VCSE Investment</u>

Statutory partners already have funding arrangements with VCSE organisations through grants or commissioned services. This has underpinned a transactional relationship and ICS guidance has encouraged a more collaborative approach to commissioning and other investment approaches. In Derbyshire approaches are not necessarily consistent and don't always maximise the value from small and local VCSE organisations. Work has already started to explore these issues with JUCD statutory colleagues, and we can build on this to,

- Explore the difference between grants and commissioning and which are best used in particular circumstances
- Explore approaches that have worked in other systems
- Look at how local VCSE organisations can better help to shape priorities, service scope and scoring criteria for tenders
- Support an approach that is asset based and provides the best opportunity to build on the expertise of a wide diversity of VCSE organisations in Derbyshire
- Ensure that processes are delivered in a way that is sympathetic to VCSE sector timescales and which encourages collaboration
- Utilise data from existing activity such as social prescribing to support "smart commissioning", (investing in VCSE activity where demand is highest)
- Support this with a consistent approach to impact and outcome measurement
- Work towards simple, longer-term funding arrangements that are joined up between funders
- Recognise the different priorities within parts of the county
- Identify additional sources of funding
- Develop a clear joined up approach to VCSE infrastructure investment
- Identify and clarify location of and access to funding sources. How can we ensure that VCSE providers get to hear about tender opportunities? Where does system wide VCSE funding best sit, within the ICB or at Place? Should there a small grants facility delegated to Place Alliances to support small local VCSE organisations?

The aspiration would be to develop a VCSE Investment Strategy and a commissioning framework that better facilitates the engagement of the VCSE sector.

Achieved so far	Looking forward
Identification of range of commissioning issues restricting VCSE engagement from local and system wide events. Cross sector endorsement of work to address this at ICP	Cross sector working group to explore commissioning framework
Work with ICB/DCC on general and infrastructure funding approach. Infrastructure funding review underway	Development of VCSE Investment and Development strategy that incorporates infrastructure approach
Work on social prescribing reveals intelligence on local VCSE investment needs	Approach with Local Place Alliances to use a smart commissioning approach to invest in local capacity

4. <u>Enabling Support for the VCSE Sector</u>

A diverse VCSE sector has diverse support needs. As a system we need,

- A healthy and diverse sector that reflects the needs of its communities to help effectively address determinants of ill-health and health inequalities.
- VCSE support services of consistent quality that can be accessed from any part of the county but which also reflect the nature of the local VCSE sector
- Sustainable infrastructure provision that can plan long-term
- Support to help VCSE providers be "commission ready", (this would include looking at issues of governance, quality, impact, marketing, product awareness etc).
- Support to VCSE organisations to enable them to engage with the system and engage the communities they serve in identifying need, determining priorities and designing services. With communities of place this will be particularly important at Place Alliance level
- Support to help VCSE organisations work together. This is needed to help small/medium VCSE organisations to engage with the ICS and to take advantage of commissioning changes. Amongst other things this would mean support for the

development of VCSE provider collaboratives. This also means helping organisations work together to identify and address gaps.
- Support to help the sector promote its contribution and to advocate for its involvement
- Support to develop the VCSE workforce
- The ability to address barriers that get in the way of effective engagement such as data sharing.

Local VCSE infrastructure organisations are the primary provider of these services and work is underway to bring them, commissioners and frontline organisations together to explore needs, what is happening now, gaps and how these might be filled. Support is also provided at system level by the VCSE "Engaging the VCSE sector in the ICS" lead, the VCSE Strategic Engagement Manager for Mental Health, Learning Disabilities and Neurodiversity and network support posts. System partner staff also have a role to play where their focus is on areas where the VCSE sector has a contribution to make. This includes, workforce development, planning, commissioning, communications, data interpretation/collection and funding. Bringing these system "enablers" together would help to coordinate efforts across the system. Finally, there may be scope to look at other support mechanisms including peer support between groups and consultant support where there are specialist needs.

Achieved so far	Looking Forward
Cross sector infrastructure working group has started to look at future provision	Approach to long-term investment in VCSE infrastructure agreed
Cross sector enablers group concept shared and supported by other partners	Cross sector enablers group established
Extensive VCSE sector engagement achieved in ICS structures, awareness of VCSE sector raised and relationships established	Continued work to extend VCSE engagement and turn this into practical outcomes
Initial thinking in parts of county around a VCSE provider collaborative approach	Identify an approach to help VCSE organisations collaborate to access tender opportunities
Identification of local approaches to gather impact information on VCSE services	Gather practice and develop guidance based on this
Approaches to establish data sharing protocols	Attempt to move work forward

5. Workforce Development

ICS Guidance talks about looking at combined health and social care partners as "one workforce". The VCSE workforce is quite substantial (10,000 FTE staff in the County alone in 2011) and also has quite significant differences in the use of volunteers, (up to 70% of VCSE organisations have no paid staff) and the engagement of unpaid Trustees.

There has been no recent analysis done of the VCSE workforce but it is apparent that there are significant challenges that would benefit from a system approach. These include,

- Significant recruitment problems in common with other sectors but exacerbated by less competitive salaries. Remuneration and recruitment approaches including a look at secondment opportunities might be helpful
- Lack of progression/succession planning within and across the VCSE sector
- The often-isolated role of VCSE CEOs and a consequent need for leadership/management development and coaching/mentoring/peer support.

Programmes such as the Mary Seacole programme have already been opened up to the VCSE sector and this is something to build on

- Challenges in recruiting volunteers including Trustees which could benefit from exploring volunteering from within the workforces of system partners
- Building mutual understanding and awareness between system partners and how to work effectively together. This might be particularly true for system staff that need strong links with VCSE organisations such as commissioners. Input into induction may be one way of doing this.
- Linking training and development to other key ICS areas such as community engagement
- Looking at the potential development of volunteering within hospitals and other care settings

Achieved so far	Looking forward
Involvement in system wide Workforce Advisory Group	Explore potential for a VCSE workforce analysis and VCSE workforce strategy
Engagement in work on leadership and quality conversations	Generate VCSE leadership development opportunities through access to existing programmes and new initiatives such as learning sets
Identification of workforce development needs arising from other work on relationship building and commissioning	Raise understanding amongst commissioners and others around working with the VCSE sector through approaches such as induction
Engagement in Mental Health, Learning Disability and Neurodiversity workforce planning	Incorporated into general workforce plan
	Look at how to support the contribution of volunteering

6. Practical Outcomes

It is important that the system can show that the approaches detailed above can lead to practical successful outcomes. Two examples below are pieces of work underway that should do this.

- Social Prescribing can provide an effective way of providing individuals with non-medical support. Nationally funded and based within VCSE infrastructure organisations or GP practices, social prescribing is connecting with local VCSE services and collecting intelligence on local need. However, it could be done better. There is no funding following referrals for provider organisations, the intelligence collected doesn't seem to influence planning/investment and social prescribing doesn't seem particularly well connected with other system initiatives. An NHS Leadership Academy facilitated "Leading for System Change" initiative is bringing system players together to explore challenges and improvements around social prescribing. This will take proposals to the Integrated Place Executive for discussion and should result in improvements.

- More recently as one of the Alliance Topic based discussions, the VCSE Alliance has worked with JUCD to explore how the VCSE sector contribution might be better joined up to work on hospital discharge. A lively session produced thoughts which others unable to attend have been invited to add to online. What is happening in other

systems is also being explored. Alongside other recommendations there will be proposals around improving the VCSE sector connection which may include looking at VCSE sector hubs linked to discharge processes. As a result of this work, we were able to respond quickly to short timescales to support a number of VCSE initiatives that should help with discharge.

It is interesting that discussions on different topics all suggest the concept of local VCSE sector hubs that could link across and into hospital discharge, social prescribing, initiatives such as TeamUp and with Local Place Alliances to engage a diversity of organisations and provide intelligence and thoughts on commissioning priorities. Local VCSE infrastructure would have a key role in building on existing practice to explore such an approach.

Achieved so far	Looking forward
Social prescribing adopted as topic for the Leading for System Change programme now underway with cross sector involvement	Proposals to improve social prescribing and to better link it into the system developed and taken forward
Cross sector hospital discharge session held and analysis of approaches elsewhere	Proposals to better integrate VCSE sector provision with hospital discharge developed and taken to system
	Areas where greater VCSE integration would be beneficial to the ICS (such as Teamup) identified and progressed in a similar way
	Consideration as to the potential to join up VCSE engagement in social prescribing, hospital discharge and TeamUp at local level

7. Culture

The ICS guidance promotes the need to do things differently and engage the VCSE sector as a partner in a collaborative rather than transactional way. As another ICS summarises, moving away from a parent child to a more adult relationship. This is not as easy to achieve as it sounds. Statutory partners don't always understand the breadth of the sector, it's potential contribution and the challenges it faces in engaging in the system. VCSE organisations don't always understand the nature of statutory partners and the restrictions they operate under. Previous relationships have often been operational which is reflected in the nature and level of the contact. Although the system may be new, the people are generally the same, so this is requiring people to think, work and behave in different ways. Working and engaging with the VCSE sector may also require a less risk averse culture with a greater focus on what could be achieved rather on what might go wrong. Work so far has helped to build greater understanding and foster new relationships, particularly at strategic level. Improved understanding has helped discussions to become more honest and open. This has been achieved through engagement in the system, in partnership programmes and through information.

The aspiration to work differently is happening in a difficult context with intense pressure on budgets and services. However, the need for strong partnerships is more important than ever in these circumstances. The VCSE sector can contribute at all points of the planning cycle and should be involved at inception rather than at several points down the line. The question should be "why wouldn't you involve the VCSE sector?" rather than "why would you?".

At the same time, the VCSE sector also has to adjust. We need to be willing to understand the pressures that statutory colleagues are under and to focus on how we can help solve problems rather than starting with funding. We also need to collaborate better internally and handle the element of competition.

Building a partnership culture is essential for success. Without is the best systems will fail. The activities outlined above can help and the agreement between the VCSE Alliance and the ICB should set out the behaviours we all commit to including,

- Valuing everyone's experience and expertise equally
- Committing to collaborative working
- Following commitments through and walking the talk
- Being outcome focussed and willing to cede leadership to where it works best
- Taking time to understand and take account of the ways different organisations and sectors work
- Being creative and working differently to best engage VCSE organisations being careful not to undermine diversity through structure
- Involving VCSE organisations at all stages, in setting the destination and planning the route as well as the choice of vehicle
- Committing the time and resources collaboration needs
- Acting as equals and move away from traditional "parent-child" type relationships
- Accepting constructive challenge
- Learning from what we do and from what happens elsewhere
- Ensuring collaborative working is generating benefits for service users. If it isn't, it isn't working

Finally, it is important that we are a learning system, that we build in time to reflect on what is working well and what could be done better. In relation to VCSE engagement this will be helped by having a clear set of measurements that capture what successful VCSE engagement would look like and which can be revisited at the cross sector strategic sessions.

Achieved so far	Looking forward
Relationships established particularly at strategic level through programmes such as Executive Leadership and Population Health Management as well as direct contact	Continue to establish through system engagement and development of distributed leadership
Awareness raised through information and presentation including Derbyshire Dialogue and Team Derbyshire	Develop information flow through mechanisms such as the Virtual Platform and promotion through a VCSE video and a system wide strategic event
Initial thoughts generated on what successful engagement of VCSE sector would look like	Discussion of indicators to be included in the VCSE Alliance/ICB/ICS agreement
Identification of behaviours and approaches needed for effective partnership working	Input into workforce development activity together with a quick guide to "considerations when working with the VCSE sector"
	Provide opportunities for reflection and learning as to how work to engage the VCSE sector is developing

Summary of Key Priorities

Area of Work
Development and signing off of VCSE Alliance and ICB MoUwhich includes agreed behaviours and outcomes
Development and launch of VCSE Alliance Virtual Platform
Commissioning Framework that facilitates VCSE contribution supported by building of VCSE sector collaborative approaches
Strategy and roadmap for VCSE infrastructure support services
Approach in place to engage communities of place and interest in system
VCSE engagement in ICS structure including ICB and ICS development
Further development of VCSE hospital discharge contribution with further topics including TeamUp to follow
Strategic system wide event on VCSE engagement
VCSE Investment and Development strategy
VCSE Workforce Development Strategy
Working to engage the VCSE sector in the Mental Health, Neurodiversity and Learning Disability Delivery Board/Alliance
Proposals developed to improve social prescribing
Proposals to improve link up of VCSE contribution to hospital discharge

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

19th January 2023

Item: 070

Report Title	Integrated Assurance and Performance Report
Author	Brigid Stacey, Deputy Chief Executive and Chief Nurse Officer Craig Cook, Chief Data Analyst Amanda Rawlings, Chief People Officer Craig West, Acting Associate Chief Finance Officer
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer
Presenter	Introduction – Dr Chris Clayton, Chief Executive Officer Quality – Brigid Stacey, Deputy Chief Executive and Chief Nurse Officer Performance – Zara Jones, Executive Director of Strategy and Planning Workforce – Amanda Rawlings, Chief People Officer Finance – Darran Green, Acting Operational Director of Finance

Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐

Appendices	Appendix 1 – Integrated Assurance and Performance Report
Assurance Report Signed off by Chair	Not Applicable
Which committee has the subject matter been through?	Various ICB Committees

Recommendations
The ICB Board are recommended to **RECEIVE** the Integrated Assurance and Performance Report for assurance purposes.
Purpose
The purpose of this report is to present progress against compliance and commitment targets as required for 2022/23. The report includes progress against quality, performance, workforce and finance.
Background
The Integrated Assurance and Performance Report provides the ICB Board with progress against compliance and commitment targets during 2022/23.
Report Summary
The report includes assurance against the following: • Quality; • Performance; • Workforce; and • Finance.

Identification of Key Risks		
Risks are identified within the report.		
Has this report considered the financial impact on the ICB or wider Integrated Care System?		
Yes ☒	No☐	N/A☐
Details/Findings As detailed within the finance section of the report.		**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?		
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 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 The ICB is committed to the achievement of Net Zero Targets and the delivery of the Derbyshire ICS Green Plan.					

NHS
Derby and Derbyshire
Integrated Care Board

Integrated Assurance & Performance Report

January 2023

Dr Chris Clayton – ICB Chief Executive Officer
Brigid Stacey – Deputy Chief Executive Officer and Chief Nurse Officer
Zara Jones – Executive Director of Strategy & Planning
Amanda Rawlings – Chief People Officer
Darran Green - Acting Operational Director of Finance

Quality

Brigid Stacey – Deputy Chief Executive Officer and Chief Nurse Officer

Quality – Community Providers (1)

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Eating Disorders

- The Children and Young People (CYP) Eating Disorder Access Recovery Action Plan (RAP) monitors progress against actions, activity trajectory, and risks to delivery. Progress is monitored at the MH, LD & A Delivery Board.
- Significant additional funding was provided for a comprehensive service for people with a primary eating disorder in Derby City and the High Peak 2021/22. In 2022/23 it is anticipated that the service will increase to a similar extent as the improved access is rolled out to other areas of Derbyshire.
- Development of a Derbyshire wide written agreement between providers in Community Eating Disorders Service, secondary care, and primary care is ongoing to ensure a consistent approach to medical monitoring for CYP with eating disorders.
- Expansion of services to 7 days a week, across extended hours.
- Providing Paediatric Inpatient support for ED, including specialist ED play therapy.
- Work with the East Midlands CAMHS Provider Collaborative to ensure pathway integration with specialist tier 4 inpatient services.

Quality – Community Providers (2)

Derby and Derbyshire Integrated Care Board

Perinatal Mental Health Services

- Perinatal Community recovery oversight group formed to monitor progress against Quality Improvement plans in the RAP on a monthly basis. A second service wide group meets six-weekly and includes clinical Community Perinatal staff to discuss progress and plan internal service plans and action from the oversight group.
- Recruitment of Psychologists into the Maternal Mental Health Service is complete, additional Psychology recruitment continues for the Perinatal Community Service with a Band 8a Psychologist out to advert at present. Further recruitment into the New Year will continue.
- Additional SystmOne service wide training on recording assessments consistently has been undertaken. This has also identified a more consistent way of recording referrals.
- Additional staff groups have been added to those who will do assessments including OT and social worker. Additional Assistant Psychologist will commence assessments under supervision and reviewed regarding number of assessments.
- An exercise to ascertain referrals by GP has been undertaken showing the need for wider engagement with referrers across Derbyshire and plans for awareness raising of the service are being formulated.

Quality – Acute Providers (1)

Derby and Derbyshire Integrated Care Board

Infection Prevention & Control – Clostridium Difficile (C.diff)

The ICB have a YTD total of 254 cases against a trajectory of 252, actions taken to date:

- Q1 increase reviewed in Derbyshire Infection Prevention and Control System Assurance Group (IPCSAG) and at internal Trust Infection Control Committees;
- Acute Provider IPC leads from both trusts commenced a deep dive to understand the trends and themes and met with ICB IPC reps at the end of August 2022 to review findings;
- action plans developed to address the rise in C Diff numbers;
- 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; and
- visits by NHSE/I and the ICB to CRH, RDH, QHB sites and focus groups with staff undertaken at the end of November and beginning of December 2022.

Assurance around the implementation of the action plans will be gained through attendance at Trust internal Infection Control Committees and reported through the Clinical Quality Review Groups.

Quality – Acute Providers (2)

Derby and Derbyshire Integrated Care Board

Hospital Standardised Mortality Ratio (HSMR)

The most recent HSMR figures from July 2022 were reported to the UHDB Trust Board and ICB Clinical Quality Review Group Meeting in November 2022. It is of note that the rate has increased by 4 in July 2022 to 108.7 (May 2022 – 104.11; June 2022 – 108.9). The top 7 codes underneath the HSMR have been identified as requiring further investigation and action, detailed assurance work is underway. Actions in place:

- monitoring monthly Structured Judgement Review (SJR) reporting compared to deaths recorded per business unit. Work is in progress as there are many delayed reviews;
- a mortality summit was held on the 20 October 2022 to share learning from SJR's, Medical Examiner as well as good practice;
- from 1 November 2022, all deaths that have occurred within a 48-hour Emergency Department (ED) length of stay will have a SJR to identify if the prolonged ED stay has contributed to the cause of death;
- End of Life improvement group working to improve understanding around AMBER care bundle completion;
- the CORS system is having the learning disability death SJR's module added to it; and
- a more robust process to report on avoidable deaths has been developed and launched by triangulating coronial referrals with risk and SJR's.

Quality – Acute Providers (3)

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Perinatal Mortality Review Tool (PMRT)

- UHDB Stillbirth rates rising slowly with a current rate of 3.89/1000 (4 cases reported in November 2022) and Neonatal death rates showed a slight decrease to 2.06/1000 (2 cases reported in November 2022). Rates are below the ONS (2021) rate but higher than the MBRRACE (2022) rates based on 2020 data. Monthly reporting of cases to the LMNS is requested with a further deep dive in March 2023 for assurance.
- CRH stillbirth rate is 2.76/1000 and the neonatal death rate is 0.35/1000. Both are below the national averages.
- Both Trusts have Patient Safety Review themes including foetal surveillance and escalating major obstetric haemorrhage, with actions which are reviewed monthly.

Performance

Zara Jones – Executive Director of Strategy & Planning

Urgent & Emergency Care

Derby and Derbyshire Integrated Care Board

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire ICB Current Month	NHS Derby & Derbyshire ICB YTD	NHS Derby & Derbyshire ICB consecutive months non-compliance	Chesterfield Royal Hospital FT Current Month	Chesterfield Royal Hospital FT YTD	Chesterfield Royal Hospital FT consecutive months non-compliance	University Hospitals of Derby & Burton FT Current Month	University Hospitals of Derby & Burton FT YTD	University Hospitals of Derby & Burton FT consecutive months non-compliance	NHS England Current Month	NHS England YTD	NHS England consecutive months non-compliance
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Nov-22	↑	66.9%	70.3%	86	71.5%	79.8%	15	61.3%	62.2%	86	71.7%	73.8%	86
		A&E 12 Hour Trolley Waits	0	Nov-22					48	217	8	323	3259	28	37837	237703	86

EMAS Dashboard for Ambulance Performance Indicators

	Area	Indicator Name	Standard	Latest Period	Direction of Travel	East Midlands Ambulance Service Performance (NHSD&DICB only - National Performance Measure) Current Month	YTD	consecutive months non-compliance	EMAS Performance (Whole Organisation) Current Month	YTD	consecutive months non-compliance	EMAS Completed Quarterly Performance 2022/23 Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	NHS England Current Month	YTD	consecutive months non-compliance
Urgent Care	Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Nov-22	→	00:08:46	00:09:03	29	00:09:02	00:09:30	28	00:09:37	00:09:30			00:09:26	00:09:16	19
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Nov-22	→	00:15:01	00:15:52	10	00:16:21	00:17:14	17	00:17:31	00:17:13			00:16:51	00:16:29	17
		Ambulance - Category 2 - Average Response Time	00:18:00	Nov-22	→	00:57:09	00:54:20	28	00:58:05	01:04:20	29	01:04:56	01:02:40			00:48:08	00:50:17	28
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Nov-22	→	02:05:52	01:58:32	28	02:08:19	02:23:39	28	02:33:40	02:24:47			01:45:18	01:51:08	20
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Nov-22	→	07:42:17	07:38:10	28	07:44:13	08:30:26	28	08:15:21	08:25:17			06:40:57	06:58:45	20
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Nov-22	→	04:34:05	06:14:29	20	06:05:46	08:09:01	20	08:25:38	08:10:03			08:06:59	08:00:32	20

111 Indicators

Area	Indicator Name	Standard	Latest Period	Direction of Travel	DHU Performance Current Month
111 Key Indicators	Abandonment Rate	5%	Oct-22	↓	3.9%
	Average Speed of Answer	00:00:27	Oct-22	↓	00:01:31

Key:	
	Performance Meeting Target
	Performance Not Meeting Target
	Indicator not applicable to organisation

Performance Improved From Previous Period	↑
Performance Maintained From Previous Period	→
Performance Deteriorated From Previous Period	↓

Planned Care & Cancer

Derby and Derbyshire Integrated Care Board

Key:	
	Performance Meeting Target
	Performance Not Meeting Target
	Indicator not applicable to organisation

Performance Improved From Previous Period	↑
Performance Maintained From Previous Period	→
Performance Deteriorated From Previous Period	↓

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Planned Care	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Oct-22	↓	58.0%	60.0%	57	59.8%	61.8%	42	55.6%	57.5%	58	60.1%	61.2%	80
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-22	↓	8128	47725	33	1309	8904	31	8052	47072	32	383724	2560697	186
		Number of 78 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-22	↑	1212	7742	19	134	1274	19	1140	6459	19	46157	376734	19
		Number of 104 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-22	↓	19	682	19	4	112	18	7	483	19	1822	34216	19
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Oct-22	↓	33.60%	37.18%	53	32.02%	31.66%	31	33.61%	37.79%	32	27.50%	28.22%	110
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Oct-22	↑	87.1%	82.3%	26	91.9%	87.1%	4	81.5%	77.4%	26	77.8%	77.6%	29
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Oct-22	↑	88.7%	83.2%	5	89.2%	81.7%	2	92.4%	88.2%	1	75.7%	69.1%	29
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Oct-22	↓	69.9%	71.7%	14	79.7%	77.9%	0	65.8%	68.2%	15	68.5%	69.7%	19
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Oct-22	↓	85.3%	86.8%	22	83.2%	83.6%	14	88.3%	89.4%	27	92.0%	92.0%	22
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Oct-22	↑	67.1%	69.5%	35	68.2%	81.5%	2	81.6%	79.1%	17	80.9%	81.2%	51
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Oct-22	↑	100.0%	97.7%	0	100.0%	100.0%	0	100.0%	96.9%	0	98.8%	98.2%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Oct-22	↑	85.7%	83.6%	7				84.2%	71.5%	7	90.8%	90.9%	8
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Oct-22	↑	53.5%	54.5%	44	70.3%	80.2%	39	49.6%	51.2%	54	60.3%	61.5%	82
		First Treatment Administered - 104+ Day Waits	0	Oct-22	↑	58	307	79	5	51	54	57	284	79	1788	11811	82
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Oct-22	↓	46.5%	48.6%	42	37.8%	31.1%	42	63.3%	72.2%	23	67.1%	68.9%	55
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Oct-22	↑	82.6%	80.7%		91.3%	90.1%		83.3%	81.4%		73.9%	74.7%	
	Cancelled Operations	% Of Cancelled Operations Rebooked Over 28 Days	N/A	2022/23 Q2	↑				32.1%	39.8%		22.0%	19.5%		21.3%	23.4%	

Mental Health

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Pathway	Indicator	Target	Actual	National Benchmark	Latest period	Provider Breakdown						RAP Date Agreed	RAP Recovery Date
						DHcFT	DCHS	CRH	Insight	Trent	Vita		
IAPT	Access Rate	2.1%	2.8%	2.4%	Aug-22								
	Recovery Rate	50%	47.6%	50.1%	Aug-22	51.5%			50.0%	45.0%	58.3%		
	Waiting times - 6 weeks	75.0%	65.0%	88.8%	Aug-22	80.4%			90.0%	53.8%	91.7%		
	Waiting Times - 18 weeks	95.0%	100.0%	98.5%	Aug-22	100%			100%	100%	100%		
	1st to 2nd treatment >90days	*10.0%*	***8.0%***	*20.0%*	*Jun-22*								
	Recovery Rate - White		***53.0%***	*52.0%*	*Jun-22*								
	Recovery Rate - BAME		***49.0%***	*46.0%*	*Jun-22*								
CYP Community	*Access - 1+ Contact*	*12,000*	***11,565***		*Jun-22*								
	Access Rate	*2.8%*	***12.4%***	*0.4%*	*Jun-22*								
CYP Eating Disorder	Waiting Time - Urgent - 1 week	95.0%	57.9%	63.6%	Q2 22/3	53.8%		66.7%				✓	31/03/22
	Waiting Time - Routine - 4 weeks	95.0%	65.8%	68.5%	Q2 22/3	62.1%		74.4%					
Dementia	Diagnosis Rate	67.0%	62.5%	62.0%	Sep-22								
Perinatal	Access Rate (rolling 12 months)	10.0%	4.4%		Sep-22	3.7%						✓	31/03/22
EIP	2 week waits	60%	73%	68.20%	Sep-22	66%							
Out Of Area Placements and Inpatients	OAP Bed Days	468	630		Aug-22	630							
	Adult Acute Long LoS (60+ days)	8	10	8.0	Oct-22	10							
	Older Adult Acute Long LoS (90+ days)	8	9	11.9	Oct-22	9							
	Discharges followed up within 72 hours	80.0%	94.4%	79%	Oct-22	94.4%							
	Admissions with no prior contact (all)		15%	13.0%	Oct-22	15%							
	Admissions with no prior contact (white British)		11%	11.0%	Oct-22	11%							
	Admissions with no prior contact (BAME)		12%	16.0%	Oct-22	12%							
SMI	SMI Physical Healthchecks	60.0%	38.1%	43.5%	Q2 22/23	Primary Care							
IPS	Individual Placement Support		235		Sep-22	235							
Community Mental Health	Access (2+ contacts)	*9,495*	8,736		Oct-22	8,736						✓	31/12/22

Please note:

- Several indicators still cannot be updated this month due to the data being unavailable nationally. These are shown by having red text in the 'Indicator' and 'Latest period' columns.
- Blank cells show data items that are still being sourced.
- Grey cells show data items that are not relevant due to that service not being provided by that provider, no agreed target or no national benchmark.

Workforce

Amanda Rawlings – Chief People Officer

Workforce Performance Headlines

Derby and Derbyshire Integrated Care Board

Table 1: Total Derbyshire Health & Care Workforce

Organisation	Headcount	FTE
Derbyshire - Adult Social Care	29,000	21,460.00
University Hospitals Derby and Burton	13,933	11,971.80
Derbyshire Community Health Services	4,352	3,524.53
East Midlands Ambulance Services	4,034	3,854.49
Chesterfield Royal Hospital	5,018	4,202.88
General Practice Staff	3,678	2,735.00
Derbyshire Healthcare	2,922	2,565.04
Derbyshire Health United	1,923	1,600.00
NHS Derby and Derbyshire CCG	492	436.80
Primary Care Network (additional roles reimbursement scheme)	315	277.00
Total	**65,667**	**52,627.54**

Table 2: Key NHS People Measures

Measure	*UHDB*	*CRHFT*	*DHcFT*	*DCHS*	*EMAS*
Vacancy %	*7.68%*	*7.53%*	*4.69%*	*3.23%*	0.27%
Turnover %	*11.61%*	*10.28%*	*13.18%*	*9.53%*	0.92%
Sickness %	*5.62%*	*5.97%*	*7.04%*	*5.62%*	7.98%
Mandatory Training %	*86.87%*	*81.52%*	*86.62%*	*96.75%*	79.42%

Summary and Key Messages:

- **Table 1** describes the total health and care workforce in the Derbyshire Integrated Care System.
  - 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. We also set an ambition to reduce staff sickness, vacancies and improve retention.
  - We planned to reduce agency staff usage during 2022/23, but we are above plan due to operational demands and increased staff sickness and staff turnover for the period April to October, this improved during November and December.
  - We have increased the pool of bank staff, to reduce the reliance on agency staff.
  - Further plans are in place to increase our workforce to support the additional winter plan and virtual ward initiatives, progress to date show this is on track with increased staffing levels.

- **Table 2** shows a set of key people metrics, These people metrics are for NHS staff at present. This is an initial list of proposed metrics that we will iterate as time progresses. These metrics will provide quantitative data to measure progress against a number of domains, and they will be considered alongside qualitative data and data to enable a more comprehensive and nuanced understanding of progress
  - Vacancies have reduced by 124.78 WTE from the October to November position, the system is now reporting a total of 1,333.28 WTE vacancies
  - Recruitment to substantive positions has increased by 431.88 WTE from April to November 2022

Key People & Workforce Development Headlines

Derby and Derbyshire Integrated Care Board

System Wide People Development Work

Workforce

- Workforce Planning and Transformation Lead now in post focusing on ICS One Workforce Strategy and Plan
- Recruitment progressing to increase winter staffing capacity
- Working with Social Care partners to develop system support to tackle the workforce recruitment and retention challenge
- Reservist workforce model launched and available to Health and Social Care
- Collaborative work to develop our response to Industrial Action

Staff Support

- System wide health and wellbeing offer in place
- Focus on a cost of living support package for all staff across Derbyshire

EDI

- Progressing work to achieve a Cultural Intelligence inclusive recruitment process to tackle disparity and improve the experience of those with protected characteristics

System Development

- Co creation and development of the ICB strategic framework is under way
- ICS Organisational Development requirements being scoped
- The People Services teams are making progress on their 7 x 5 collaborative work programmes

Finance

Darran Green - Acting Operational Director of Finance

Month 8 Position

Derby and Derbyshire Integrated Care Board

Month 08 Position	2022/23 Year to Date Actuals and Likely Forecast Outturn					
Organisation	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's	Annual Plan £m's	Likely Forecast Outturn £m's	Forecast Variance £m's
NHS Derby and Derbyshire ICB	0.0	(1.4)	(1.4)	0.0	0.0	0.0
Chesterfield Royal Hospital	(0.8)	(10.5)	(9.7)	0.0	0.0	0.0
Derbyshire Community Health Services	(0.3)	(0.4)	(0.1)	0.0	0.0	0.0
Derbyshire Healthcare	(1.0)	(0.4)	0.7	0.0	0.0	0.0
East Midlands Ambulance Service	(1.2)	(0.8)	0.5	0.0	0.0	0.0
University Hospitals of Derby And Burton	(3.7)	(14.8)	(11.2)	0.0	0.0	0.0
JUCD Total	**(7.1)**	**(28.2)**	**(21.2)**	**0.0**	**0.0**	**0.0**

- Year to date (YTD) shows significant pressure across the system, pressure for efficiencies increases
- YTD system deficit position of £28.2m as at M8
- Likely case 2022/23 forecast outturn at M8 of £29.9m, a £5.5m improvement from M7
- The system has agreed a £19m deficit position for 22/23, a road-map has been developed between system partners to achieve this. The reported system FOT will move to this £19m in M9
- M8 System Capital position is £3.4m surplus with breakeven full year FOT expected

2023/24 Outlook

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- Current system shortfall against M8 efficiency target of £18.9m
- This position is bolstered by non-recurrent efficiencies which shall adversely affect our position into 2023/24
- Work is being undertaken 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
- In light of the challenging economic climate, extensive improvement will be required across the system
- It remains the intention in 2023/24 to ringfence resources for population health issues and help reduce health inequalities

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

19th January 2023

Item: 072

Report Title	Audit & Governance Committee Assurance Report – November to December							
Author	Suzanne Pickering, Head of Governance							
Sponsor (Executive Director)	Helen Dillistone, Executive Director of Corporate Affairs							
Presenter	Sue Sunderland, Non-Executive Member for Audit & Governance							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	N/A							
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, 24th November 2022 and 22nd December 2022							

Recommendations
The ICB Board are recommended to **NOTE** the Audit & Governance Committee Assurance Report.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Audit & Governance Committee on the 24th November 2022 and 22nd December 2022.
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 24 November 2022 and 22 December 2022

Matters of concern or key risks to escalate	Decisions made
Mandatory Training – The importance of all employees completing their mandatory training is to be flagged to all employees. The ICB's target is 95% for all mandatory training (which is currently not being met) however, it is recognised that there is a system issue in ESR which is affecting the accuracy of the figures which is being investigated.	1. The following HR Policies were approved: • Career Break Policy. • Disability & Long-Term Conditions Policy. • Disciplinary Policy. • Maternity, Paternity, Adoption, Shared Parental and Parental Leave Policy. • Secondary Employment Policy. • Secondment Guidance and Procedure. • Travel and Expenses Policy • Working Time Directive Policy. 2. Approved inclusion of a separate review of General Ledger and Financial Reporting controls in the 2022/23 Internal Audit Plan. 3. Approved External Audit Plan April to June 2022 re closure of NHS Derby and Derbyshire CCG 4. Approved the revised ICB Incident Response Plan and the Emergency Planning Resilience and Response Strategy which now fully reflects the requirements of a category 1 responder. 5. Approved revised ICB Scheme of Reservation and Delegation. Changes focus on simplifying arrangements whilst maintaining high levels of control and accountability, specifically. • 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.

Major actions commissioned or work underway	Positive assurances received
The process of the development, future monitoring, and reporting arrangements of the Board Assurance Framework (BAF) is ongoing but progressing well. The draft BAF will be reported to the ICB Public Board 19th January 2023.	1. The ICB Risk Register Report and the risks responsible to the Audit and Governance Committee, including the virtual approval received for the CLOSURE of Risks 04, 12 and 14. 2. Emergency Planning Resilience and Response (EPRR) Update: • ICB EPRR Core Standards Self- Assessment 2022-23 is non-compliant (mainly linked to the increased requirements as a category 1 responder), the committee were reassured that there is an action plan in place to move to forwards over the next 12 months. • Effective application of Business Continuity plans in relation to industrial action and potential power outages. • Operational (System) Control Centre set up. • Testing controls through Operation Arctic Willow desk exercise and critical incident response 3. Information Governance Assurance Report. 4. Digital and Cyber Security Report. 5. Conflicts of Interest Report 6. Internal Audit Recommendations Report – there are no outstanding actions. 7. Mandatory Training Compliance Report. 8. ICB Committee Meeting log.

Comments on the effectiveness of the meeting
The meetings are well focused and participants are engaged and contribute effectively. Now that the bulk of the policies have been reviewed and approved it has been decided that the committee can move to bi-monthly meetings. 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

19th January 2023

Item: 074

Report Title	People & Culture Committee Assurance Report – September to December							
Author	Amanda Rawlings, Chief People Officer							
Sponsor (Executive Director)	Amanda Rawlings, Chief People Officer							
Presenter	Margaret Gildea, Non-Executive Member, Chair of People and Culture							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Margaret Gildea, Non-Executive Member, Chair of People and Culture							
Which committee has the subject matter been through?	ICB People & Culture Committee – 7th September 2022 and 7th December 2022							

Recommendations
The ICB Board are recommended to **NOTE** the ICB People & Culture Committee Assurance Report.
Items to escalate to the ICB Board
At the September meeting the Committee members signed off the People and Culture Committee terms of reference, and reviewed the issues arising in achieving the year end position with the NHS agency control target. In December the Committee discussed the plans for managing the NHS industrial action as well as considering the plans to attract and retain additional staff for health and social care for winter and beyond.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the ICB People & Culture Committee on the 7th September 2022 and 7th December 2022.
Background
The ICB People & Culture Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
The ICB 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?
Not applicable.

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.					

Board Assurance Report

ICB People & Culture Committee on 7th September 2022 and 7th December 2022

Matters of concern or key risks to escalate	Decisions made
• Focus on recruiting and retaining staff for health and social care, to recruit and retain sufficient capacity for winter and beyond including the new Reservist Model. • The ICS NHS Trusts are over-spending against NHSE agency cap of £22.5m with a run rate of £23.1m at month 7 and forecast outturn is £38.7m. Medical agency is a significant proportion of agency staffing. • The impact of industrial action across NHS Providers and the joint working together to plan and mitigate impact on patients.	• Committee terms of reference agreed. • Board Assurance Risks for People and Culture discussed and agreed.
Major actions commissioned or work underway	**Positive assurances received**
• Development of the Integrated Care System One Workforce Strategy and Workforce Plan. ▪ Work has commenced on a 12 month nationally funded project to deliver against high impact actions to retain nursing and midwifery staff across Derbyshire.	• 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 second and third ICB People and Culture Meetings. 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

19th January 2023

Item: 075

Report Title	Quality and Performance Committee Assurance Report – November to December							
Author	Jo Hunter, Director of Quality							
Sponsor (Executive Director)	Brigid Stacey, Chief Nursing Officer and Deputy Chief Executive							
Presenter	Dr Buk Dhadda, Partner - Swadlincote Surgery Non-Executive Director for Quality & Performance Vice-Chair NHS Derby & Derbyshire Integrated Care Board							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Dr Buk Dhadda Chair, Derbyshire System Quality & Performance Committee							
Which committee has the subject matter been through?	Quality and Performance Committee – 24th November 2022 and 22nd December 2022							

Recommendations
The ICB Board are recommended to **NOTE** the Quality and Performance Committee Assurance Report.
Items to escalate to the ICB Board
None noted.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Quality and Performance Committee on 24th November 2022 and 22nd December 2022.
Background
The Quality and Performance Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
The Quality & Performance Committee (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 Quality and Performance 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

Quality & Performance Committee on 24th November 2022 and 22nd December 2022

Matters of concern or key risks to escalate	Decisions made
None noted.	The following items were approved by the Committee: • System Risk Register • Strategic Risk / Draft Board Assurance Framework • ICB Escalation Policy for Ratification • National Oversight Framework Templates
Major actions commissioned or work underway	**Positive assurances received**
The Committee received a presentation on the challenges of discharge across the system and noted there will be a further deep dive around the transformation elements of discharge at the meeting in January 2023. The focus of the presentation was the work around Virtual Wards and the Discharge to Assess nursing bed project.	The following papers were presented for assurance: • Integrated Performance Report • Assessment of the Winter Plan from a Quality and Safety Perspective • System Quality Group Assurance Report (September, October and November meetings)
Comments on the effectiveness of the meeting	
Those present agreed that the meetings had been effective. There was a discussion regarding the interface with the System Quality Group and it was agreed that a joint meeting be organised in the coming months.	

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

19th January 2023

Item: 076

Report Title	Population Health & Strategic Commissioning Committee Assurance Report – December to January							
Author	Julian Corner, (Chair) Non-Executive Member for 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 for 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 for Population Health and Strategic Commissioning and Public Partnerships							
Which committee has the subject matter been through?	Population Health & Strategic Commissioning Committee – 8th December 2022 and 12th January 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 8 December 2022 and 12 January 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 on 8 December 2022 and 12 January 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**
Feedback was received in regards to a previous discussion regarding strategic priorities.	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 • Decommissioning North DD ICB Parenteral Methotrexate Homecare Service • Operating Plan Guidance and Joint Forward Plan Guidance • Derbyshire Integrated Community Equipment Services - Budget Proposal
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. It was agreed that going forward PHSCC would now meet bi-monthly to agree business items and then in between have development sessions to focus on Integrated Commissioning, Population Health, outcomes and health inequalities.	

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

19th January 2023

Item: 077

Report Title	Draft 2022/23 Board Assurance Framework							
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 – Draft 2022/23 Board Assurance Framework							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	ICB Board – 17 November 2022							

Recommendations
The ICB Board is asked to **APPROVE** the ICB's draft 2022/23 Board Assurance Framework.
Purpose
The purpose of this report is to present to the Board the draft 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 17 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.

For each strategic risk, a corresponding BAF template has been populated. This can be explained as follows:

- The strategic risk is highlighted, together with the strategic aim it relates to.
- The committee agrees an overall assurance level against that risk, highlighted at the very top of the template, which is broken down in the 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 their February/March meetings, the committees will set a risk appetite score, that is to say the highest score that can be tolerated, which may be higher than, or at the same level as, the target score.
- The strategic risk is then broken down into the key threats that result in the overall risk, and the impacts that may result from those threats.
- For each threat, the existing controls and sources of assurance are considered, together with any gaps. 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 above templates, a summary sheet has been provided at Appendix 1 to enable an overview of the current position in terms of the risk scores and owners. The risk appetite score for the nine strategic risks will be confirmed at the Committee meetings in January and February and are marked "to be confirmed".

Each responsible Committee reviewed their draft strategic risks at the Committee meetings in December to populate the templates. The ICB's Internal Auditors, 360 Assurance, have also attended Committee meetings during December and January to support the Committee in their responsibilities relating to the BAF and to consider the scores for risk appetite and target score for the strategic risks.

Each Committee has given virtual approval of the draft BAFs prior to this report being presented to the Board.

Work will continue during this quarter to further refine the BAF templates and develop greater consistency in their completion, with the final BAF being presented to the March ICB Board and quarterly thereafter. As work continues to develop on the strategy, the strategic risks may therefore be further refined to reflect any changes.

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 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.*		**Has this been signed off by a finance team member?** 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	22.12.2022	10	20	20	TBC	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	22.12.2022	10	20	20	TBC	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	06.01.2023	9	16	16	TBC	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	06.01.2023	TBC 24.01.2023	16	16	TBC	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	09.01.2023	12	20	20	TBC	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	09.01.2023	9	12	12	TBC	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	06.01.2023	9	12	12	TBC	Partially assured
SR8	There is a risk that the system does not deliver digital transformation and establish intelligence and analytical solutions to support effective decision making.	Finance & Estates Committee	Jim Austin	17.11.2022	06.01.2023	8	12	12	TBC	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	06.01.2023	12	16	16	TBC	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** :Dr Buk Dhadda, 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: 22.12.2022**

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 **TBC**	**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 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)**
Threat 1	• Derbyshire ICS Integrated Quality and Performance Report • 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.	• Intelligence and evidence to understand health inequalities, make decisions and review ICS progress	• Quality and Performance Committee • System Quality Group
Threat 2	• System Quality infrastructure in place across Derbyshire • Integrated Care Partnership (ICP) established • System Quality & Performance dashboard to include inequality measures • NHSE Core20PLUS5 Improvement approach to support the reduction of health inequalities • Derbyshire ICS Green Plan • Derby and Derby City Air Quality Strategy	• ICS Health Inequalities Strategy	• Dr Robyn Dewis, Director of Public Health Derby City is Chair of Health Inequalities Group across the System • Integrated Care Partnership Terms of Reference • County and City Health and Wellbeing Boards • Core20PLUS5

Threat 3	• Cost Improvement Programme (CIP) and Service Benefit Reviews challenge process. • Prioritisation tool. • Population Health Strategic Commissioning Committee providing clinical oversight of commissioning and decommissioning decisions. • Robust system QEIA process for commissioning/ decommissioning schemes • Citizen engagement	• 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.	• ICS 5 Year Strategy • JUCD Operational Plan • Quality and Performance Committee • Population Health Strategic Commissioning Committee • System Quality Group • Public Partnerships Committee • NHSE Assurance Reviews and Assurance Letters

Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)
Threat 1 -	Intelligence and dashboard to evidence Core20PLUS5 principles	Dr Robyn Dewis	30/04/2023	Partially assured
Threat 2 -	Development of a system Health Inequalities strategy as part of the wider Integrated Care Partnership strategy	Dr Robyn Dewis	30/04/2023	Partially assured
Threat 3 –	Develop Patient Experience Plan	Letitia Harris	31/05/2023	Not 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:** Dr Buk Dhadda, 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:** 22.12.2022

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 TBC	**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)**
Threat 1	• System Quality infrastructure in place across Derbyshire • System Committees • Integrated Care Partnership (ICP) established • 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.	• Intelligence and evidence to understand health inequalities, make decisions and review ICS progress	• Population Health Strategic Commissioning Committee and minutes • Quality and Performance Committee • System Quality Group • ICB Board • NHS Executive Team • NHSE Assurance Meetings
Threat 2	• ICS 5 Year Strategy • ICS Operational Plan • System planning & co-ordination group managing overall approach to planning • Commissioning Intentions	• 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.	• ICB Board Minutes • ICB Board agreement of Strategic Objectives

Threat 3	• NHSE Core20PLUS5 Improvement approach to support the reduction of health inequalities • System Quality & Performance dashboard to include inequality measures • Health and Wellbeing Boards • Citizen engagement		• Health Inequalities Strategy • Ensuring prevention is embedded in all Care pathways • Alignment between the ICS and the City and County Health and Wellbeing Boards	• County and City and Wellbeing Boards • Public Partnerships Committee
Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)
Threat 1 -	Develop the Intelligence and evidence to understand health inequalities	Dr Robyn Dewis	30/04/2023	Partially assured
Threat 2 -	Develop Patient Experience Plan	Letitia Harris	31/05/2023	Not assured
Threat 3 –	Development of a system Health Inequalities strategy as part of the wider Integrated Care Partnership strategy	Dr Robyn Dewis	30/04/2023	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: 06.01.2023**		
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** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee** **TBC**		**Initial** **16**	**Current** **16**	**Target** **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)**
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 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.	• 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 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	• 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.

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 • NOF evidence, self-assessment and submission (tbc) • Benchmarking against comparator ICS approaches
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)
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 January 2023 31 March 2023+ 31 March 2023+ 31 March 2023+ 31 March 2023	TBC on 24.01.2023
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 January 2023 31 March 2023 31 March 2023	TBC on 24.01.2023
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+	TBC on 24.01.2023
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.	Sean Thornton Sean Thornton	31 March 2023 31 March 2023	TBC on 24.01.2023

	• Implement remaining elements of Communications and Engagement Strategy chapters	Sean Thornton & team	31 March 2023	

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**	Partially Assured				
	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: 06.01.2023**	
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 **TBC**			**16**	**16**	**TBC on 24.01.2023**
Strategic threats (what might cause this risk to materialise)	**Strategic threats**		**Impact** (what are the impacts of each of the strategic threats)				
	1. Rising demand, capacity issues, and availability and cost of workforce 2. Current productivity levels are below those pre covid with circa 16% less patients seen 3. CIP Programme – failure to deliver against plan and/or to transform services		1. Unable to meet financial plan / return to sustainable financial position 2. Increasing costs agency / staff 3. Unable to meet CIP programme				

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	• Quality & Performance / System Quality Group • Finance and Estates Committee • People & Culture Committee oversight of workforce • Planned Care Delivery Board / Emergency Care Delivery Board.	• Triangulated Demand, Workforce and Financial planning	• Winter Plan • Operation Plan • Committee agenda and papers and minutes • ICB Board Finance and Estates Committee Assurance Report to escalate concerns and issues. • Monthly Reporting to Finance and Estates Committee, ICB Board, NHSE and NHS Executive Team
Threat 2	• Development of new workforce and clinical models • Quality and Performance Committee • System Quality Group • Provider Collaborative Leadership Board • Clinical Leadership Framework in place across the system to support governance and clinical workstreams	• New Workforce and Clinical Models Plan	• System Quality and Performance Report • Quality and Performance Committee Minutes • System Quality Group Minutes

Threat 3	• Finance and Estates Committee • Executive Team ownership of the CIP programme for the ICB • ICB CIP programme in place with owners allocated • Engagement programme with staff re CIP about to commence • EPMO established led by transformation director • System CIP plan target and approach • System Financial Plan	• 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	• Regular reviews conducted by Executive Team • SLT monthly finance updates provided – including recalibration of programme in response to emerging issues • Finance and Estates Committee oversight • NHSE regulator review and overview of monthly financial submissions.

Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)
Threat 1 -	Development of Triangulated Demand, Workforce and Financial plan	Zara Jones	Awaiting national guidance Estimated 31/03/2023	Partially assured
Threat 2 -	Development of new Workforce and Clinical Models Plan	Amanda Rawlings/ Chris Weiner	End Quarter 1 2023/24	Partially assured
Threat 3 –	CIP Engagement Plan being implemented	Tamsin Hooton	End February 2023	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:** 09.01.2023

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 **TBC**	**20**	**20**	**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 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. Trusts in neighbouring systems implement incentives to attract staff that the ICS cannot match 4. 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. Increased turnover and difficulty recruiting leading to gaps in the staffing required to deliver services 4. 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)**
Threat 1	• Integrated planning approach • System level SRO for Workforce Planning • System People and Culture Committee • Workforce Advisory Group	• There is not an agreed integrated planning tool or system across all partners	• Monthly monitoring of workforce numbers and temporary staffing spend vs budget • System One Workforce Strategy and workforce plan • People and Culture Committee Minutes • Workforce Advisory Group Minutes • ICB Board Integrated Assurance Report
Threat 2	• Comprehensive staff wellbeing offer • Regular staff engagement processes • Annual staff opinion survey • System People and Culture Committee • System Wellbeing Group	• Funding for wellbeing offer is not recurrent	• Monthly monitoring of absence and turnover • People and Culture Committee Minutes • System Wellbeing Group Minutes

Threat 3	• Development of overall system retention offer and bespoke elements for each organisation • System Retention Lead post funded for 12 months by NHSE • System People and Culture Committee	• Increase influence of provider Collaborative/mental health Alliance with other systems • Retention Lead not recurrent	• Monthly monitoring of turnover • Monthly report on implementation of the Retention programme • People and Culture Committee Minutes
Threat 4	• Promotion of social care roles as part of Joined Up careers programme • System People and Culture Committee • Integrated Care Partnership (ICP) and Terms of Reference	• More work required to understand how the NHS can provide more support to care sector employers • ICP Workforce representation	• Monthly monitoring of vacancies via Skills for Care data • People and Culture Committee Minutes • ICP minutes

Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)
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	31. 03.23	TBC on 08.03.23
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 31.03.23	TBC on 08.03.23
Threat 3 –	Finalise and implement System Retention Plan	Kim Broadhurst	Retention Strategy to be presented to PCC on 08.03.23	TBC on 08.03.23
Threat 4	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	TBC on 08.03.23

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:** 09.01.2023

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 **TBC**	**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)**
Threat 1	• Work is underway to develop a One Workforce Strategy and plan aligned to a developing Integrated Care Strategy involving all system partners • Integrated Care Strategy is in development • System People and Culture Committee • Workforce Advisory Group • HR Directors Delivery Group • 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 • System Workforce Strategy and implementation plan • People and Culture Committee minutes • Workforce Advisory Group minutes • ICB Board Integrated Assurance Report • People Services Collaborative Delivery Group minutes
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 • System People and Culture Committee • Workforce Advisory Group • HR Directors Delivery Group	• 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.
Threat 3	• System People and Culture Committee • Workforce Advisory Group • 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	• People and Culture Committee minutes • Workforce Advisory Group minutes • ICB Board Integrated Assurance Report • ICB Board minutes

Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)
Threat 1 -	Develop One Workforce Strategy Integrated Care strategy being developed	Sukhi Mahil Kate Brown	Initial draft by 31.03.23 31.03.23	TBC on 08.03.23
Threat 2 -	System Wide TNA process to be developed and implemented	Faith Sango	Process developed by 28th February	TBC on 08.03.23
Threat 3 –	Develop One Workforce Strategy Integrated Care strategy being developed	Sukhi Mahil Kate Brown	Initial draft by 31.03.23 31.03.23	TBC on 08.03.23

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:** 06.01.2023

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 **TBC**	**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)**
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 • Formal risk sharing arrangements in place across organisations (via Section 75s/ Pooled Budgets)	• 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 • Consistent management reporting across the system to be agreed • Implement routine mechanism for shared reporting of risks and risk management across the system • 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 • Draft Integrated Care Strategy • JUCD Operational Plan

	• 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	• 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	• Agreed process for establishing and monitoring financial and operational benefits
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 minutes • System Quality Group and minutes • 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
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
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.	• 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

	• 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			
Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)
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	28/02/23 31/03/23 31/03/23	Not assured Not assured Partially assured (work started)
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	Not assured
Threat 3 –	Prioritisation process agreed in the system to better manage our time and use of resource	ICB / ICP	?? Linked to 23/24 plan?	Not assured
Threat 4	Development of log System Board decisions Establishment System ICB Board Meetings	HD HD	Quarter 1 2023/24 Quarter 1 2023/24	Not 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: 06.01.2023**	
Strategic risk (what could prevent us achieving this strategic objective)	**There is a risk that the system does not deliver digital transformation and establish intelligence and analytical solutions to support effective decision making.**	**Risk appetite: target, tolerance and current score**			**Initial**	**Current**	**Target**
		RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee **TBC**			**12**	**12**	**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 – mitigations – perm recruitment of Chief Data Analyst; Allocation of analytical resource from within current workforce; development of analytical workforce in line with investment plan 2. Digital improvements and substitutions to clinical pathways are not delivered – mitigations – clear prioritisation of clinical pathway transformation opportunities; Support room CPLG and D3B on those transformation priorities and digital project resource directed to support that activity; exploitation of Derbyshire Shared Care Record capabilities; acceptance and adoption of digital improvements by operational teams (COO, primary care and comms support needed – links to digital people plan) 3. Citizen engagement of adoption of alternative (digital) clinical solutions (eg PIFU, Virtual Ward, self-serve on line) – mitigations – deeper engagement with DCC and voluntary sector to assist with adoption; Public comms support on transition; Clear tracking of activity to demonstrate how resource can be released/redirected required 4. Budget allocation and reconciliation process across ICB for Digital, Data and Technology are not agreed.	1. Unable to deliver the Digital and Data strategy key priorities 2. Unable to effective support strategic commissioning and service change/development work 3. Failure to secure benefits from digitally enabled care and implement alternative care pathways - Financial oversight, allocation and monitoring of Digital, Data and Technology investments may not support the ICB requirements 4. Failure to deliver against the required budget allocation for Digital, Data and Technology

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	• Digital and Data Board (D3B) • ICB Finance and Estates Committee	• Prioritisation and investment decision making process	• D3B minutes • Monthly Reporting to Finance and Estates Committee, ICB Board, NHSE and NHS Executive Team • ICB Scheme of Reservation and Delegation

Threat 2	• Digital and Data Board (D3B) • ICS Provider Collaborative Leadership Board • Clinical Professional Leadership Board	• Prioritisation and investment decision making process	• Data and Digital Strategy • D3B minutes • Provider Collaborative Leadership Board Minutes • Clinical Professional Leadership Board Minutes • ICB Scheme of Reservation and Delegation
Threat 3	• Digital and Data Board (D3B) • ICS Provider Collaborative Leadership Board • Citizen's Engagement forums • Public Partnerships Committee	• Data and Digital Engagement Plan	• D3B minutes • Provider Collaborative Leadership Board Minutes • Clinical Professional Leadership Board Minutes • ICB Scheme of Reservation and Delegation • Data and Digital Strategy • ICB Board Finance and Estates Committee Assurance Report to escalate concerns and issues. • Public Partnerships Committee minutes
Threat 4	• Digital and Data Board (D3B) • ICB Finance and Estates Committee • ICS Provider Collaborative Leadership Board	• Agreed budget process and allocation	• D3B minutes • Provider Collaborative Leadership Board Minutes • Clinical Professional Leadership Board Minutes • ICB Scheme of Reservation and Delegation • Data and Digital Strategy • ICB Board Finance and Estates Committee Assurance Report to escalate concerns and issues.

Actions to treat threat	Action	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)
Threat 1 -	Prioritisation and investment decision making process in development	Jim Austin/Darran Green	End March 2023	Partially assured
Threat 2 -	Prioritisation and investment decision making process in development	Jim Austin/ Darran Green	End March 2023	Partially assured
Threat 3 –	Development of Data and Digital Engagement Plan	Jim Austin/ Sean Thornton	Quarter 1 2023/24	Partially assured
Threat 3 –	Budget allocation process in development	Jim Austin/ Darran Green	End February 2023	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: 06.01.2023**

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** **RISK APPETITE OR TOLERABLE LEVEL OF RISK as agreed by committee** **TBC**	**Initial**	**Current**	**Target**
			**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)**
Threat 1	• Integrated Care Partnership Board in place with Terms of Reference agreed and work programme in place. • 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 • Derbyshire ICS Green Plan and action plan approved by Derbyshire Trusts and adopted by the ICB Board July 2022	• 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. • Development of clear narrative for provider collaborative, and participation in ICS and place-based discussions	• 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 • Workforce resilience • Demand in the system • Audit and Governance Committee oversight and scrutiny • HOSC • EDI Committee reporting • Derbyshire ICS Greener Delivery Group and minutes

		• 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	• Reporting to ICB Board • ICB Board Development sessions • 2022/23 Winter Plan • Alignment between the ICS and the City and County Health and Wellbeing Boards • Health Inequality strategy • NHSEI oversight and reporting
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	• 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 • Health Inequality strategy • ICB Board and minutes • ICP and minutes
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. • Prevention work - winter plan and evidence base of where impact can be delivered.	• 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 • Health Inequality strategy

Actions to treat threat	Action (to address gaps in controls)	Action owner	Due date	Committee level of assurance (eg assured, partially assured, not assured)
Threat 1 -	• Review alternative funding formula to Carr Hill – scope cost and logistics	GPPB/ CN/ Finance	01/04/2024	Not assured
Threat 2 -	• Development of priorities for the ICP and delivery commences	ICP/ZJ/KB	01/04/2023	Partially assured
Threat 3 –	• Discuss approach with Public Partnerships committee	Julian Corner/ Sean Thornton	30/04/2023	Not assured
Threat 4 -	• Development of priorities for the ICP and delivery	ICP/ZJ/KB	01/04/2023	Partially assured

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

19th January 2023

Item: 078

Report Title	Integrated Care Board Risk Register Report – as at 31st December 2022							
Author	Fran Palmer, Corporate Governance 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 – November and December 2022							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Integrated Care Board (ICB) Committees – November and December 2022							

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 31st December 2022; • Appendix 2, which summarises the movement of all risks in November and December 2022. The Board are also requested to **APPROVE** the **CLOSURE** of risk 10.
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.
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

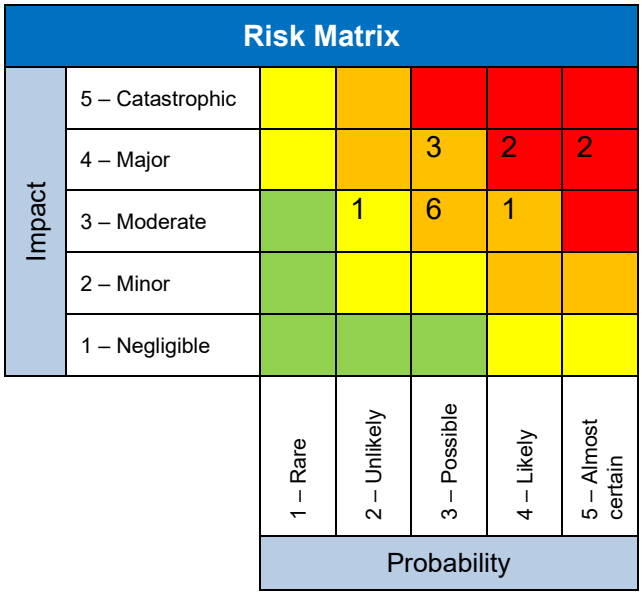
The purpose of this report is to present the ICB Board with the very high (red) operational risks from the ICB's Corporate Risk Register in order to provide assurance that robust management actions are being taken to mitigate them.

2. VERY HIGH OPERATIONAL RISKS

The ICB currently has 4 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>November 2022 performance:</u> • CRH reported 71.5% (YTD 79.8%) and UHDB reported 61.3% (YTD 62.2%). • CRH: The combined Type 1 & streamed attendances remain high, with an average of 105 Type 1 and 176 streamed attendances per day. • UHDB: The volume of attendances remains high, with Derby seeing an average of 201 Type 1 adult attendances per day, 137 children Type 1s and 141 co-located UTC. At Burton there was an average of 198 Type 1 attendances per day and 28 per day through Primary Care Streaming.	Overall score 20 **Very High** (5 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	• The acuity of the attendances was high, with Derby seeing an average of 12 Resuscitation patients & 185 Major patients per day and Burton seeing 76 Major/Resus patients per day.		
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:** • Winter Plan complete and agreed. Communication sent to all practices. Winter Plan group has been established and meeting twice weekly to review the OPEL status and actions in relation to the Winter Plan. The GP Access Group has been established to support practices with inputting of GP Access data.	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 30 November 2022, the system result is a £28.2m deficit, however the JUCD are committed to delivering breakeven for the 2022/23 financial year. Whilst the system is forecasting a breakeven result for this financial year at M8, CEOs and DoFs agreed a revised System position, however there continues to be a considerable amount of work to address the underlying issues in order to achieve this. The System likely unmitigated forecast outturn is a £30.9m deficit, which will impact not only this year's position, but future years also. Though this likely case position demonstrates continuing improvements from previous months, this trajectory must be maintained to achieve the system's commitment. 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: ○ agreed a revised control total with NHSEI based on cost pressures recognised in this year's financial position that are outside of JUCD's control such as cost of living, inflationary pressure and Covid; ○ transformation planning process drafted. Provider CFOs group in place to support this and the Delivery Boards; ○ PCLB is working with the CPLG to engage on clinical priorities for transformation for 2023/24 and beyond; ○ discussed the digital funding at various forums to upgrade within CDEL;	Overall score 16 **Very High** (4 x 4)	Finance and Estates Committee

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	○ JUCD system planning kick off session held on the 5 December. Roles and responsibilities and draft timeline were put forward; and ○ CRHFT have applied for PDC, and await confirmation. • 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.		
NEW 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:** • New risk approved at November System Quality Group. • Wording of risk description reviewed and changed at December SQG – risk score to remain the same. • UEC Handover Summit held on the 19th October 2022. Systems to decide five key interventions likely to provide improvement.	Overall score 20 **Very High** (5 x 4)	System Quality Group

3. RISK CLOSURES

One risk is recommended to be closed:

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
Risk 10	*The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.* **Update:** • Medical Support Worker likely to be fast-tracked to Consultant by March 23. In addition two ACP's are being interviewed this month to further strengthen the team and a proposal is in place to introduce 7-day CNS service. CRH identified that a report is to be submitted to their Quality Board to identify that all RCP recommendations have now been met. Request for report to be shared with ICB Quality Directorate to agree governance route. As the above had taken place, it was agreed in December to reduce the risk from a 12 to a 9 (target rating) and close the risk.	Overall score 9 **High** (3x3)	System Quality Group

4. RISK MOVEMENT

As risk is reported to the ICB Board on a bi-monthly basis, Appendix 2 details the movement of risk scores during November and December. In summary:

November 2022:

Three risks decreased in score:

Risk 07: relating to Information Governance breaches and inaccurate personal details due to failure of holding accurate staff files securely. This was decreased from a high score of 9 to a moderate score of 6.

Risk 09: relating to continuing delays in treatment resulting in increased clinical harm to patients. This was decreased from a very high score of 16 to a high score of 12.

Risk 16: relating to increased anxiety amongst staff due to the uncertainty and the impact on well-being. This was decreased from a high score of 12 to a high score of 9.

December 2022:

Two risks decreased in score:

Risk 10: relating to the sustainability of the Hyper Acute Stroke Unit at CRHFT and service provision for the population of North Derbyshire. This was decreased from a high score of 12 to a high score of 9 and recommended for closure.

Risk 15: relating to having sufficient resource and capacity to service the functions to be delegated by NHSEI. This was decreased from a very high score of 16 to a high score of 9.

5. NEW RISKS

November and December 2022:

One new risk has been approved by the System Quality Group:

Risk 19: relating to the failure of delivering 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. This risk is scored at a very high score of 20.

6. CONCLUSION

The ICB Board are requested to consider the report and provide any comment they feel appropriate.

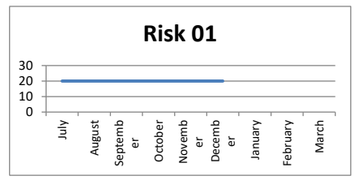
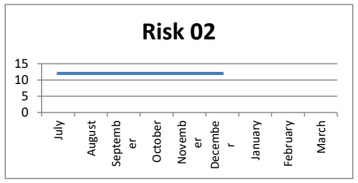
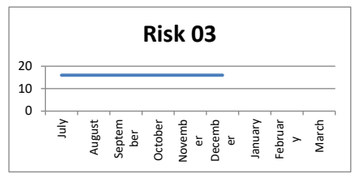
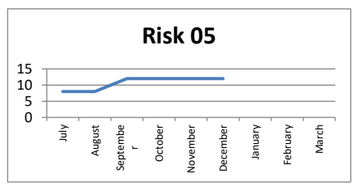
Appendix 1 - Derby and Derbyshire ICB Risk Register - as at December 2022

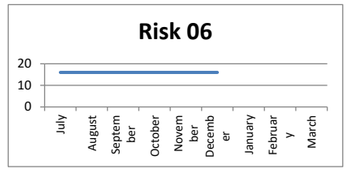
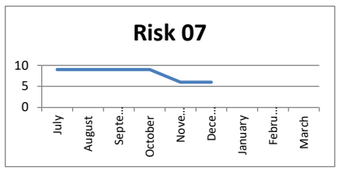
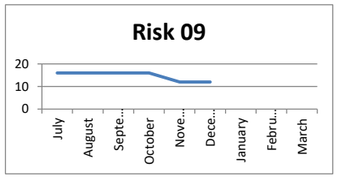
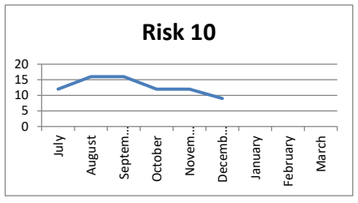
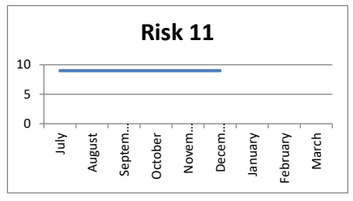
NHS Derby and Derbyshire Integrated Care Board

Risk Reference	Year	Risk Description	Responsible Committee	ITT / Corporate / Programme	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 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	Commissioned Services 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.	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. - 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. - 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. - 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.	November 2022 performance CRH reported 71.5% (YTD 79.8%) and UHDB reported 61.3% (YTD 62.2%). CRH: The combined Type 1 & streamed attendances remain high, with an average of 105 Type 1 and 176 streamed attendances per day. UHDB: The volume of attendances remains high, with Derby seeing an average of 201 Type 1 adult attendances per day, 137 children Type 1s and 141 co-located UTC. At Burton there was an average of 198 Type 1 attendances per day and 28 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average of 12 Resuscitation patients & 185 Major patients per day and Burton seeing 76 Major/Resus patients per day.	5	4	20	5	4	20	3	3	9	On going	3bc	Dec-22	Jan-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 / Mandate	3	3	9	•The implementation date for 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 in place. This has been agreed and a framework for this to happen is being developed and an account with the COP has been set up.	August/September- This risk will be reviewed in October following Liberty Protection Safeguards paper being presented at System Quality Group. October: Government have yet to provide the LPS Code of Practice or the results of their LPS consultation. Situation therefore remains the same. The ICB is sighted on developments. Report provided internally within ICB Governance structures. Novenbe/December: The situation remains as per previous submission. There is a full review in Jan with attention focussed upon the cost of living pressures and there impact upon risk. No change until after that review.	3	4	12	3	4	12	3	3	9	April 2023	3bc	Dec-22	Jan-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 & Integrated Care 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.	May: General Practice continues to deliver the three priorities: Delivery of General Practice; Recovery and Restoration including reduction in backlogs and improving access; COVID 19 vaccination programme and managing long COVID. General Practice continues to experience high levels of absence due to COVID 19 and increasing patient demand. June: Publication of the Fuller Stocktake - Integrated Primary Care including actions for ICS and ICB. July/August: Review of Primary Care governance and reporting arrangements following transition to ICB. September: Primary Care sub-group now established. First meeting 13th September. Terms of Reference approved by PHSCC. Review of primary care governance arrangements and reporting arrangements underway. Development of primary care winter plan to support system pressures over the winter period. October: Meeting to be arranged with GP Provider Board to review this risk and update in line with the mitigating actions that will be part of the winter plan and on going collaboration with the GP Provider Board. The risk score remains the same as increasing risk of COVID outbreaks, workforce and winter pressures. November/December: Winter Plan complete and agreed. Communication sent to all practices. Winter Plan group has been established and meeting twice weekly to review the OPEL status and actions in relation to the Winter Plan. The GP Access Group has been established to support practices with inputting of GP Access data.	4	4	16	4	4	16	4	3	12	On going	3bc	Dec-22	Jan-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	October EPRR National Core Standards Submitted to NHSE by ICB Derbyshire Providers submitted National Core Standards to NHSE and ICB for initial assessment Initial assessment of Providers EPRR Core Standards carried out jointly with NHSE and ICB Further Principals of Health Command training delivered Floodex exercise planned for November and COMAH exercise for December Structured debrief training to be delivered. Dates to be confirmed December EPRR Core Standards position for Derbyshire agreed by LHRP. Overall Position Partial. DDICB non compliant Head of EPRR commenced in post Action Plan developed for improvements against EPRR Core Standards Work undergoing for management of strike action Preparatory work for possible power outages including exercise Arctic Willow Review of Derbyshire wide risks by HEPOG on behalf of LHRP Advertisement to be set up for Band 7 support to EPRR side of programme of work to go through ET by end Jan 23	3	4	12	3	4	12	2	2	4	On going	3bc	Dec-22	Jan-23	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Chrissy Tucker - Director of Corporate Delivery / Richard Heaton, Business Resilience Manager
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 current financial year's outturn position to break even, 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. December update: A number of actions have been taken, which include: - JUCD DoFs regularly reviewing and challenging the financial position, - System wide meetings taking place at various levels to drive forward a triangulated 2023/24 plan - Comply with requirements for digital maturity, but within funding streams, - Transformation Group to lead system forums. Commenced discussions surrounding clarity of System Governance to move forward with skills, clearer reporting, and system strategy enabling programmes of transformation. - Discussions have commenced with NHSEI regarding cash support mechanisms for JUCD providers, in addition to the consideration of additional PDC drawdown.	As of 30th November 2022, the system result is an £28.2m deficit, however the JUCD are committed to delivering break-even for the 2022/23 financial year. Whilst the system is forecasting a break-even result for this financial year at M8, CEOs and DoFs agreed a revised System position, however there continues to be a considerable amount of work to address the underlying issues in order to achieve this. The System likely unmitigated forecast outturn is a £30.9m deficit, which will impact not only this year's position, but future years also. Though this likely case position demonstrates continuing improvements from previous months, this trajectory must be maintained to achieve the system's commitment. 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: - Agreed a revised control total with NHSEI based on cost pressures recognised in this year's financial position that are outside of JUCD's control such as cost of living, inflationary pressure and Covid, - Transformation planning process drafted. Provider CFOs group in place to support this and the Delivery Boards, - PCLB is working with the CPLG to engage on clinical priorities for transformation for 2023/24 and beyond, - Discussed the digital funding at various forums to upgrade within CDEL - JUCD system planning kick off session held on the 5th December. Roles and responsibilities and draft timeline were put forward - CRHFT have applied for PDC and await confirmation. 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	3bc	Dec-22	Jan-23	Keith Griffiths, Chief Financial Officer	Darran 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.	September/October - A plan has been articulated but not yet implemented due to current work pressures and subsequent resource availability. November/December: Project team meeting held. HR files moved to South Floor at Cardinal Square. Scoping exercise commenced to review time/resource commitment required for scanning in HR files onto the HR drive on the network. Reduced probability to unlikely as resource identified subject to business case to scan in HR paper files onto the network.	2	3	6	2	3	6	1	2	2	Mar-23	3bc	Dec-22	Jan-23	Beverley Smith, Director of Corporate Strategy & Development	James Lunn, Head of People and Organisational Development
09	22/23	Revised risk description: 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 decreased due to improved processes are in place for assurance: embedded in Quality Schedule with quarterly reports to SQG, and updates to SQPC. December: No change to previous month	3	4	12	3	4	12	3	2	6	Dec-22	8bc	Dec-22	Jan-23	Brigid Stacey, Chief Nursing Officer & Deputy Chief Executive	Letitia Harris Clinical Risk Manager
10	22/23	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	System Quality Group	Clinical	4	5	20	Short term work has been undertaken and assurance re the safety of services has been provided by the Medical and Nursing Director at CRHFT, however the long term sustainability of the service now needs to be addressed. March update: CRH Stroke Service Contingency Plan has been implemented, with sign-off from impacted surrounding trusts (Kings Mill, Hallamshire, UHDB, and Stepping Hill). Short-term mitigations in place to support service continuity, reducing the risk of service suspension and patient divert. July 22- Kings Mill and Nottingham Hospitals have provided consultant support at CRH over the summer period (July- August 22) to cover the period where there is no consultant cover. This is a short term intervention. July 22- Weekly system meetings that includes ICB Execs, CRH Execs, NHSE Clinical Leads, EMAS and Neighbouring Trusts to monitor the current workforce and assure the risk at CRH. A Contingency plan is in place to enact a patient divert to neighbouring trusts if required in the future. Nov 22- Monthly Stroke Delivery Group to drive Critical Services Review and to review service issues, risks and mitigations.	• Locum Consultant cover is in place • Clinical Leadership support is being provided by Liverpool Consultant • Trust to go out for advert to recruit new Stroke Lead consultant & work being done to make advert attractive • Former CCG , ICB, NHSE & System working with Trust Medical Director to contact other organisations and the Stroke Network for support. • Trust reviewing staff daily and escalating as per safer staffing policy as required, including red flag acuity reporting • CRHFT and Integrated Stroke Delivery Network (ISDN) leads to develop service contingency plan to understand internal measures, mutual aid options, and patient divert impact. • SOP to operationalise the contingency plan. • A task and finish group to commence a service review of the HASU, including options appraisal. All options to be reviewed with the aim of providing a sustainable service. July 22- CRH required to update SOP detail within the Contingency Plan. ICB have recently refreshed the data within the plan. Nov 22- Complete Critical Service Review to identify future workforce solutions on a larger geographical footprint.	Sept 22- A Critical Services Review is scheduled for 4th October 2022 to be attended by Executive leads of neighbouring trusts (CRH, UHDB, STH, Kings Mill, Stockport, EMAS), ISDN's, ICB Executive leads and NHSE. Having discussed this situation locally and with NHSE Midlands, a wider discussion is to take place, to include partner organisations affected by flows of patients from within our community. It is proposed that this could then lead to the necessary next steps for consideration across the network of patient services. Oct 22- Decrease risk in score from 16 to 12, agreed at the Stroke Delivery Group. CRH have had staff return from leave and recruited additional staff. Improvements include: Emergency Department to support thrombolysis and thrombectomy- ongoing.; Additional CNS bank staff opportunities provided; Locum Consultant returned from leave on 1st September; Acute Physician to join the Stroke team on a secondment, and Medical Support Worker commenced contract 22nd Sept – to be fast tracked through the Certificate of Eligibility for Specialist Registration (CESR) route to Consultant by early 2023. Nov 22 - Medical Support Worker likely to be fast-tracked to Consultant by March 23. In addition two ACP's are being interviewed this month to further strengthen the team and a proposal is in place to introduce 7-day CNS service. CRH identified that a report is to be submitted to their Quality Board to identify that all RCP recommendations have now been met. Request for report to be shared with ICB Quality Directorate to agree governance route. Subject to the above taking place, it is proposed to reduce the risk to a 9 (target rating) and close the risk. Dec 22 - As the above had taken place, it is proposed to reduce the risk to a 9 and close the risk.	3	4	12	3	3	9	3	3	9	Mar-23	8bc	Dec-22	Jan-23	Dr Chris Weiner - Chief Medical Officer	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways Scott Webster Head of Strategic Clinical Conditions and Pathways

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 Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
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	Derbyshire Provider Trust Green plans ICS and NHS England February 2022 Derbyshire ICS Green plan in development and will be approved April 2022. NHSE Midlands Green Delivery Board Terms of Reference NHSE Midlands Green Delivery Board Agenda and Minutes Derbyshire ICS Greener Delivery Board Terms of Reference Derbyshire ICS Greener Delivery Board Agenda and Minutes Communications and Staff Engagement toolkits published by NHSE Nitrous Oxide Medicine Toolkit published by NHSE 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 December 2022 - NHSE Funding of £30k received to support he Net Zero delivery and targets to the end of 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	Oct-22	3b6	Dec-22	Jan-23	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Suzanne Pickering Head of Governance
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 Partnership Committee	Corporate	4	4	16	•Detailed work programme for the engagement team •Clearly allocated portfolio leads across team to share programmes December: Assessment of transformation programmes in ePMO system underway to quantify engagement workload.	•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. The score remains the same this month as there is still delivery required against the mitigating factors before we will see an improvement. 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. December 2022 - review of engagement team portfolios to maximise equality of work and efficiency of process. December 2022 - system discussion ongoing regarding distributed leadership, including Provider Collaborative Leadership Board.	3	3	9	3	3	9	2	2	4	tbc	3b6	Dec-22	Jan-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.	Sept: Risk description re-worded from TWG register transfer: *'There is a risk that the operating model being developed by NHSEI ready to delegate services and functions to ICBs may not have sufficient staffing and capacity.'* Oct: It has been confirmed that there will be an East/West operating model, with Nottingham and Nottinghamshire ICB being identified as the host organisation for the East Midlands, however the detail of how this will operate and how it might affect individual ICBs is not yet worked through. Nov: An East/West operating model has been confirmed and work is in progress to identify governance processes. A number of organisations have volunteered to act as the host organisation for the East Midlands, however the detail of how this will operate and how it might affect individual ICBs is not yet worked through. Risk score remains the same. Dec: A number of functions in the ICB are working with regional colleagues in NHSE and ICBs and participating in meetings considering the models to be utilised, governance processes etc. It has has been confirmed that Nottingham & Nottinghamshire ICB will act as host for the POD and that Birmingham & Solihull ICB will act as host for Specialised Commissioning. Further work to identify the impact on DDICB continues, however the hosting arrangements will reduce the resource requirements from DDICB and therefore a reduction in score is now appropriate.	4	4	16	3	3	9	3	2	6	tbc	3b6	Dec-22	Jan-23	Helen Dillistone - Executive Director of Corporate Affairs	Chrissy Tucker - Director of Corporate Delivery
16	22/23	Risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being.	Audit and Governance Committee	Corporate	4	3	12	Employment Commitment for staff below Board level - publication of FAQs. Regular communication with staff. Sharing information with staff as soon as this became available. Continuation of regular 1 to 1 wellbeing checks throughout the transition process. Undertake People Impact Assessment to identify staff well-being needs during the transition and share and seek feedback from colleagues.	No significant change in sickness absence.	September: Continued promotion of wellbeing offers, including mental health awareness. There may still be a risk of increased anxiety amongst staff until the alignment under the new Board structure and any resulting structure changes have been concluded. October: 1 to 1 wellbeing conversations encouraged, linked to the Hybrid Operating Model and increased on-site working. November/December: Continued promotion of wellbeing offers. Self care pack developed and reasonable adjustment passport launched with a requirement for all line managers to hold 1 to 1 health and wellbeing conversations, linked to the Hybrid Operating Model and increased on-site working. Sickness absence has increased from 2.42% over the 12 months period ending 31 October 2021 to 3.12% in the 12 months to 31 October 2022. FTE days lost due to Anxiety/Stress/Depression/other psychological illness has increased by around 75% (From 888.70 to 1558.71 FTE days lost) and FTE days lost due to infectious diseases by around 215% (329.42 to 1037.22 FTE days lost). Probability score reduced to 3 as ICB structure review unlikely to result in significant change impacting on job security.	3	3	9	3	3	9	3	2	6	Jul-23	3b6	Dec-22	Jan-23	Helen Dillistone - Executive Director of Corporate Affairs	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 Partnership 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.	•- 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 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	3	2	6	tbc	tbc	Dec-22	Jan-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.	Place Partnership Committee	Place Leads	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 25th 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.	3	3	9	3	3	9	2	2	4	Mar-23	tbc	Dec-22	Jan-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
NEW RISK 19	22/23	There is a risk to both the inflow and outflow from the Acute Hospitals due to the failure to deliver a timely response to patients in line with commissioned national standards, to ensure a safe level of service leading to excessive Handover delays and transfer of patients to the appropriate care setting and significant response times for patients calling for an ambulance resulting in potential significant levels of harm to patients whilst waiting to be triaged at hospital and whilst waiting in the community for an ambulance response. Alternative risk description following November SQG: 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 Delivery 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 specialities 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.	5	4	20	5	4	20	2	5	10	Apr-23	tbc	Dec-22	Jan-23	Brigid Stacey Chief Nursing Officer & Deputy Chief Executive	Jo Hunter Director of Quality

Appendix 2 - ICB Risk Register - Movement - November and December 2022

Risk Reference	Risk Description	Previous Rating (August)			Residual/ Current Risk Rating (September)			Movement - November	Rationale	Previous Rating (September)			Residual/ Current Risk Rating (October)			Movement - December	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	⇔	Attendances continue to be high - risk score to remain the same	5	4	20	5	4	20	⇔	Attendances remain high at both CRHFT and UHDB - risk score to remain the same	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	⇔	Full review expected in January - no change until after that review.	3	4	12	3	4	12	⇔	Full review expected in January - no change until after that review.	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	⇔	The risk score remains the same due to increasing risk of COVID outbreaks, workforce and winter pressures.	4	4	16	4	4	16	⇔	The risk score remains the same due to continued risk of COVID outbreaks, workforce and winter pressures.	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	3	4	12	⇔	Head of EPRR has commnced role - risk score to remain the same	3	4	12	3	4	12	⇔	EPRR Core Standards position for Derbyshire agreed by LHRP. Overall Position Partial. DDICB non compliant, therefore risk score to remain the same	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Chrissy Tucker - Director of Corporate Delivery / Richard Heaton, Business Resilience Manager	

Risk Reference	Risk Description	Previous Rating (August)			Residual/ Current Risk Rating (September)			Movement - November	Rationale	Previous Rating (September)			Residual/ Current Risk Rating (October)			Movement - December	Rationale	Executive Lead	Action Owner	Graph detailing movement
		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	⟷	There continues to be a considerable amount of work to address the underlying issues in order to achieve breakeven - risk score to remain the same	4	4	16	4	4	16	⟷	There continues to be a considerable amount of work to address the underlying issues in order to achieve breakeven - risk score to remain the same	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.	3	3	9	2	3	6	↓	Score reduced due to a resource identified (subject to business case) to scan in HR paper files onto the network.	2	3	6	2	3	6	⟷	Resource identified (subject to business case) to scan in HR paper files onto the network - risk score to remain the same	Beverley Smith, Director of Corporate Strategy & Development	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	3	4	12	↓	Risk score decreased due to improved processes: embedded in Quality Schedule with quarterly reports to SQG, and updates to SQPC.	3	4	12	3	4	12	⟷	No change to previous month - - risk score to remain the same.	Brigid Stacey, Chief Nursing Officer & Deputy Chief Executive	Letitia Harris Clinical Risk Manager	
10	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	3	4	12	3	4	12	⟷	All RCP recommendations have now been met. Posts to be filled before reduce risk.	3	4	12	3	3	9	RISK REDUCED IN SCORE AND RECOMMENDED FOR CLOSURE	Now that all actions have been complete, the risk is recommended for closure.	Dr Chris Weiner - Chief Medical Officer	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways	
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	⟷	Risk cannot be reduced until the ICS starts to achieve its targets through the action plan for 2022/23.	3	3	9	3	3	9	⟷	Risk 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	

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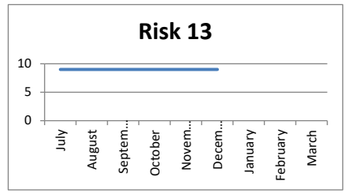
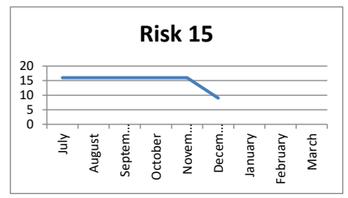
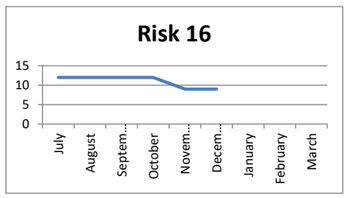
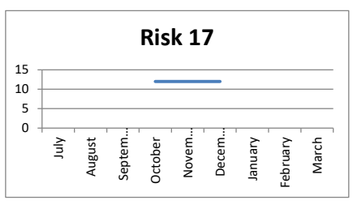
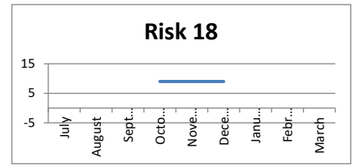
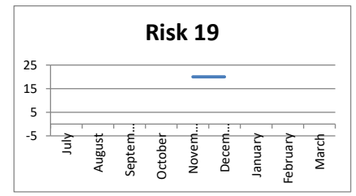
		Probability	Impact	Rating	Probability	Impact	Rating			Probability	Impact	Rating	Probability	Impact	Rating					
13	Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support 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	⟷	Resourcing review still to be completed - risk score to remain the same.	3	3	9	3	3	9	⟷	Reviews of schemes and portfolios still to be completed (January 2023) risk score to remain the same	Helen Dillistone - Executive Director of Corporate Affairs	Sean Thornton - Deputy Director Communications and Engagement	
15	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	4	4	16	4	4	16	⟷	Process for volunteer host organisations to be worked through - risk score to remain the same.	4	4	16	3	3	9	↓	A reduction in score is now appropriate as it has been confirmed other ICBs are hosting which will reduce the likelihood that we cannot resource the work, albeit we are not sure what work remains for the ICB to undertake.	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.	4	3	12	3	3	9	↓	Probability score reduced to 3 as ICB structure review unlikely to result in significant change impacting on job security.	3	3	9	3	3	9	⟷	No improvement in staff sickness absence levels - risk score to remain the same	Helen Dillistone - Executive Director of Corporate Affairs	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	⟷	Score remains the same as there is still delivery required against the mitigating factors before we will see an improvement.	4	3	12	4	3	12	⟷	Score remains the same as there is still delivery required against the mitigating factors before we will see an improvement.	Helen Dillistone - Executive Director of Corporate Affairs	Sean Thornton - Deputy Director Communications and Engagement	

Risk Reference	Risk Description	Previous Rating (August)			Residual/ Current Risk Rating (September)			Movement - November	Rationale	Previous Rating (September)			Residual/ Current Risk Rating (October)			Movement - December	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating			Probability	Impact	Rating	Probability	Impact	Rating					
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	⟺	Plan to support increasing the level of action for patients submitted - risk score to remain the same.	3	3	9	3	3	9	⟺	Plan to support increasing the level of action for patients submitted - risk score to remain the same.	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	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	NEW RISK	*New risk approved at November System Quality Group - risk description: There is a risk to both the inflow and outflow from the Acute Hospitals due to the failure to deliver a timely response to patients in line with commissioned national standards, to ensure a safe level of service leading to excessive Handover delays and transfer of patients to the appropriate care setting and significant response times for patients calling for an ambulance resulting in potential significant levels of harm to patients whilst waiting to be triaged at hospital and whilst waiting in the community for an ambulance response.*	5	4	20	5	4	20	⟺	Wording of risk description reviewed and changed - risk score to remain the same.	Brigid Stacey, Chief Nursing Officer & Deputy Chief Executive	Jo Hunter, Director of Quality	

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

19th January 2023

Item: 079

Report Title	ICB Constitution Update							
Author	Suzanne Pickering, Head of Governance Chrissy Tucker, Director of Corporate Delivery							
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 – NHS England (Midlands) Letter to ICB Chief Executive dated 14 December 2022 confirming amendments to ICB Constitution Appendix 2 – Updated ICB Constitution							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Not applicable							

Recommendations
The Board are recommended to **NOTE** the decision by NHS England (Midlands) approving the amendments to the ICB's Constitution.
Purpose
The purpose of the report is to make the Board aware that a letter has been received from NHS England (Midlands) confirming the amendments to the ICB Constitution.
Background
On the 18 August 2022, a summary paper was presented to the ICB Board in relation to amending the ICB constitution with the intention of reducing the number of Non-Executive Members by one and introducing the role of a Clinical Lead Member. A report was also presented to the Board on 20 October 2022, in relation to the options available for the replacement of the Board's Mental Health Lead. On the 1 November 2022, the ICB submitted an application to NHS England to amend the ICB Constitution.
Report Summary
On the 14 December 2022, the ICB's Chief Executive Officer received a letter from NHS England (Midlands) approving the above amendments to the ICB's Constitution.

In accordance with section 14Z29 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2022), the ICB published the revised constitution on the ICB's website on the 15 December 2022. The updated Constitution has also been provided at Appendix 2.					
Identification of Key Risks					
Not applicable.					
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					
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 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 Not applicable.					

Appendix 1

14th December 2022

From the office of Dale Bywater
Regional Director – Midlands

Cardinal Square – 4th Floor
10 Nottingham Road
Derby
DE1 3QT

T: 0113 539 6979
E: dale.bywater1@nhs.net

Chris Clayton
Chief Executive
Derby and Derbyshire ICB

Sent via e-mail:
Chris.clayton2@nhs.net

Dear Chris

Amendments to Integrated Care Board Constitution

Thank you for your application to amend your constitution, dated 1st November 2022.

I am writing to notify you of NHS England's decision in relation to the application for proposed changes to the Constitution of NHS Derby and Derbyshire ICB**.**

Decision

Following our review, NHS England has agreed that the proposed changes to the Constitution of NHS Derby and Derbyshire ICB complies with the particular requirements of the National Health Service Act 2006 as amended by the Health and Social Care Act 2022 and is otherwise appropriate.

Accordingly, the proposed changes to NHS Derby and Derbyshire ICB constitution have been approved.

What do you need to do next?

According to section 14Z29 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2022), you will be required to publish the revised constitution. This should be done as soon as reasonably practical after the receipt of this decision letter.

Conclusion

Should you require any assistance following this decision, please contact James Ilott james.ilott@nhs.net.

Yours sincerely

Dale Bywater
Regional Director – Midlands

cc: John Macdonald, Chair, Derby and Derbyshire ICB
Fran Steele, Director of Strategic Transformation, NHS Midlands

NHS
Derby and Derbyshire
Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board

Constitution

Version	Amendment	Effective date
V1.0	ICB Board, 1 July 2022	1 July 2022
V1.1	Amendment to Constitution to reflect changes in Board composition September 2022 Amendment to Section 1.3.3 - Area Covered by the ICB NHSE amendments in line with annex to final guidance on preparing ICB Constitutions updated by legal team.	14 December 2022

CONTENTS

1. INTRODUCTION

1.1 Background/Foreword

1.1.1 NHS Derby and Derbyshire Integrated Care Board (ICB) is the health statutory body for the Derby City and Derbyshire population. The ICB is a new statutory organisation and will take over the duties and responsibilities of the NHS Derby and Derbyshire Clinical Commissioning Group which will be disestablished on 30th June 2022. The ICB will also be responsible for a range of new statutory duties set out in the Act.

1.1.2 ICSs are partnerships of health and care organisations that come together to plan and deliver joined-up services and to improve the health of people who live and work in their area. Each ICS will comprise of an:

(a) Integrated Care Board bringing the NHS together locally to improve population health and care; and an

(b) Integrated Care Partnership (ICP): the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.

1.1.3 NHSE has set out the following as the four core purposes of ICSs:

(a) improve outcomes in population health and healthcare.

(b) tackle inequalities in outcomes, experience and access.

(c) enhance productivity and value for money.

(d) help the NHS support broader social and economic development.

The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people.
- supporting people to stay well and independent.
- acting sooner to help those with preventable conditions.
- supporting those with long-term conditions or mental health issues.
- caring for those with multiple needs as populations age.
- getting the best from collective resources so people get care as quickly as possible.

1.1.4 The Derbyshire ICS will have an NHS Body Integrated Care Board which has a distinct purpose, with governance and leadership arrangements designed to promote greater collaboration across the NHS and with other local partners. Adapting to this requires a significant change in the way commissioning activities are delivered and functions are carried out to understand population needs, plan

services and allocate resources, which address the Derby City and Derbyshire population's health outcomes and secure the provision of services collaboratively with partners.

1.1.5 The Derbyshire ICS will also have an ICP at system level, established as equal partner members. The ICP will operate as the forum to bring partners e.g. local government, NHS and others, together across the Derbyshire ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for the population of Derby City and Derbyshire. For a number of years there have been local collaborative arrangements at the 'neighbourhood' level. These have involved a coalition of commissioners, NHS Trust providers, local authorities, primary care, the voluntary and community sector, and the public working together to better meet the needs of local people. Two Place Partnerships on the local authority footprints have been formed, which retain and further strengthen local place alliances. The Place Partnerships will have an ethos of equality between partners and be established to deliver a range of functions on behalf of the ICB and ICP. These will include:

(a) co-ordinating and integrating local services built on a mutual understanding of the population and a shared vision;

(b) taking accountability for the delivery of coordinated, high quality care and improved outcomes for their populations; and

(c) 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.

The overall approach will 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. There is a collective ambition for delegated responsibility and accountability to enable maximum impact from existing and enhanced structures.

1.1.6 Provider collaboratives are partnership arrangements involving two or more trusts (foundation trusts or NHS trusts and could also include community interest companies providing NHS care), that collectively work across multiple places to realise the benefits of mutual aid and working at scale. The purpose of provider collaboratives is to better enable their members to work together to continuously improve quality, efficiency, and outcomes, including proactively addressing unwarranted variation and inequalities in access and experience across different providers.

[1] It is a proposed common duty for NHS bodies that plan and commission services (NHS England and ICBs) and that provide services (Trusts and Foundation Trusts). It will oblige these bodies to consider the effects of their decisions on:

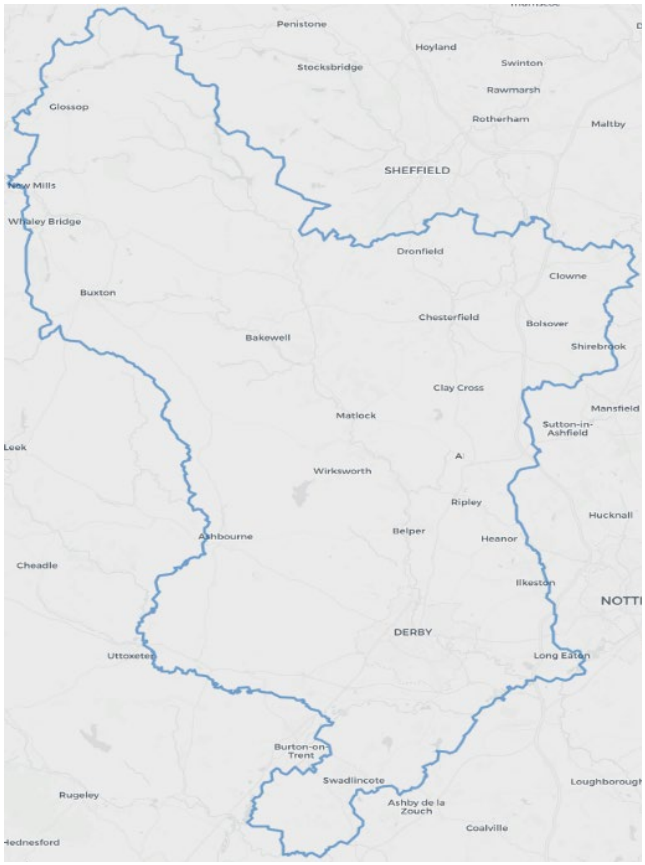
- the health and wellbeing of the people of England
- the quality of services provided or arranged by both themselves and other relevant bodies
- the sustainable and efficient use of resources by both themselves and other relevant bodies

1.2 **Name**

The name of this Integrated Care Board is NHS Derby and Derbyshire ICB ("the ICB").

1.3 **Area Covered by the Integrated Care Board**

1.3.1 The area covered by the ICB is approximately 2,495 km^2 within Derbyshire and Derby City.



1.3.2 As the ICB is fully coterminous with the areas covered by Local Authorities, the area covered by the ICB is defined by the Lower Layer Super Output Areas (LSOAs) as listed below.

1.3.3 The following are the District and Borough Councils and the Upper Tier Local Authority which the ICB covers, the:

(a) County Council of Derbyshire

(b) City Council of Derby

(c) Borough of Chesterfield

(d) Borough of High Peak (including Glossop)

(e) Borough of Amber Valley

(f) Borough of Erewash

(g) District of Bolsover

(h) District of North East Derbyshire

(i) District of Derbyshire Dales

(j) District of South Derbyshire

(k) Peak District National Park Authority

1.4 **Statutory Framework**

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a Constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its Constitution (section 14Z29). This Constitution is published at www.ddicb.nhs.uk.

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

(a) having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);

(b) exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);

(c) duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014);

(d) adult safeguarding and carers (the Care Act 2014);

(e) equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35);

(f) information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000); and

(g) provisions of the Civil Contingencies Act 2004.

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:

(a) section 14Z34 (improvement in quality of services);

(b) section 14Z35 (reducing inequalities);

(c) section 14Z38 (obtaining appropriate advice),

(d) section 14Z40 (duty in respect of research),

(e) section 14Z43 (duty to have regard to effect of decisions);

(f) section 14Z45 (public involvement and consultation);

(g) sections 223GB to 223N (financial duties); and

(h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on the 1st of July 2022 by The Integrated Care Boards (Establishment) Order 2022' which made provision for its Constitution by reference to this document.

1.5.2 This Constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.

1.5.3 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

(a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and

(b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

The Chief Executive Officer may periodically propose amendments to the Constitution which shall be considered and approved by the ICB Board members where:

(a) changes are thought to have a material impact;

(b) changes are proposed to the reserved powers of the members;

(c) at least half (50%) of all the ICB board Members formally request that the amendments be put before the full ICB board members for approval.

Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved. This is set out in Appendix One, Standing Orders Section 4.9 Decision Making.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

(a) **Standing orders** – which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published.

(a) **Scheme of Reservation and Delegation (SoRD)** – sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

(b) **Functions and Decision map** – a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

(c) **Standing Financial Instructions** – which set out the arrangements for managing the ICB's financial affairs.

(d) **The ICB Governance Handbook**–This brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:

(i) The above documents (a) – (c);

(ii) terms of reference for all committees and sub-committees of the board that exercise ICB functions;

(iii) delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act; and

(iv) terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.

(v) The up-to-date list of eligible providers of primary medical services under clause 3.6.2.

(e) **Corporate Governance Framework** – brings together a range of corporate statutory documents in one place to assist in building a consistent corporate approach and forms part of the corporate memory.

(f) **Governance Structure**

(g) **Key policy documents** which should also be included in the Governance Handbook or linked to it – including:

(i) Standards of Business Conduct Policy;

(ii) Conflicts of Interest Policy and Procedures; and

(iii) Policy for Public Involvement and Engagement.

2. COMPOSITION OF THE BOARD OF THE ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in Section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website www.ddicb.nhs.uk.

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the board" and members of the ICB are referred to as "board Members") consists of:

(a) a Chair;

(b) a Chief Executive;

(c) at least three Ordinary members.

2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England Policy, requires the ICB to appoint the following additional Ordinary Members:

(a) three executive members, namely:

(i) Executive Director of Finance

(ii) Executive Medical Director; and

(iii) Executive Director of Nursing and Quality.

And in addition to the two mandated Non-Executive Members for Audit and Remuneration there will be:

(b) an additional two Non-Executive Members.

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following, and appointed in accordance with the procedures set out in Section 3 below:

(a) NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description;

(b) the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description;

(c) the local authorities which are responsible for social care and whose area coincides with or includes the whole or any part of the ICB's area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has five Partner Members

(a) One NHS Trust and Foundation Trust Partner Member

(b) One NHS Trust and Foundation Trust Partner member who shall have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

(c) One Primary Medical Services Partner Member; and

(d) Two Local Authority Partner Members.

2.2.2 The ICB has also appointed the following further Ordinary Members to the board:

(a) Executive Director of People and Culture (Chief People Officer);

(b) Clinical Lead Member.

2.2.3 The board is therefore composed of the following sixteen members:

(a) Chair;

(b) Chief Executive;

(c) Two Partner Members NHS and Foundation Trusts

(d) One Partner Member Primary Medical Services;

(e) Two Partner Members Local Authorities;

(f) Four Non-Executive Members;

(g) One Clinical Lead Member;

(h) Executive Director of Finance;

(i) Executive Medical Director;

(j) Executive Director of Nursing and Quality; and

(k) Executive Director of People and Culture (Chief People Officer).

2.2.4 The Chair will exercise their function to approve the appointment of the ordinary members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The board will keep under review the skills, knowledge, and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular Participants and Observers at Board Meetings

2.3.1 The board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit. Participants will be affiliated to the ICB Executive Team but will not be a member of the ICB.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote. Regular participants will include the following:

(a) Executive Director of Corporate Affairs (Board Secretary);

(b) Chair of the Clinical and Professional Advisory Committee;

(c) Chief Digital Information Officer;

(d) Other Executives.

2.3.3 Observers will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

2.3.4 Participants and / or Observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the Standing Orders.

3. APPOINTMENTS PROCESS FOR THE BOARD

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:

(a) comply with the criteria of the “fit and proper person test”;

(b) be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles); and

(c) fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification Criteria for Board Membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a board member (“the candidate”) is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate’s involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted:

(a) in the United Kingdom of any offence; or

(b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in

either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

(a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office;

(b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings;

(c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest; or

(d) of misbehaviour, misconduct or failure to carry out the person's duties.

3.2.7 A Health Care Professional or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

(a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated;

(b) the person's erasure from such a register, where the person has not been restored to the register;

(c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded; or

(d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

(a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002; or

(b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under:

(a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities); or

(b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 **Chair**

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at clause 3.1, this member must fulfil the following additional eligibility criteria:

(a) the Chair will be independent; and

(b) must meet the core competencies identified for the role of Chair and be subject to performance appraisal.

3.3.3 Individuals will not be eligible if:

(a) they hold a role in another health and care organisation within the ICB area;

(b) any of the disqualification criteria set out in clause 3.2 apply;

(c) any other exclusion criteria set out in the applicable NHS England guidance applies.

3.3.4 The term of office for the Chair will be up to 2 years for the initial terms and up to 3 years for subsequent terms and the maximum number of terms a Chair may serve is 3 terms.

3.4 **Chief Executive**

3.4.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.4.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.4.3 The Chief Executive must fulfil the following additional eligibility criteria:

(a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act; and

(b) meets the requirements as set out in the Chief Executive role description and person specification.

3.4.4 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) subject to clause 3.4.3(a), they hold any other employment or executive role;

(c) the process of disqualification is to be overseen by NHS England and Improvement and the Independent Non-Executive Member for Audit.

3.5 **Partner Members – NHS Trusts and Foundation Trusts within the ICB area**

3.5.1 The Partner Member (s) is jointly nominated by the NHS Trusts and/or FTs which provide services for the purpose of the health service within the ICB's area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition. Those Trusts and Foundation Trusts are:

(a) Chesterfield Royal Hospital NHS Foundation Trust;

(b) Derbyshire Healthcare NHS Foundation Trust;

(c) East Midlands Ambulance Services NHS Trust;

(d) University Hospitals of Derby and Burton NHS Foundation Trust; and

(e) Derbyshire Community Health Services NHS Foundation Trust.

3.5.2 This member(s) must fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria

(a) be an Executive Director of one of the NHS Trusts or Foundation Trusts within the ICB's area (from those listed at 3.5.1 above);

(b) One member will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness

3.5.3 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) any other exclusion criteria set out in the applicable NHS England guidance applies;

(c) a conflict of interest is evident, as determined by the Chair, which results in the individual being unable to fulfil the role.

3.5.4 These members will be appointed by the Chief Executive subject to the approval of the Chair.

3.5.5 The appointment process will be as follows:

(a) Joint Nomination

- When a vacancy arises for the Partner Member (s) from the Trusts or Foundation Trusts, including where one of these roles is also the lead for mental health, each eligible organisation listed at 3.5.1 will be invited to make one nomination per vacancy.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within five working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

(b) Assessment, selection, and appointment subject to approval of the Chair under 3.5.5(c)

- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

(c) Chair's approval

The Chair will determine whether to approve the appointment of the most suitable nominee as identified under 3.5.5(b).

3.5.6 The term of office for these Partner Members will be 3 years but individual terms may change subject to that individual fulfilling their substantive position and the total number of terms they may serve is 3 as a maximum. However, after the sixth year it may be permissible to extend by a single year at a time up to a total of 9 years by exception.

3.6 **Partner Member – Providers of Primary Medical Services**

3.6.1 This Partner Member is jointly nominated by providers of Primary Medical Services for the purposes of the health service within the ICB's area, and are Primary Medical Services contract holders responsible for the provision of essential services, within core hours to a list of registered persons whom the ICB has core responsibility.

3.6.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.

3.6.3 This member must fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

(a) be a health care professional from the Primary Medical Services;

(b) meet the requirements as set out in the Partner Member – Primary Medical Services role description and person specification.

3.6.4 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) any other exclusion criteria set out in the applicable NHS England guidance applies;

(c) a conflict of interest is evident, as determined by the Chair, which results in the individual being unable to fulfil the role.

3.6.5 This member will be appointed by a panel and approved by the Chair and the Chief Executive.

3.6.6 The appointment process will be as follows:

(a) Joint Nomination

- When a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make one nomination per vacancy.
- The nomination of an individual must be seconded by 2 other eligible organisations. [seconding is most suitable when there are large numbers of nominating organisations].
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within five working days being deemed to constitute agreement. If they do agree, the list will be put forward to

step b) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

(b) Assessment, selection, and appointment subject to approval of the Chair under 3.6.6(c)

- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

(c) Chair's approval

The Chair will determine whether to approve the appointment of the most suitable nominee as identified under 3.6.6(b).

3.6.7 The term of office for this Partner Member will be 3 years and the total number of terms they may serve is 3 terms.

3.7 **Partner Members – Local Authorities**

3.7.1 These Partner Members are jointly nominated by the local authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

(a) Derby City Council;

(b) Derbyshire County Council.

3.7.2 This member will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

(a) be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at clause 3.7.1;

(b) meet the requirements as set out in the Partner Member – Local Authority role description and person specification.

(c) one of these members must have knowledge and experience in public health

(d) one of these members must have knowledge and experience in child and adult social care

3.7.3 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) any other exclusion criteria set out in the applicable NHS England guidance applies.

3.7.4 This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.7.5 The appointment process will be as follows:

(a) Joint Nomination

- When a vacancy arises, each eligible organisation listed at 3.7.1(a) will be invited to make one nomination per vacancy.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within five working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

(b) Assessment, selection, and appointment subject to approval of the Chair under 3.7.1(c)

- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

(c) Chair’s approval

The Chair will determine whether to approve the appointment of the most suitable nominee as identified under 3.7.1(b).

3.7.6 To support the appointment process for the above, the process for selection for the Local Authority Partner Members will be that the ICB will set out the requirements of the roles, namely and the upper tier local authorities will consider how best to serve the Board of the ICB with senior Officers from adults and children's social care and public health. The two Local Authority Members must therefore balance membership for each of those functions;

3.7.7 The term of office for this Partner Member will be 2 years, and the total number of terms they may serve is 3 terms.

3.8 **Executive Medical Director**

3.8.1 This member will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

(a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;

(b) be a registered Medical Practitioner;

(c) meets the requirements as set out in the Executive Medical Director role description and person specification.

3.8.2 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) any other exclusion criteria set out in the applicable NHS England guidance applies.

3.8.3 This member will be appointed by the Chief Executive, following a competitive process, subject to the approval of the Chair.

3.9 **Executive Director of Nursing and Quality**

3.9.1 This member will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

(a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;

(b) be a registered Nurse;

(c) hold current valid registration with the Nursing and Midwifery Council;

(d) meet the requirements as set out in the Executive Director of Nursing role description person specification.

3.9.2 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) any other exclusion criteria set out in the applicable NHS England guidance applies.

3.9.3 This member will be appointed by the Chief Executive, following a competitive process, subject to the approval of the Chair.

3.10 **Executive Director of Finance**

3.10.1 This member will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

(a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act;

(b) be a qualified Accountant with full membership and evidence of up-to-date continuing professional development;

(c) Meets the requirements as set out in the Executive Director of Finance role description and person specification.

3.10.2 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) any other exclusion criteria set out in the applicable NHS England guidance applies.

3.10.3 This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.11 **Four Non-Executive Members**

3.11.1 The ICB will appoint four Non-Executive Members.

3.11.2 These members will be appointed by the Chair subject to the recruitment and selection process. These members will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

(a) not be an employee of the ICB or a person seconded to the ICB;

(b) not hold a role in another health and care organisation in the ICS area;

(c) one shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee;

(d) another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee;

(e) one member should have specific knowledge, skills and experience that makes them suitable to take the role of a senior independent member and take a lead role in the appraisal of the ICB Chair. This may not be the Chair of the Audit Committee.

3.11.3 Individuals will not be eligible if:

(a) any of the disqualification criteria set out in clause 3.2 apply;

(b) they hold a role in another health and care organisation within the ICB area;

(c) any other exclusion criteria set out in the applicable NHS England guidance applies;

(d) a conflict of interest is evident, as determined by the Chair, which results in the individual being unable to fulfil the role.

3.11.4 The usual term of office for a Non-Executive Member will be 3 years and the total number of terms an individual may serve is 2 terms with the potential to renew annually up to a maximum of 3 full terms (9 years).

3.11.5 In order to avoid a majority of the Non-Executive Member terms ending simultaneously, the Chair and Chief Executive will set the length of the initial term of office at between 2 and 3 years on a staggered basis across the roles.

3.11.6 Subject to satisfactory performance assessed through appraisal the ICB Chair may approve the re-appointment of a Non-Executive Member up to the maximum number of terms permitted for their role.

3.12 **Other Board Members**

3.12.1 Executive Director of People and Culture (Chief People Officer)

(a) This member will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

(i) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act;

(ii) meets the requirements as set out in the Executive Director of People and Culture (Chief People Officer) role description and person specification

(b) Individuals will not be eligible if:

(i) any of the disqualification criteria set out in clause 3.2 apply;

(ii) any other exclusion criteria set out in the applicable NHS England guidance applies;

(c) This member will be appointed by the Chief Executive subject to the approval of the Chair.

3.12.2 Clinical Lead Member (Clinical Chair of Quality and Performance Committee)

(a) This member will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

(i) Will need to meet the requirements as set out in the Clinical Lead role description and person specification.

(b) Individuals will not be eligible if:

(i) any of the disqualification criteria set out in clause 3.2 apply;

(ii) any other exclusion criteria set out in the applicable NHS England guidance applies.

(c) This member will be recruited, selected and appointed on a contract for services by the Chief Executive, subject to the approval of the Chair.

3.12.3 Regular Participants

(a) These participants will fulfil the eligibility criteria set out at clause 3.1 and also the following additional eligibility criteria:

(i) Executive Director of Corporate Affairs (Board Secretary);

(ii) Chair of Clinical and Professional Advisory Group (who will be a clinician); and

(iii) Other Executive Directors.

(b) Individuals will not be eligible if:

(i) any of the disqualification criteria set out in clause 3.2 apply; any other exclusion criteria set out in the applicable NHS England guidance applies;

(c) The above participants will be appointed by the Chief Executive subject to the approval of the Chair.

3.13 **Board Members: Removal from Office**

3.13.1 Arrangements for the removal from office of board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

3.13.2 With the exception of the Chair, board members shall be removed from office if any of the following occurs:

(a) if they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance;

(b) if they fail to attend a minimum of 50% of the meetings to which they are invited unless agreed with the Chair in extenuating circumstances;

(c) if they are deemed to not meet the expected standards of performance at their annual appraisal;

(d) if they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise;

(e) are deemed to have failed to uphold the Nolan Principles of Public Life;

(f) are subject to disciplinary proceedings by a regulator or professional body;

(g) if the role is no longer required (e.g. restructuring).

3.13.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in clause 3.13.2 apply.

3.13.4 Executive Directors (including the Chief Executive) will cease to be board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.13.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.

3.13.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

(a) terminate the appointment of the ICB's Chief Executive; and

(b) direct the chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.14 Terms of Appointment of Board Members

3.14.1 With the exception of the Chair and Non-Executive Members, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published www.ddicb.nhs.uk and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-Executive Members will be set by the Chief Executive.

3.14.2 Other terms of appointment will be determined by the Remuneration Committee.

3.14.3 Terms of appointment of the Chair will be determined by NHS England.

3.15 Specific arrangements for appointment of Ordinary Members made at establishment

3.15.1 Individuals may be identified as "designate ordinary members" prior to the ICB being established.

3.15.2 Relevant nomination procedures for partner members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5 to 3.7.

3.15.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate ordinary members should follow, as far as possible, the processes set out in section 3.5 to 3.12 of this Constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.15.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and [one other] will appoint the ordinary members who are expected to be all

individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments.

3.15.5 For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial ordinary members and all appointments post establishment will be made in accordance with clauses 3.5 to 3.12.

4. ARRANGEMENTS FOR THE EXERCISE OF OUR FUNCTIONS.

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

4.1.2 The ICB will agree a code of conduct and behaviours which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB code of conduct and behaviours will be published in the Governance Handbook.

4.2 General

4.2.1 The ICB will:

(a) comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;

(b) comply with directions issued by the Secretary of State for Health and Social Care;

(c) comply with directions issued by NHS England;

(d) have regard to statutory guidance including that issued by NHS England;

(e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England; and

(f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with clause 4.2.1(a) – (f) above, documenting them as necessary in this Constitution, its governance handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

(a) any of its members or employees;

(b) a committee or sub-committee of the ICB.

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the Scheme of Reservation and Delegation.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full www.ddicb.nhs.uk.

4.4.2 Only the board may agree the SoRD and amendments to the SoRD may only be approved by the board.

4.4.3 The SoRD sets out:

(a) those functions that are reserved to the board;

(b) those functions that have been delegated to an individual or to committees and sub committees;

(c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published www.ddicb.nhs.uk.

4.5.3 The map includes:

(a) key functions reserved to the board of the ICB;

(b) commissioning functions delegated to committees and individuals;

(c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; and

(d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and Sub-Committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the Board. All terms of reference are published in the Governance Handbook.

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and subcommittees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub committees that fulfil delegated functions of the ICB, will be required to:

(a) operate under terms of reference and membership agreed by the ICB as relevant. Appropriate reporting and assurance mechanisms must be developed as part of agreeing terms of reference for Committees and Sub-Committees and reported to the board;

(b) ensure that committee terms of reference are approved by the board and aligned with the SoRD;

(c) ensure membership of the committees are specified by the board;

(d) provide reports to the board on their activities at agreed intervals;

(e) attend board Meetings at the invitation of the Chair;

(f) comply with the outputs of internal audit findings and committee effectiveness reviews;

(g) submit to the ICB board a decision and assurance report following each Committee meeting;

(h) submit their confirmed minutes to the ICB board for assurance;

(i) comply with agreed internal audit findings and committee effectiveness reviews;

(j) demonstrate consideration of the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity;

(k) ensure that members abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of, or include, persons who are not ICB Members or employees.

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise

4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the standing orders as well as the SFIs and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

(a) **Audit Committee** – This committee is accountable to the board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit Committee will be chaired by a Non-Executive Member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters;

(b) **Remuneration Committee** – This committee is accountable to the board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration Committee will be chaired by a Non-Executive Member other than the ICB Chair or the Chair of Audit Committee.

4.6.9 The terms of reference for each of the above committees are published in the governance handbook.

4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per clause 4.3.2, the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB,

NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.

4.7.4 The board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the governance handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5. PROCEDURES FOR MAKING DECISIONS

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

(a) conducting the business of the ICB;

(b) the procedures to be followed during meetings; and

(c) the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the Standing Orders is included in Appendix 1 and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs published in the Governance Handbook available www.ddicb.nhs.uk.

6. ARRANGEMENTS FOR CONFLICT OF INTEREST MANAGEMENT AND STANDARDS OF BUSINESS CONDUCT

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the website www.ddicb.nhs.uk.

6.1.3 All board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of interest Policy and the Standards of Business Conduct Policy.

6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

(a) act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;

(b) be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;

(c) support the rigorous application of conflict of interest principles and policies;

(d) provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;

(e) provide advice on minimising the risks of conflicts of interest.

6.2 **Principles**

In discharging its functions the ICB will abide by the following principles:

6.2.1 decision-making will be open and transparent, will be inclusive and incorporate diverse views across the system. Decisions will be made in the interests of the health of the population and consistent with the statutory responsibilities of the ICB and ICS. Any individual involved in decisions relating to the ICB functions must be acting in the interests of the people of Derby and Derbyshire rather than furthering direct or indirect financial, personal, professional, or organisational interests. Decision making will be devolved to Place where appropriate.

6.2.2 the ICB has been created to give statutory NHS providers, local authority, and primary medical services (general practice) nominees a role in decision-making. These individuals will be expected to act in accordance with section 6.2.1(a), and it should not be assumed that they are personally or professionally conflicted by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations;

6.2.3 the personal and professional interests of all ICB board members, ICB committee members and ICB staff who are involved in decision taking must to be declared, recorded and managed appropriately. Declarations must be made as soon as practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days of the person becoming aware. This includes being clear and specific about the nature of any interest, and about the nature of any conflict that may arise regarding a particular decision;

6.2.4 actions to mitigate conflicts of interests should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible. Mitigation should take account of a range of factors including the impact that the perception of an unsound decision might have, and the risks and benefits of having a particular individual involved in making the decision;

6.2.5 the ICB will clearly distinguish between those individuals who should be involved in formal decision taking, and those whose input informs decisions, including shaping the ICB's understanding of how best to meet patients' needs and deliver care for their populations. The way conflicts of interest are managed should reflect this distinction. For example, where independent providers (including the VCSE sector) hold contracts for services it would be appropriate and reasonable for the body to involve them in discussions, for example about pathway design and service delivery, particularly at place-level. However, this would be clearly distinct from any considerations around contracting and commissioning, from which they would be excluded;

6.2.6 where decisions are being taken as part of a formal competitive procurement of services, any individual who is associated with an organisation that has a vested interest in the procurement should excuse themselves from the process; and

6.2.7 the way conflicts of interest are declared and managed will contribute to a culture of transparency about how decisions are made.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

(a) Members of the ICB;

(b) Members of the board's committees and sub-committees; and

(c) its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website www.ddicb.nhs.uk.

6.3.3 All relevant persons as per clauses 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per clause 6.3.1

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

(a) act in good faith and in the interests of the ICB;

(b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);

(c) comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct Policy.

7. ARRANGEMENTS FOR ENSURING ACCOUNTABILITY AND TRANSPARENCY

7.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Principles

7.2.1 Subsidiarity: arrangements should be designed to facilitate decisions being taken as close to local communities as possible, and at a larger scale where there are clear benefits from collaborative approaches and economies of scale.

7.2.2 Population-focused vision: decisions should be consistent with a clear vision and strategy that reflects the four core purposes.

7.2.3 Shared understanding: partners should have a collective understanding of the opportunities available by working together and the impact of individual organisational decisions on other parts of the system.

7.2.4 Co-design and co-production: addressing system challenges and decision-making should involve working with people, communities, clinicians, and professionals in an equal way, sharing influence, skills and experience to design, deliver and monitor services and projects.

7.2.5 Timely access to information and data: system partners should share accurate and complete data (quantitative and qualitative) in an open and timely manner to enable effective decision-making.

7.2.6 Clear and transparent decision-making: system partners should work in an open way ensuring that decision-making processes stand up to independent scrutiny.

7.2.7 Accountability: arrangements should be in line with the accountability framework and to each other.

7.3 Meetings and publications

7.3.1 Board meetings, and committees composed entirely of board members or which include all board members will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.3.2 Papers and minutes of all meetings held in public will be published.

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

7.3.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.3.6 Information will be provided to NHS England as required.

7.3.7 The Constitution and governance handbook will be published as well as other key documents including but not limited to:

(a) Conflicts of Interest Policy and procedures;

(b) Registers of Interests;

(c) key policies.

7.3.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

(a) section 14Z34 to 14Z45 (general duties of integrated care boards); ;

(b) sections 223H and 223J (financial duties); and

(c) the proposed steps to implement the Derby City and Derbyshire County joint local health and wellbeing strategies.

7.4 Scrutiny and Decision Making

7.4.1 At least three Non-Executive Members will be appointed to the board including the Chair; and all of the board and committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.4.2 7.4.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.4.3 The ICB will comply with the requirements of the NHS Provider Selection Regime, including: complying with existing procurement rules until the provider selection regime comes into effect.

7.4.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.5 Annual Report

7.5.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

(a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)

(b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)

(c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and

(d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8. ARRANGEMENTS FOR DETERMINING THE TERMS AND CONDITIONS OF EMPLOYEES.

8.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.2 The board has established a Remuneration Committee which is chaired by a Non-Executive Member other than the Chair or Audit Chair.

8.3 The membership of the Remuneration Committee is determined by the board. No employees may be a member of the Remuneration Committee but the board will ensure that the Remuneration Committee has access to appropriate advice by:

8.3.1 permitting the Remuneration Committee to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions, provided that it follows any procedures put in place by the ICB for obtaining legal or professional advice;

8.3.2 the Human Resources Advisor may act as an attendee to the Remuneration Committee.

8.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the board.

8.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in relating to paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the Governance Handbook.

8.6 The duties of the Remuneration Committee include:

8.6.1 setting the ICB remuneration policy (or equivalent) and standard terms and conditions;

8.6.2 making arrangements to pay employees such remuneration and allowances as it may determine;

8.6.3 set remuneration and allowances for members of the board;

8.6.4 set any allowances for members of committees or sub-committees of the ICB who are not members of the board;

8.6.5 for the Chief Executive, Directors and other Very Senior Managers; determine all aspects of remuneration including but not limited to salary (including any performance-related elements), bonuses, pensions and cars;

8.6.6 determine arrangements for termination of employment and other contractual terms and non-contractual terms;

8.6.7 for all staff; determine the ICB remuneration policy (including the adoption of remuneration frameworks such as Agenda for Change);

8.6.8 oversee contractual arrangements;

8.6.9 determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate;

8.6.10 oversee the arrangements for the performance review for Directors/Senior Managers;

8.6.11 receive assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and Proper Person Regulation (FPPR);

8.6.12 setting the ICB remuneration policy (or equivalent) and standard terms and conditions;

8.6.13 set any allowances for members of committees or sub-committees of the ICB who are not members of the board; and

8.6.14 any other relevant duties.

8.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9. ARRANGEMENTS FOR PUBLIC INVOLVEMENT

9.1 In line with section 14Z45(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

9.1.1 the planning of the commissioning arrangements by the Integrated Care Board;

9.1.2 the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them; and

9.1.3 decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.2 In line with section 14Z54 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

9.2.1 use our engagement model to put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS to ensure the voices of patients, service users, communities and staff are involved and that their insights are sought and utilised;

9.2.2 co-produce and redesign services and tackle system priorities in partnership with people and communities;

9.2.3 engender a culture of continuous engagement with people and communities and work with Healthwatch and community leaders as key partners;

9.2.4 build on the engagement assets of all partners in the ICS – networks, relationships, activity in local places;

9.2.5 start engagement at a formative stage when developing plans and feed back to people and communities how it has influenced activities and decisions;

9.2.6 understand our community's needs, experience and aspirations for health and care, using engagement to find out if change is working;

9.2.7 build relationships with excluded or harder to reach groups – especially those affected by inequalities – and create opportunities to engage where they do not currently exist;

9.2.8 provide clear and accessible public information about vision, plans and progress to build understanding and trust; and

9.2.9 govern our engagement strategy and activities through the relevant committee.

9.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities:

9.3.1 put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS;

9.3.2 start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions;

9.3.3 understand the community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect;

9.3.4 build relationships with excluded groups – especially those affected by inequalities;

9.3.5 work with Healthwatch and the voluntary, community and social enterprise sector as key partners;

9.3.6 provide clear and accessible public information about vision, plans and progress to build understanding and trust;

9.3.7 use community development approaches that empower people and communities, making connections to social action;

9.3.8 use co-production, insight and engagement to achieve accountable health and care services;

9.3.9 co-produce and redesign services and tackle system priorities in partnership with people and communities; and

9.3.10 learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.4 In addition the ICB has agreed the following:

9.4.1 these principles will be used when developing and maintaining arrangements for engaging with people and communities;

9.4.2 these arrangements, include:

(a) a Communications and Engagement Strategy that is frequently reviewed by the ICB and where delivery is overseen by the relevant committee;

(b) ensure arrangements are put in place that enable patient and public involvement at local Place level, and in the work of Provider Collaboratives;

(c) appointment of a Non-Executive Member with a specific role to seek assurance on the ICB's arrangements for discharging its duties in relation to patient and public involvement;

(d) deployment of our assets to support engagement, including:

(i) our Citizen's Panel;

(ii) our Online Engagement Platform;

(iii) the System Insight Group and insight library;

(iv) ensuring sufficient expertise, training and resources are available to support effective engagement;

(v) arranging system-wide and place-based events and activities to speak to all stakeholders, including the ongoing deployment of our Derbyshire Dialogue model of online engagement.

Appendix 1 – Standing Orders

1. INTRODUCTION

These Standing Orders have been drawn up to regulate the proceedings of NHS Derby and Derbyshire Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. AMENDMENT AND REVIEW

2.1 The Standing Orders are effective from the 1st of July 2022.

2.2 Standing Orders will be reviewed on an annual basis or sooner if required.

2.3 Amendments to these Standing Orders will be made as per section 5.1 of the Constitution.

2.4 All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. INTERPRETATION, APPLICATION AND COMPLIANCE

3.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 2.

3.2 These standing orders apply to all meetings of the board, including its committees and sub-committees unless otherwise stated. All references to board are inclusive of committees and sub-committees unless otherwise stated.

3.3 All members of the board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the Executive Director of Corporate Affairs will provide a settled view which shall be final.

3.5 All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6 If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the board for action or ratification and the Audit Committee for review.

4. MEETINGS OF THE INTEGRATED CARE BOARD

4.1 Calling Board Meetings

4.1.1 Meetings of the board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2 In normal circumstances, each member of the board will be given not less than one month's notice in writing of any meeting to be held. However:

(a) the Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing;

(b) one third of the members of the board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting; and

(c) in emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3 A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed if part of a meeting is not likely to be open to the public.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the board.

4.2.2 If the Chair is absent or is disqualified from participating by a conflict of interest, a member of the ICB, board, committee or sub-committee respectively shall be chosen by the members present, or by a majority of them, and shall preside.

4.2.3 The board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The

agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at www.ddicb.nhs.uk.

4.4 **Petitions**

4.4.1 Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the board in accordance with the ICB policy as published in the Governance Handbook.

4.5 **Nominated Deputies**

4.5.1 With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to attend a meeting of the board that they are unable to attend. The deputy may speak and vote on their behalf. Partner Members and Executive Directors will ensure the attendance of a nominated deputy at all meetings where they are unable to attend.

4.5.2 The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6 **Virtual attendance at meetings**

The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

4.7 **Quorum**

4.7.1 The quorum for meetings of the Board will be at least 7 members, including:

(a) ICB Chair; plus

(b) either the Chief Executive or the Executive Director of Finance;

(c) either the Executive Medical Director or the Executive Director of Nursing and Quality;

(d) at least two Non-Executive Members; and

(e) at least two Partner Members.

4.7.2 For the sake of clarity:

(a) no person can act in more than one capacity when determining the quorum;

(b) an individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum; and

(c) for all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8 Vacancies and defects in appointments

4.8.1 The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

(a) a representative from the specific category where the vacancy or defect exists would attend.

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

(a) all members of the board who are present at the meeting will be eligible to cast one vote each;

(b) in no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so;

(c) for the sake of clarity, any additional Participants and Observers (as detailed within paragraph 2.2 of the Constitution) will not have voting rights;

(d) a resolution will be passed if more votes are cast for the resolution than against it;

(e) if an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote; and

(f) should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

4.9.3 <u>Disputes</u>

Where helpful, the board may draw on third party support to assist them in resolving any disputes, such as peer review or mediation by NHS England.

4.9.4 Urgent decisions

(a) In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply.

(b) The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair (or Vice Chair in the Chair's absence) and Chief Executive (or Deputy Chief Executive in the Chief Executive's absence) subject to every effort having been made to consult with as many board members as possible in the given circumstances.

(c) The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit Committee for oversight.

4.10 **Minutes**

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 **Admission of public and the press**

4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960 All meetings of the board and all meetings of committees which are comprised of entirely board members or all board members at which public functions are exercised will be open to the public.

4.11.2 The Board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board’s business shall be conducted without interruption and disruption.

4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the board.

5. SUSPENSION OF STANDING ORDERS

5.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members.

5.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. USE OF SEAL AND AUTHORISATION OF DOCUMENTS.

6.1 **Integrated Care Board's seal**

The ICB may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

6.1.1 the Chief Executive;

6.1.2 the Executive Director of Finance;

6.1.3 the Executive Director of Corporate Affairs (Board Secretary).

6.2 **Execution of a document by signature**

The following individuals are authorised to execute a document on behalf of the ICB by their signature.

6.2.1 the Chief Executive;

6.2.2 the Executive Director of Finance;

6.2.3 the Executive Director of Corporate Affairs (Board Secretary).

Appendix 2 – Definitions of Terms Used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
ICB board	Members of the ICB.
Area	The geographical area that the ICB has responsibility for, as defined in paragraph 2 of this Constitution.
Committee	A committee created and appointed by the ICB board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Governance Handbook	The ICB Governance Handbook the contents which are described in section 1.7.3 (d)
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Provider Collaborative	NHS Trusts working together to achieve better outcomes for people and ensure sustainable services in the future.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following**:** • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

	NHS England expects, so the ICB achieves ongoing compliance, that this requirement will be met through appointment against appropriate criteria of: a Partner Member (jointly nominated by all NHS trusts/foundation trusts, additional to the minimum of one partner member of each category required by the Act);or a separately appointed board member (i.e. not jointly nominated) likewise normally a mental health trust/foundation trust executive which could be a Chief Executive; or, where appropriate, an ICB executive director for mental health .*
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002
	ICBs should add local definitions as required and should always include any local terms that refer to legally prescribed roles or functions.

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

19th January 2023

Item: 080

Report Title	Joint Forward Plan and 2023/24 Planning Guidance							
Author	NHS England							
Sponsor (Executive Director)	Zara Jones, Executive Director of Strategy and Planning							
Presenter	Zara Jones, Executive Director of Strategy and Planning							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Appendix 1 – Guidance on developing the joint forward plan Appendix 2 – 2023/24 priorities and operational planning guidance							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Not applicable							

Recommendations
The Board are recommended to **NOTE** the Joint Forward Plan and 2023/24 Planning Guidance.
Purpose
The purpose of the report is to make the Board aware of the Joint Forward Plan and 2023/24 Planning Guidance.
Background
ICBs and their partner trusts have a duty to prepare a first Joint Forward Plan before the start of the financial year 2023/24. For this first year, however, NHS England is to specify that the date for publishing and sharing the final plan with NHS England, their integrated care partnerships (ICPs) and Health and Well-being Boards (HWBs), is 30 June 2023. We therefore expect that the process for consulting on a draft (or drafts) of the plan, should be commenced with a view to producing a version by 31 March, but recognise that consultation on further iterations may continue after that date, prior to the plan being finalised in time for publication and sharing by 30 June. The 2023/24 Planning Guidance has been developed to assist the ICB in meeting the following three national objectives: • recover our core services and productivity; • as we recover, make progress in delivering the key ambitions in the Long Term Plan (LTP); and • continue transforming the NHS for the future.

Report Summary					
As above, the report is to make the Board aware of the Joint Forward Plan and 2023/24 Planning Guidance.					
Identification of Key Risks					
Not applicable.					
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					
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 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 Not applicable.					

Classification: Official

Publication approval reference: PR1940

Guidance on developing the joint forward plan

Version 1.0, 23 December 2022

Contents

1. Introduction

This guidance supports integrated care boards (ICBs) and their partner NHS trusts and foundation trusts (referred to collectively in this guidance as partner trusts) to develop their first 5-year joint forward plans (JFPs) with system partners. The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires ICBs and their partner trusts[1] to prepare their JFP before the start of each financial year.

This guidance sets out a flexible framework for JFPs to build on existing system and place strategies and plans, in line with the principle of subsidiarity. It also states specific statutory requirements that plans must meet.

It should be read alongside guidance on NHS priorities and operational planning which can be found here. Specific JFP supporting resources will be available here.

1.1 Action required of integrated care boards (ICBs) and their partner trusts

ICBs and their partner trusts have a duty to prepare a first JFP before the start of the financial year 2023/23 – i.e. by 1 April. For this first year, however, NHS England is to specify that the date for publishing and sharing the final plan with NHS England, their integrated care partnerships (ICPs) and Health and Well-being Boards (HWBs), is 30 June 2023. We therefore expect that the process for consulting on a draft (or drafts) of the plan, should be commenced with a view to producing a version by 31 March, but recognise that consultation on further iterations may continue after that date, prior to the plan being finalised in time for publication and sharing by 30 June.

ICBs and their partner trusts must consult with those for whom the ICB has core responsibility[2] and anyone else they consider appropriate. This should include the ICP and NHS England (with respect to the commissioning functions that have been

[1] The ICB's partner NHS trusts and foundation trusts are named in its constitution
[2] People who are registered with a GP practice associated with the ICB, or unregistered patients who usually reside in the ICB's area (as described in the ICB constitution).

and will be delegated to ICBs). A draft JFP should be shared with the relevant ICP and NHS England; see section 4.1.

ICBs and their partner trusts must involve relevant HWBs in preparing or revising the JFP. This includes sharing a draft with each relevant HWB, and consulting relevant HWB's on whether the JFP takes proper account of each relevant joint local health and wellbeing strategy (JLHWS); see section 4.1.

ICBs and their partner trusts should agree processes for finalising and signing off the JFP. The final version must be published, and ICBs and their partner trusts should expect to be held to account for its delivery – including by their population, patients and their carers or representatives – and in particular through the ICP, Healthwatch and the local authorities' health overview and scrutiny committees. JFPs must be reviewed and, where appropriate, updated before the start of each financial year; see section 4.2.

1.2 Purpose of the joint forward plan

Systems have significant flexibility to determine their JFP's scope as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner trusts. However, we encourage systems to use the JFP to develop a shared delivery plan for the integrated care strategy (developed by the ICP) and the JLHWS (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.

As a minimum, the JFP should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments[3], address ICSs' four core purposes and meet legal requirements[4].

1.3 Relationship with NHS planning

ICBs and their partner trusts will continue to separately submit specific operational and financial information as part of the nationally co-ordinated NHS planning

[3] For the purposes of this guidance, universal NHS commitments are those described in the annual NHS priorities and operational planning guidance and NHS Long Term Plan.
[4] This includes the National Health Service Act 2006 and the requirements of the Public Sector Equality Duty, section 149 of the Equality Act 2010.

process. We will work with systems to avoid duplication and ensure alignment between NHS planning submissions and the public-facing JFP.

2. Principles

Three principles describing the JFP's nature and function have been co-developed with ICBs, trusts and national organisations representing local authorities and other system partners.

Box 1: JFP principles

Principle 1: Fully aligned with the wider system partnership's ambitions.

Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.

Principle 3: Delivery focused, including specific objectives, trajectories and milestones as appropriate.

3. Legislative requirements

Statute describes the purpose of the JFP, the NHS mandate, the integrated care strategy, JLHWSs, joint strategic needs assessments (JSNAs) and system capital plans. For the relationship between the various requirements, see Appendix 1.

Appendix 2, Table 1 describes each statutory requirement the JFP must meet.

4. Developing the joint forward plan

4.1 Consultation

Close engagement with partners will be essential to the development of JFPs[5]. This includes working with:

- the ICP (ensuring this also provides the perspective of social care providers)[6]
- primary care providers[7]
- local authorities and each relevant HWB
- other ICBs in respect of providers whose operating boundary spans multiple ICSs
- NHS collaboratives, networks and alliances
- the voluntary, community and social enterprise sector
- people and communities that will be affected by specific parts of the proposed plan, or who are likely to have a significant interest in any of its objectives, in accordance with the requirement to consult described below.

Where an ICB and its partner trusts are developing their JFP or revising an existing plan in a way they consider to be significant (see section 4.2 for revision of plans), there is a statutory duty to consult:

- people for whom the ICB has core responsibility: i.e. those registered with a GP practice associated with the ICB or unregistered patients who usually reside in the ICB's area (as described in the ICB constitution)

[5] This relates to the general duty of ICBs to involve the public (s14Z45 of the NHS Act 2006), the duty of NHS trusts to involve the public (s242 of the NHS Act 2006) and the ICB duty to consult with the public and other relevant persons when developing the JFP (s14Z54 of the NHS Act 2006).
[6] See guidance on adult social care principles for ICPs; this advises on how ICPs and adult social care providers should work together.
[7] This includes the full breadth of primary care services, including general practice, community pharmacy, optometry and dental services.

- anyone else they consider it appropriate to consult: e.g. specific organisations with an interest in the plan or whose views it would be useful to obtain, and out-of-area patients who receive treatment funded by the ICB.

The approach should be determined by the ICB and its partner trusts but could involve working with people to understand how services can better meet local needs, developing priorities for change and gathering feedback on draft JFPs.

As JFPs will build on and reflect existing JSNAs, JLHWSs and NHS delivery plans, we do not anticipate their development will require full formal public consultation, unless a significant reconfiguration or major service change is proposed.[8]

Previous local patient and public engagement exercises and subsequent action should inform the JFP. The ICB and its partners will need to consider how this is managed to maximise the benefits from engagement and fulfil these statutory duties efficiently.

The JFP must be reviewed and either updated or confirmed annually before the start of each financial year. For consistency and to avoid duplication of effort, we recommend ICBs and their partner trusts develop a standard approach to consulting on the JFP, while recognising this may need to change over time.

In developing the JFP, ICBs and their partner trusts should consider other relevant duties: e.g. seeking the views of underserved groups (such as inclusion health and vulnerable populations) as part of the duty to reduce inequalities. They must also show they have discharged their legal duty under the Public Sector Equality Duty (s.149, Equality Act 2010).

ICBs and their partner trusts must include in their JFP a summary of the views expressed by anyone they have a duty to consult and explain how they have taken them into account.

Further guidance on public engagement and consultation for ICBs is on our website.

[8] See also Cabinet Office guidance on consultation principles and Local authority health scrutiny guidance (which provides guidance on service reconfigurations and scrutiny by health overview and scrutiny committees).

NHS England's role

We will support ICBs and their partner trusts to develop JFPs – please engage early with us. This will be of particular importance, for example, in relation to the services that we will delegate in future to ICBs.

We will review and comment on the draft JFP, and we recommend this is done in parallel with the review by HWBs (see below). This will not be a formal assurance process but an opportunity to support ICBs and their partner trusts to develop their plans.

Separately we will continue to conduct formal assurance of the information submitted in operational planning returns.

Role of health and wellbeing boards

In preparing or revising their JFPs, ICBs and their partner trusts are subject to a general legal duty to involve each HWB whose area coincides with that of the ICB, wholly or in part. The plan itself must describe how the ICB proposes to implement relevant JLHWSs.[9]

ICBs and their partner trusts must send a draft of the JFP to each relevant HWB when initially developing it or undertaking significant revisions or updates. They must consult those HWBs on whether the draft takes proper account of each JLHWS published by the HWB that relates to any part of the period to which the JFP relates. A HWB must respond with its opinion and may also send that opinion to us, telling the ICB and its partner trusts it has done so (unless it informed them in advance that it was planning to do so)[10].

If an ICB and its partner trusts subsequently revises a draft JFP, the updated version should be sent to each relevant HWB, and the consultation process described above repeated.

The JFP must include a statement of the final opinion of each HWB consulted.

[9] A joint local health and wellbeing strategy (JLHWS) is defined as a strategy under section 116A of the Local Government and Public Involvement in Health Act 2007, as amended by the Health and Care Act 2022.

[10] We may discuss this opinion with the ICB and its partner NHS trusts and foundation trusts.

4.2 Revision of joint forward plans

Annual updates

ICBs and their partner trusts should review their JFP before the start of each financial year, by updating or confirming that it is being maintained for the next financial year. They may also revise the JFP in-year if they consider this necessary.

We recognise that 2022/23 is a transition year for ICSs and that it will require time and extensive engagement to fully develop integrated care strategies. The annual refresh of JFPs allows plans to be iterated and provides the opportunity for further engagement and collaboration, as well as the opportunity to continue to reflect the most appropriate delivery mechanisms and partners' actions.

Where an ICB and its partner trusts update the JFP, in a way they consider to be significant, the same requirements regarding engagement and consultation apply.

Available support

Supporting resources providing further content recommendations will be available soon.

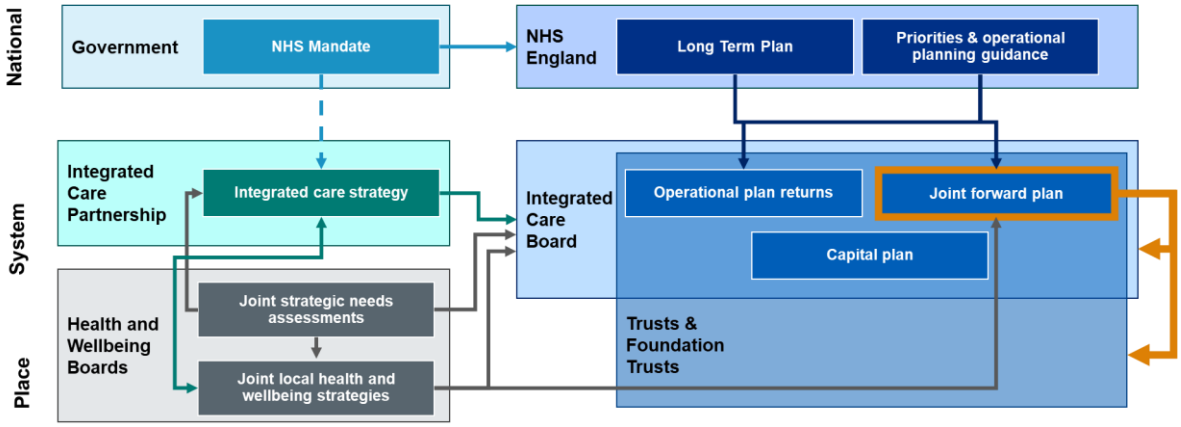
NHS England regional teams can offer support and advice and should be engaged early.

Please direct any technical queries to england.nhs-planning@nhs.net.

Appendix 1: Legislative framework – further detail

Figure 1 shows the statutory framework relating to the JFP. Please note, it does not show interaction with wider system partners.

Figure 1: Relationship of the JFP with other strategies and plans[11]



NHS mandate

The government's mandate to NHS England sets out our objectives, revenue and capital resource limits. This informs both our guidance on priorities and planning requirements and the integrated care strategy.

The JFP will address objectives in the government mandate regarding the ambitions in the NHS Long Term Plan and NHS planning guidance. It will also deliver on the integrated care strategy, which must have regard to the mandate.

Integrated care strategy

The Department of Health and Social Care has issued guidance on the development of integrated care strategies.

[11] In some systems, HWBs' geography is coterminous (or nearly coterminous) with the system footprint and therefore the relationships may be different.

The Local Government and Public Involvement in Health Act 2007, as amended by the Health and Care Act 2022, requires the ICP to produce an integrated care strategy. This should describe how the local population's assessed needs will be met through the exercise of functions by the ICB, local authorities and NHS England. It must address integration of health and social care and should address integration with health-related services.

In addition, the ICP must have regard to the NHS mandate in developing the integrated care strategy. As such, it should reflect both NHS priorities described in the mandate and the local population's assessed needs.

The ICB has a statutory duty to have regard to the relevant integrated care strategy in exercising its functions. The JFP is expected to set out steps for delivering the integrated care strategy.

Capital plan

Before the start of each financial year, ICBs and their partner trusts must set out their planned capital resource use. We will publish separate guidance on preparing capital plans.

The content of the JFP should be consistent with this capital plan.

Joint strategic needs assessments (JSNA)

JSNAs, developed by each responsible local authority and its partner ICBs, assess needs that can be met or be affected by the responsible local authority, its partner ICBs or NHS England. These include the local community's current and future health, care and wellbeing needs, as well as the wider determinants of health which affect those needs, to inform local decision-making and collaboration on development of JLHWSs and the integrated care strategy.

The ICB has a statutory duty to have regard to JSNAs when exercising any relevant functions. The JFP is expected to describe delivery plans to meet the population health needs of people in the ICB's area.

Joint local health and wellbeing strategies

Each responsible local authority and its partner ICBs will have produced a JLHWS. This is a strategy to meet the needs identified in JSNAs and is unique to each local area. The ICP is expected to build on the JLHWS, which may be facilitated by shared membership across HWBs and the ICP.

Each responsible local authority and its partner ICBs are required to consider whether JLHWSs need to be updated in response to any new or updated integrated care strategy.

The ICB has a statutory duty to have regard to JLHWSs in exercising any relevant functions. The steps that the ICB proposes to take to implement any JLHWS must be described in the JFP.

Appendix 2: Legislative requirements – further detail

Table 1: Summary of legislative requirements

Legislative requirement	Description	Implications for the JFP
Describing the health services for which the ICB proposes to make arrangements	The plan must describe the health services for which the ICB proposes to make arrangements in the exercise of its functions.	The plan should set out how the ICB will meet its population's health needs. As a minimum, it should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet the physical and mental health needs of their population.
Duty to promote integration	Each ICB must exercise its functions with a view to ensuring that health services are delivered in an integrated way and that their provision is integrated with that of health-related or social care services, where this would: • improve quality of those services • reduce inequalities in access and outcomes.	Plans should describe how ICBs will integrate health services, social care and health-related services to improve quality and reduce inequalities. This could include organisational integration (e.g. provider collaboratives), functional integration (e.g. non-clinical functions), service or clinical integration (e.g. through shared pathways, multidisciplinary teams, clinical assessment processes).

Legislative requirement	Description	Implications for the JFP
		This must include delivery on the integration ambitions described in the relevant integrated care strategy and joint local health and wellbeing strategies (JLHWSs).
Duty to have regard to wider effect of decisions	In making decisions about the provision of healthcare, an ICB must consider the wider effects of its decisions, also known as the 'triple aim' of (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing), (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies.	The plan should articulate how the triple aim was considered in its development. It should also describe approaches to ensure the triple aim is embedded in decision-making and evaluation processes.
Financial duties	The plan must explain how the ICB intends to discharge its financial duties	The plan must describe how the financial duties under sections 223GB to 223N of the NHS Act 2006 will be addressed. This includes ensuring that the expenditure of each ICB and its partner trusts in a financial year (taken together) does not exceed the aggregate of any sums received by them in the year,

Legislative requirement	Description	Implications for the JFP
		and complying with NHS England financial objectives, directions and expenditure limits. It should also set out how the efficiency and productivity of NHS services will be improved in line with the core purpose to ‘enhance productivity and value for money’. This should include the key actions the ICB will take to ensure that the collective resources of the health system are used effectively and efficiently. This could include specific plans to support the effectiveness of financial governance and controls; address unwarranted variation; strengthen understanding of the cost of whole care pathways; maximise consolidation and collaboration opportunities across corporate services; unlock efficiency through capital investment; and improve use of NHS estate.
Implementing any JLHWS	The plan must set out the steps that the ICB proposes to take to implement any JLHWSs to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.	The plan must set out steps the ICB will take to deliver on ambitions described in any relevant JLHWSs, including identified local target outcomes, approaches and priorities.

Legislative requirement	Description	Implications for the JFP
Duty to improve quality of services	Each ICB must exercise its functions with a view to securing continuous improvement in: • the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness • outcomes including safety and patient experience.	The plan should contain a set of quality objectives that reflect system intelligence. It should include clearly aligned metrics (on processes and outcomes) to evidence ongoing sustainable and equitable improvement. Quality priorities should go beyond performance metrics and look at outcomes and preventing ill-health, and use the Core20PLUS5 approach to ensure inequalities are considered. Plans should align with the National Quality Board principles.
Duty to reduce inequalities	Each ICB must have regard to the need to (a) reduce inequalities between persons with respect to their ability to access health services and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. There is also a duty to have regard to the wider effects of decisions on inequalities. The duty to promote integration requires consideration of securing integrated provision across health, health-related and social	The plan should set out how the ICB intends to deliver on the national vision to ensure delivery of high-quality healthcare for all, through equitable access, excellent experience and optimal outcomes. ICBs must also be mindful of, and comply with, the requirements of the Public Sector Equality Duty, section 149 of the Equality Act 2010.

Legislative requirement	Description	Implications for the JFP
	services where this would reduce inequalities in access to services or outcomes achieved.	
Duty to promote involvement of each patient	Each ICB must promote the involvement of patients, and their carers and representatives (if any), in decisions that relate to (a) the prevention or diagnosis of illness in the patients or (b) their care or treatment.	The plan should describe actions to implement the Comprehensive model of personalised care, which promotes the involvement of each patient in decisions about prevention, diagnosis and their care or treatment.
Duty to involve the public	ICBs and partner trusts have a duty to involve people and communities in decisions about the planning, development and operation of services commissioned and provided.	The plans should describe how: • the public and communities were engaged in the development of the plan • the ICB and partner trusts will work together to build effective partnerships with people and communities, particularly those who face the greatest health inequalities, working with wider ICS stakeholders to achieve this • activity at neighbourhood and place level informs decisions by the system and how public involvement legal duties are met and assured.

Legislative requirement	Description	Implications for the JFP
Duty to patient choice	Each ICB must act with a view to enabling patients to make choices with respect to aspects of health services provided to them.	The plan should describe how ICBs will ensure that patient choice is considered when developing and implementing commissioning plans and contracting arrangements, and delivering services. The plan should also describe how legal rights are upheld and how choices available to patients are publicised and promoted.
Duty to obtain appropriate advice	Each ICB must obtain appropriate advice to enable it to effectively discharge its functions from persons who (taken together) have a broad range of professional expertise in (a) the prevention, diagnosis or treatment of illness and (b) the protection or improvement of public health.	The plan should outline the ICB's strategy for seeking any expert advice it requires, including from local authority partners and through formal governance arrangements and broader engagement.
Duty to promote innovation	Each ICB must promote innovation in the provision of health services (including in the arrangements made for their provision).	The plan should set out how the ICB will promote local innovation, build capability for the adoption and spread of proven innovation and work with academic health science networks and other local partners to support the identification and adoption of new products and pathways that align with population health needs and address health inequalities.

Legislative requirement	Description	Implications for the JFP
Duty in respect of research	Each ICB must facilitate or otherwise promote (a) research on matters relevant to the health service and (b) the use in the health service of evidence obtained from research.	The plan should set out how the ICB will facilitate and promote research, and systematically use evidence from research when exercising its functions. This could include considering research when commissioning, encouraging existing providers to support and be involved in research delivery, recognising the research workforce in workforce planning, and supporting collaboration across local National Institute for Health and Care Research (NIHR) networks. Plans should address the research needs of the ICB's diverse communities.
Duty to promote education and training	Each ICB must have regard to the need to promote education and training[12] so as to assist the Secretary of State and Health Education England (HEE)[13] in the discharge of the duty under that section.	The plan should describe how the ICB will apply education and training as an essential lever of an integrated workforce plan that supports the delivery of services in the short, medium and long term. The plan should articulate the role of education and training in securing healthcare staff supply and

[12] This duty relates specifically to persons mentioned in section 1F(1) National Health Service Act 2006. They are "persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England".

[13] Subject to the parliamentary passage of the required Regulations, it is intended that HEE will merge with NHS England in April 2023.

Legislative requirement	Description	Implications for the JFP
		responding to changing service models, as well as the role of trainees in service delivery.
Duty as to climate change, etc	Each ICB must have regard to the need to (a) contribute towards compliance with (i) section 1 of the Climate Change Act 2008 (UK net zero emissions target) and (ii) section 5 of the Environment Act 2021 (environmental targets), and (b) adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008.	The plan should describe how the ICB and its partner trusts will deliver against the targets and actions in Delivering a 'Net Zero' NHS , including through aligning the JFP with existing green plans.
Addressing the particular needs of children and young persons	The plan must set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.	This could include using data and gathering insights to ensure the plan identifies and sets steps for delivery of the longer-term priorities and ambitions for the ICB's population of children, young people and families.
Addressing the particular needs of victims of abuse	The plan must set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic and sexual abuse, whether children or adults). It must have due regard to the	This should include related health inequalities and access to, and outcomes from, services. The plan should also cover the needs of staff who are victims of abuse.

Legislative requirement	Description	Implications for the JFP
	provisions of the Domestic Abuse Act 2021 and accompanying statutory guidance, and relevant safeguarding provisions.	This should include the use of data and lived experience to ensure the plan identifies and sets out steps for the delivery of longer-term priorities and ambitions for supporting victims, tackling perpetrators and the prevention of abuse, including through the commissioning of services.

Other content

Table 2: Other recommended content

Content	Brief description
Workforce	Evidence-based, integrated, inclusive workforce plans that ensure the right workforce with the right skills is in the right place to deliver operational priorities aligned to finance and activity plans.
Performance	Specific performance ambitions with trajectories and milestones that align with NHS operational plan submissions and pay due regard to the ambitions of the NHS Long Term Plan, as appropriate.
Digital/data	Steps to increase digital maturity and ensure a core level of infrastructure, digitisation and skills. These actions should contribute to meeting the ambition of a digitised, interoperable and connected health and care system as a key enabler to deliver more effective, integrated care. This could include reducing digital inequity and inequalities and supporting net zero objectives.
Estates	Steps to create stronger, greener, smarter, better, fairer health and care infrastructure together with efficient use of resources and capital to deliver them. This should align with and be incorporated within forthcoming ICS infrastructure strategies.
Procurement/supply chain	Plans to deliver procurement to maximise efficiency and ensure aggregation of spend, demonstrating delivery of best value. This could include governance and development of supporting technology and data infrastructure to align or ensure interoperability with procurement systems throughout the ICS.

Content	Brief description
Population health management	The approach to supporting implementation of more preventative and personalised care models driven through data and analytical techniques such as population segmentation and financial demand modelling. This could include: developing approaches to better understand and anticipate population needs and outcomes (including health inequalities); using population health management approaches to understand future demand and financial risk; support redesign of integrated service models based on the needs of different groups; and putting in place the underpinning infrastructure and capability to support these approaches.
System development	How the system organises itself and develops to support delivery. This could include: governance; role of place; role of provider collaboratives; clinical and care professional leadership; and leadership and system organisational development.
Supporting wider social and economic development	How the ICB and NHS providers will support the development and delivery of local strategies to influence the social, environmental and economic factors that impact on health and wellbeing. This could include their role as strategic partners to local authorities and others within their system, as well as their direct contribution as planners, commissioners and providers of health services and as ‘anchor institutions’ within their communities.

Classification: Official

Publication approval reference: PRN00021

2023/24 priorities and operational planning guidance

23 December 2022

Foreword from the NHS CEO

Thank you to you, and to your teams, for your continued extraordinary efforts on behalf of our patients – particularly over the past weeks as we have prepared for and managed periods of industrial action. There is no denying it has been an incredibly challenging year for everyone working in the NHS, and arguably tougher than the first years of the pandemic.

We have already made real progress towards many of our goals for 2022/23 – in particular in all but eradicating two year waits for elective care and delivering record numbers of urgent cancer checks. This was achieved alongside continuing to respond to the build-up of health needs during the pandemic, an ongoing high level of COVID-19 infection and capacity constraints in social care, increased costs due to inflation and reduced productivity due to the inevitable disruption caused by COVID-19.

2023/24 will also be challenging. Our planning approach therefore reflects both our new ways of working, as recently articulated in the NHS Operating Framework, and an acknowledgement of the continuing complexity and pressure you face.

We will support local decision making, empowering local leaders to make the best decisions for their local populations and have set out fewer, more focused national objectives. These align with our three tasks over the coming year:

- recover our core services and productivity;
- as we recover, make progress in delivering the key ambitions in the Long Term Plan (LTP), and;
- continue transforming the NHS for the future.

To assist you in meeting these objectives, we have set out the most critical, evidence-based actions that will support delivery - based on what systems and providers have already demonstrated makes the most difference to patient outcomes, experience, access and safety.

I look forward to continuing to work with and support you over the year ahead to deliver the highest possible quality of care for patients and the best possible value for taxpayers.

Amanda Pritchard

Our priorities for 2023/24

In 2023/24 we have three key tasks. Our immediate priority is to recover our core services and productivity. Second, as we recover, we need to make progress in delivering the key ambitions in the NHS Long Term Plan. Third, we need to continue transforming the NHS for the future.

The table below sets out our national objectives for 2023/24. They will form the basis for how we assess the performance of the NHS alongside the local priorities set by systems.

Recovering our core services and productivity

To improve patient safety, outcomes and experience it is imperative that we:

- improve ambulance response and A&E waiting times
- reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard
- make it easier for people to access primary care services, particularly general practice.

Recovering productivity and improving whole system flow are critical to achieving these objectives. Essential actions include: reducing ambulance handovers, bed occupancy and outpatient follow-ups relative to first appointments; increasing day case rates and theatre utilisation; moving to self-referral for many community services where GP intervention is not clinically necessary and increasing use of community pharmacies. We must also increase capacity in beds, intermediate care, diagnostics, ambulance services and the permanent workforce. These actions are supported by specific investments, including those jointly with local authorities to improve discharge.

Our people are the key to delivering these objectives and our immediate collective challenge is to improve staff retention and attendance through a systematic focus on all elements of the NHS People Promise.

As we deliver on these objectives we must continue to narrow health inequalities in access, outcomes and experience, including across services for children and young people. And we must maintain quality and safety in our services, particularly in maternity services.

The NHS has an important role in supporting the wider economy and our actions to support the physical and mental wellbeing of people will support more people return to work.

Delivering the key NHS Long Term Plan ambitions and transforming the NHS

We need to create stronger foundations for the future, with the goals of the NHS Long Term Plan our 'north star'. These include our core commitments to improve mental health services and services for people with a learning disability and autistic people.

Prevention and the effective management of long-term conditions are key to improving population health and curbing the ever increasing demand for healthcare services. NHS England will work with integrated care systems (ICSs) to support delivery of the primary and secondary prevention priorities set out in the NHS Long Term Plan.

We need to put the workforce on a sustainable footing for the long term. NHS England is leading the development of a NHS Long Term Workforce Plan and government has committed to its publication next spring.

The long-term sustainability of health and social care also depends on having the right digital foundations. NHS England will continue to work with systems to level up digital infrastructure and drive greater connectivity- this includes development of a 'digital first' option for the public and further development of and integration with the NHS App to help patients identify their needs, manage their health and get the right care in the right setting.

Transformation needs to be accompanied by continuous improvement. Successful improvement approaches are abundant across the NHS but they are far from universal. NHS England will develop the national improvement offer to complement local work, using what we have learned from engaging with over 1,000 clinical and operational leaders in the summer.

Local empowerment and accountability

ICSs are best placed to understand population needs and are expected to agree specific local objectives that complement the national NHS objectives set out below. They should continue to pay due regard to wider NHS ambitions in determining

their local objectives – alongside place-based collaboratives. As set out in the recently published Operating Framework, NHS England will continue to support the local NHS [integrated care boards (ICBs) and providers] to deliver their objectives and publish information on progress against the key objectives set out in the NHS Long Term Plan.

Alongside this greater local determination, greater transparency and assurance will strengthen accountability, drawing on the review of ICS oversight and governance that the Rt Hon Patricia Hewitt is leading. We welcome the review which NHS England has been supporting closely, and we look forward to the next stage of the discussions as well as the final report. NHS England will update the NHS Oversight Framework and work with ICBs to ensure oversight and performance management arrangements within their ICS area are proportionate and streamlined.

Funding and planning assumptions

The Autumn Statement 2022 announced an extra £3.3 bn in both 2023/24 and 2024/25 for the NHS to respond to the significant pressures we are facing.

NHS England is issuing two-year revenue allocations for 2023/24 and 2024/25. At national level, total ICB allocations [including COVID-19 and Elective Recovery Funding (ERF)] are flat in real terms with additional funding available to expand capacity.

Core ICB capital allocations for 2022/23 to 2024/25 have already been published and remain the foundation of capital planning for future years. Capital allocations will be topped-up by £300 million nationally, with this funding prioritised for systems that deliver agreed budgets in 2022/23.

The contract default between ICBs and providers for most planned elective care (ordinary, day and outpatient procedures and first appointments but not follow-ups) will be to pay unit prices for activity delivered. System and provider activity targets will be agreed through planning as part of allocating ERF on a fair shares basis to systems. NHS England will cover additional costs where systems exceed agreed activity levels.

ICBs and NHS primary and secondary care providers are expected to work together to plan and deliver a balanced net system financial position in collaboration with other ICS partners. Further details will be set out in the revenue finance and contracting guidance for 2023/24.

Next steps

ICBs are asked to work with their system partners to develop plans to meet the national objectives set out in this guidance and the local priorities set by systems. To assist them in this, the annex identifies the most critical, evidence based actions that systems and NHS providers are asked to take to deliver these objectives. These are based on what systems and providers have already demonstrated makes the most difference to patient outcomes, experience, access and safety.

System plans should be triangulated across activity, workforce and finance, and signed off by ICB and partner trust and foundation trust boards before the end of March 2023. NHS England will separately set out the requirements for plan submission.

National NHS objectives 2023/24

	Area	Objective
Recovering our core services and improving productivity	**Urgent and emergency care***	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

**ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published;*

Annex

This annex sets out the key evidence based actions that will help deliver the objectives set out above and the resources being made available to support this. All systems are asked to develop plans to implement these. To assist systems in developing their plans a summary of other guidance, best practice, toolkits and support available from NHS England is available on the planning pages of FutureNHS.

1. Recovering our core services and productivity

1A. Urgent and emergency care (UEC)

Key actions:

- Increase physical capacity and permanently sustain the equivalent of the 7,000 beds of capacity that was funded through winter 2022/23
- Reduce the number of medically fit to discharge patients in our hospitals, addressing NHS causes as well as working in partnership with Local Authorities.
- Increase ambulance capacity.
- Reduce handover delays to support the management of clinical risk across the system in line with the November 2022 letter.
- Maintain clinically led System Control Centres (SCCs) to effectively manage risk.

In order to improve patient flow, we all agree we need to reduce bed occupancy to at least 92% (NHS review of winter), increase physical capacity in inpatient settlings to reflect changes in demographics and health demand [Projections: General and acute hospital beds in England (2018–2030)], as well as improve support for patients in the community. NHS England [working with the Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLHUC)] will develop a UEC recovery plan with further detail and this will be published in the new year. Delivery of this plan and the objectives set out in this guidance are supported by:

- £1bn of funding through system allocations to increase capacity based on agreed system plans. NHS England anticipates that capacity will be focused on increasing G&A capacity, intermediate and step-down care, and community beds with an expectation that utilisation of virtual wards is

increased towards 80% by the end of September 2023. NHS England will continue share best practice across a range of conditions to support this.

- £600m provided equally through NHS England and Local Authorities and made available through the Better Care Fund in 2023/34 (and £1bn in 2024/25) to support timely discharge. In addition, a £400m ring-fenced local authority grant for adult social care will support discharge among other goals. Further detail will be set out in the revenue finance and contracting guidance for 2023/24.
- An increase in allocations for systems that host ambulance services to increase ambulance capacity.

1B. Community health services

Key actions:

- Increase referrals into urgent community response (UCR) from all key routes, with a focus on maximising referrals from 111 and 999, and creating a single point of access where not already in place
- Expand direct access and self-referral where GP involvement is not clinically necessary. By September 2023, systems are asked to put in place:
    - direct referral pathways from community optometrists to ophthalmology services for all urgent and elective eye consultations
    - self-referral routes to falls response services, musculo-skeletal physiotherapy services, audiology-including hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services.

Expanding direct access and self-referrals empowers patients to take control of their healthcare, streamlines access to services and reduces unnecessary burden on GP appointments.

NHS England will allocate core funding growth for community health services as part of the overall ICB allocation growth, with £77m of Service Development Funding maintained in 2023/24.

1C. Primary care

Key actions:

- Ensure people can more easily contact their GP practice (by phone, NHS App, NHS111 or online).

- Transfer lower acuity care away from both general practice and NHS 111 by increasing pharmacy participation in the Community Pharmacist Consultation Service.

NHS England will publish the General Practice Access Recovery Plan in the new year which will provide details of the actions needed to achieve the goals above. In addition, once the 2023/24 contract negotiations have concluded, we will also publish the themes we are looking to engage with the profession on that could take a significant step towards making general practice more attractive and sustainable and able to deliver the vision outlined in the Fuller Stocktake, including continuity of care for those who need it. The output from this engagement will then inform the negotiations for the 2024/25 contract.

Delivery of this plan and the objectives set out in this guidance is supported by funding for general practice as part of the five year GP contract, including funding for 26,000 additional primary care staff through the Additional Roles Reimbursement Scheme (ARRS). ICB primary medical allocations are being uplifted by 5.6% to reflect the increases in GP contractual entitlements agreed in the five-year deal, and the increased ARRS entitlements. Data on general practice appointments is being published, including at practice-level, and work is ongoing to improve the quality and use of the data.

1D. Elective care

Key actions:

- Deliver an appropriate reduction in outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024
- Increase productivity and meet the 85% day case and 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings
- Offer meaningful choice at point of referral and at subsequent points in the pathway, and use alternative providers if people have been waiting a long time for treatment including through the Digital Mutual Aid System (DMAS)

The goals for elective recovery are set out in the 'Delivery plan for tackling the COVID-19 backlog of elective care'. These include delivery of around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and

guidance. Meeting this goal of course still depends on returning to and maintaining low levels of COVID-19, enabling the NHS to restore normalised operating conditions and reduce high levels of staff absence. We will agree targets with systems for 2023/24 through the planning round towards that goal on the basis that COVID-19 demand will be similar to that in the last 12 months. The contract default will be to pay for most elective activity (including ordinary, day and outpatient procedures and first appointments but excluding follow-ups) at unit prices for activity delivered.

ICBs and trusts are asked to update their local system plans, actively including independent sector providers, setting out the activity, workforce, financial plans and transformation goals that will support delivery of these objectives.

NHS England will allocate £3bn of ERF to ICBs and regional commissioners on a fair shares basis and continue to work with systems and providers to maximise the impact of the three-year capital Targeted Investment Fund put in place in 2022. Further details will be set out in the *Revenue finance and contracting guidance for 2023/24* and *Capital guidance update 2023/24.*

1E. Cancer

Key actions:

- Implement and maintain priority pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result), skin (teledermatology) and prostate cancer (best practice timed pathway)
- Increase and prioritise diagnostic and treatment capacity, including ensuring that new diagnostic capacity, particularly via community diagnostic centres (CDCs), is prioritised for urgent suspected cancer. Nationally, we expect current growth levels to translate into a requirement for a 25% increase in diagnostic capacity required for cancer and a 13% increase in treatment capacity.
- Expand the Targeted Lung Health Checks (TLHC) programme and ensure sufficient diagnostic and treatment service capacity to meet this new demand.
- Commission key services which will underpin progress on early diagnosis, including non-specific symptoms pathways (to provide 100% population coverage by March 2024), surveillance services for Lynch syndrome, BRCA and liver; and work with regional public health commissioners to increase

colonoscopy capacity to accommodate the extension of the NHS bowel screening programme to 54 year olds.

The NHS is implementing one of the most comprehensive strategies on early diagnosis anywhere in the world. Cancer Alliances and the ICBs they serve will lead the local delivery of this NHS-wide strategy. NHS England is providing over £390m in cancer service development funding to Cancer Alliances in each of the next two years to support delivery of this strategy and the operational priorities for cancer set out above. As in previous years, the Cancer Alliance planning pack will provide further information to support the development of cancer plans by alliances and these, subject to ICB agreement, are expected to form part of wider local system plans.

1F. Diagnostics

Key actions:

- Maximise the pace of roll-out of additional diagnostic capacity, delivering the second year of the three-year investment plan for establishing Community Diagnostic Centres (CDCs) and ensuring timely implementation of new CDC locations and upgrades to existing CDCs
- Deliver a minimum 10% improvement in pathology and imaging networks productivity by 2024/25 through digital diagnostic investments and meeting optimal rates for test throughput
- Increase GP direct access in line with the national rollout ambition and develop plans for further expansion in 2023/24 (NHS England will publish separate guidance to support the increase GP direct access)

Timely access to diagnostics is critical to providing responsive, high quality services and supporting elective recovery and early cancer diagnosis. NHS England has provided funding to support the development of pathology and imaging networks and the development and rollout of CDCs. £2.3bn of capital funding to 2025 has also been allocated to support diagnostic service transformation, including to implement CDCs, endoscopy, imaging equipment and digital diagnostics.

1G. Maternity and neonatal services

Key actions:

- Continue to deliver the actions from the final Ockenden report as set out in the April 2022 letter as well as those that will be set out in the single delivery plan for maternity and neonatal services .
- Ensure all women have personalised and safe care through every woman receiving a personalised care plan and being supported to make informed choices
- Implement the local equity action plans that every local maternity and neonatal system (LMNS)/ICB has in place to reduce inequalities in access and outcomes for the groups that experience the greatest inequalities (Black, Asian and Mixed ethnic groups and those living in the most deprived areas).

NHS England will publish a single delivery plan for maternity and neonatal services in early 2023. This will consolidate the improvement actions committed to in Better Births, the NHS Long Term Plan, the Neonatal Critical Care Review, and reports of the independent investigation at Shrewsbury and Telford Hospital NHS Trust and the independent investigation into maternity and neonatal services in East Kent.

To support delivery including addressing the actions highlighted in the Ockenden report NHS England has invested a further £165m through the maternity programme for 2023/24. This is £72m above the £93m baselined in system allocations to support the maternity and neonatal workforce. That investment has increased the number of established midwifery posts by more than 1;500 compared to 2021.

1H. Use of resources

To deliver a balanced net system financial position for 2023/24 and achieve our core service recovery objectives, we must meet the 2.2% efficiency target agreed with government and improve levels of productivity.

ICBs and providers should work together to:

- Develop robust plans that deliver specific efficiency savings and raise productivity consistent with the goals set out in this guidance to increase activity and improve outcomes within allocated resources.
- Put in place strong oversight and governance arrangements to drive delivery, supported by clear financial control and monitoring processes.

Plans should include systematic approaches to understand where productivity has been lost and the actions needed to restore underlying productivity, including, but not be limited to, measures to:

- **Support a productive workforce** taking advantage of opportunities to deploy staff more flexibly. Systems should review workforce growth by staff group and identify expected productivity increases in line with the growth seen.
- **Increase theatre productivity** using the Model Hospital System theatre dashboard and associated GIRFT training and guidance, and other pathway and service specific opportunities.

Plans should also set out measures to release efficiency savings, including actions to:

- **Reduce agency spending** across the NHS to 3.7% of the total pay bill in 2023/24 which is consistent with the system agency expenditure limits for 2023/24 that are set out separately. NHS England has published toolkits to support this.
- **Reduce corporate running costs** with a focus on consolidation, standardisation and automation to deliver services at scale across ICS footprints. NHS England has published annual cost data benchmarking and a corporate service improvement toolkit .
- **Reduce procurement and supply chain costs** by realising the opportunities for specific products and services. Systems should work to the operating model and commercial standards and the consolidated supplier frameworks agreed with suppliers through Supply Chain Coordination Limited (SCCL). Systems should engage with the Specialised Services Devices Programme to leverage the benefits across all device areas.
- **Improve inventory management**. NHS Supply Chain will lead the implementation of an inventory management and point of care solution. National funding will support providers that do not have effective inventory management systems.
- *Purchase medicines at the most effective price point* by realising the opportunities for price efficiency identified by the Commercial Medicines Unit, and ensure we get the best value from the NHS medicines bill. National support to deliver efficiencies will continue to be available for systems through the National Medicines Value Programme.

2. Delivering the key NHS Long Term Plan ambitions and transforming the NHS

2A. Mental health

Key actions:

- Continue to achieve the Mental Health Investment Standard by increasing expenditure on mental health services by more than allocations growth.
- Develop a workforce plan that supports delivery of the system's mental health delivery ambition, working closely with ICS partners including provider collaboratives and the voluntary, community and social enterprise (VCSE) sectors.
- Improve mental health data to evidence the expansion and transformation of mental health services, and the impact on population health, with a focus on activity, timeliness of access, equality, quality and outcomes data.

As systems update their local plans, they are also asked to set out how the wider commitments in the NHS Mental Health Implementation Plan 2019/20–2023/24 will be taken forward to improve the quality of local mental healthcare across all ages in line with population need.

NHS England has allocated funding to grow the workforce and expand services to support delivery of the mental health NHS Long Term Plan commitments. In particular, NHS England will continue to support the growth in IAPT workforce by providing 60% salary support for new trainees in 2023/24. We will also support ICBs to co-produce a plan by 31 March 2024 to localise and realign mental health and learning disability inpatient services over a three year period as part of a new quality transformation programme.

2B. People with a learning disability and autistic people

Key actions:

- Continue to improve the accuracy and increase size of GP Learning Disability registers.
- Develop integrated, workforce plans for the learning disability and autism workforce to support delivery of the objectives set out in this guidance. (The workforce baselining exercise completed during 2022/23 will assist in the development of local, integrated, workforce plans to support delivery.)

- Test and implement improvement in autism diagnostic assessment pathways including actions to reduce waiting times.

NHS England has allocated funding of £120m to support system delivery against the objectives and will publish guidance on models of mental health inpatient care to support a continued focus on admission avoidance and improving quality.

2C. Embedding measures to improve health and reduce inequalities

Key actions:

- Update plans for the prevention of ill-health and incorporate them in joint forward plans, paying due regard to the NHS Long Term Plan primary and secondary prevention priorities, including a continued focus on CVD prevention, diabetes and smoking cessation. Plans should:
    - build on the successful innovation and partnership working that characterised the COVID vaccination programme and consider how best to utilise new technology such as home testing. NHS England will publish a tool summarising the highest impact interventions that can be – and are already being – implemented by the NHS.
    - have due regard to the government's Women's Health Strategy.
- Continue to deliver against the five strategic priorities for tackling health inequalities and:
    - take a quality improvement approach to addressing health inequalities and reflect the Core20PLUS5 approach in plans
    - consider the specific needs of children and young people and reflect the Core20PLUS5 – An approach to reducing health inequalities for children and young people in plans
    - establish High Intensity Use services to support demand management in UEC.

Funding is provided through core ICB allocations to support the delivery of system plans developed with public health, local authority, VCSE and other partners. The formula includes an adjustment to weight resources to areas with higher avoidable mortality and the £200m of additional funding allocated for health inequalities in 2022/23 is also being made recurrent in 2023/24.

2D. Investing in our workforce

In 2022/23 systems were asked to develop whole system workforce plans. These should be refreshed to support:

- Improved staff experience and retention through systematic focus on all elements of the NHS People Promise and implementation of the Growing Occupational Health Strategy, improving attendance toolkit and Stay and Thrive Programme.
- Increased productivity by fully using existing skills, adapting skills mix and accelerating the introduction of new roles (e.g. anaesthesia associates, AHP support workers, pharmacy technicians and assistants, first contact practitioners, and advanced clinical practitioners).
- Flexible working practices and flexible deployment of staff across organisational boundaries using digital solutions (e-rostering, e-job planning, Digital Staff Passport).
- Regional multi professional education and training investment plans (METIP) and ensure sufficient clinical placement capacity, including educator/trainer capacity, to enable all NHS England- funded trainees and students to maintain education and training pipelines.
- implementation of the Kark recommendations and Fit and Proper Persons (FPP) test.

NHS England is increasing investment in workforce education and training in real terms in each of the next two years.

2E. Digital

Key actions:

- Use forthcoming digital maturity assessments to measure progress towards the core capabilities set out in What Good Looks Like (WGLL) and identify the areas that need to be prioritised in the development of plans. Specific expectations will be set out in the refreshed WGLL in early 2023.
- Put the right data architecture in place for population health management (PHM).
- Put digital tools in place so patients can be supported with high quality information that equips them to take greater control over their health and care.

DHSC recently published strategic plans for digital, data and technology. Data saves lives and A plan for digital health and social care set out how digitised services can support integration and service transformation. NHS England will:

- Provide funding to help ICSs meet minimum digital foundations, especially electronic records in accordance with WGLL.
- Procure a Federated Data Platform, available to all ICSs, with nationally developed functionality including tools to help maximise capacity, reduce waiting lists and co-ordinate care.
- Roll out new functionality for the NHS App, to help people take greater control over their health and their interactions with the NHS, including better support to get to the right in-person or digital service more quickly, access to their patient records, improved functionality for prescriptions and improved support for hospital appointments and choice ahead of next winter.
- Accelerate the ambition of reducing the reporting burden on providers and addressing the need for more timely automated data through the Faster Data Flows (FDF) Programme.

Funding is allocated to meet minimum digital foundations (especially electronic patient records) and scale up use of digital social care records in accordance with WGLL.

2F. System working

2023/24 is the first full year for ICSs in their new form with the establishment of statutory ICBs and integrated care partnerships (ICPs). Key priorities for their development in 2023/24 include:

- Developing ICP integrated care strategies and ICB joint forward plans.
- Maturing ways of working across the system including provider collaboratives and place-based partnership arrangements.

Improving NHS patient care, outcomes and experience can only be achieved by embedding innovation and research in everyday practice. ICBs have a statutory duty to facilitate or otherwise promote research and the use of evidence obtained from research and to promote innovation, for example AI and machine learning which is driving efficiency and enabling earlier diagnosis.

NHS England will continue to support ICSs to draw on national best practice and peer insight to inform future development.

Joint forward plans

The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires ICBs and their partner trusts (the ICB's partner NHS trusts and foundation trusts are named in its constitution) to prepare five-year JFPs before the start of each financial year.

NHS England has developed guidance to support the development of JFPs with input from all 42 ICBs, trusts and national organisations representing local authorities and other system partners, including VCSE sector leaders.

Systems have significant flexibility to determine their JFP's scope as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner trusts. However, 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 (JLHWS) (developed by local authorities and their partner ICBs, which may be through health and wellbeing boards) that is supported by the whole system, including local authorities and VCSE partners.

Delegated budgets

We are moving towards ICBs taking on population healthcare budgets, with pharmacy, ophthalmology and dentistry (POD) services fully delegated by April 2023 and appropriate specialised services delegated from April 2024. This will enable local systems to design and deliver more joined-up care for their patients and communities. NHS England will support ICBs as they take on commissioning responsibility across POD services from April 2023, supporting the integration of services.

Subject to NHS England Board approval, statutory joint committees of ICBs and NHS England will oversee commissioning of appropriate specialised services across multi-ICB populations from April 2023, ahead of ICBs taking on this delegated responsibility in April 2024.

ICBs are expected to work with NHS England through their joint commissioning arrangements to develop delivery plans. These should identify at least three key priority pathways for transformation, where integrated commissioning can support the triple aim of improving quality of care, reducing inequalities across communities and delivering best value. NHS England will provide ICBs with tools and resources to support transformation, and to further develop their understanding of specialised services and enable them to realise the benefits of integration.

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MINUTES OF THE AUDIT AND GOVERNANCE COMMITTEE

HELD ON 27 OCTOBER 2022 VIA MS TEAMS AT 2.00PM

Present:		
Sue Sunderland	SS	Non-Executive Director/Audit Chair
Dr Buk Dhadda	BD	GP
In Attendance:		
Lisa Butler	LB	Complaints Manager (part)
Andrew Cardoza	AC	Audit Director, KPMG
Debbie Donaldson	DD	EA to Chief Finance Officer (note taker)
Chloe Foreman	CM	Acting Senior Finance Manager
Darran Green	DG	Acting Operational Director of Finance
Keith Griffiths	KG	Chief Finance Officer
James Lunn	JL	Head of Human Resources and Organisational Development (part)
Suzanne Pickering	SP	Head of Governance
Chrissy Tucker	CT	Director of Corporate Delivery
Apologies:		
Helen Dillistone	HD	Executive Director of Corporate Affairs
Fran Palmer	FP	Corporate Governance Manager
Kevin Watkins	KW	Business Associate, 360 Assurance
Richard Wright	RW	Non-Executive Director

Item No.	Item	Action
AG/2223/062	**Welcome, introductions and apologies** Sue Sunderland as Chair welcomed all members to the meeting. Apologies were received from Richard Wright, Kevin Watkins, Fran Palmer and Helen Dillistone.	
AG/2223/063	**Confirmation of quoracy** The Chair declared the meeting quorate.	
AG/2223/064	**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/2223/065	**Human Resources Policies** James Lunn presented 6 policies for review by the Committee: **Annual Leave Policy:** **Audit and Governance Committee APPROVED the Annual Leave Policy.** **Long Service Award Policy:** Committee were advised there were no significant material changes to this Policy, only minor amendments/inclusions in terms of ICB branding and a 'lift and shift' from the CCG to NHS Derby and Derbyshire ICB. **Audit and Governance Committee APPROVED the Long Service Award Policy.** **Organisational Change and Redundancy Policy:** Committee were advised there were no significant material changes to this Policy, only minor amendments/inclusions in terms of ICB branding and a 'lift and shift' from the CCG to NHS Derby and Derbyshire ICB. **Audit and Governance Committee APPROVED the Organisational Change and Redundancy Policy.** **Professional Registration Policy:** Committee were advised there were no significant material changes to this Policy, only minor amendments/inclusions in terms of ICB branding and a 'lift and shift' from the CCG to NHS Derby and Derbyshire ICB. Darran Green reported that this policy appeared to relate only to Clinicians. Finance Directorate staff in some instances were required to be professionally qualified and maintain Continuous Professional Development (CPD). James Lunn agreed to review this policy to include those employees who were required to keep up a professional registration. **Audit and Governance Committee APPROVED the Professional Registration Policy for the Clinicians.** **Recruitment and Selection Policy:** Committee were advised there were no significant material changes to this Policy, only minor amendments/inclusions in terms of ICB branding and a 'lift and shift' from the CCG to NHS Derby and Derbyshire ICB. **Audit and Governance Committee APPROVED the Recruitment and Selection Policy**. **Retirement Policy:** The Retirement Policy was largely a 'lift and shift' with the removal of the requirement for a two weeks' break in service when an employee retires and subsequently returns to the organisation. This revision, agreed by the Executive Team, was to	JL

	align with our NHS system partners within JUCD and to support retention of employees within the ICB. It was noted that there would still be the 24-hour break which would break the continuity of service for the NHS pension scheme and for the NHS enhanced occupational redundancy scheme. NHS organisations within the system were similarly looking to make this change as we try to align some of our HR policies. **Audit and Governance Committee APPROVED the Retirement Policy.** James Lunn left the meeting at this point.	
FOR CORPORATE ASSURANCE		
AG/2223/066	**Aged Receivables and Payable Credit Notes** Chloe Foreman informed Committee that this report identified the total outstanding debt owed to the ICB in accounts receivables and payables as at 30 September 2022. The ICB policy was to chase outstanding debt from organisations when it exceeded a 90-day period. The report contains a detailed table which was split by NHS and Non-NHS, supported by detail regarding any write-offs and at-risk Debt. Aged receivables had increased in the quarter by £379,000, mainly driven by amounts owed to the CCG from North of England CSU totalling £350,000. However, as at 19th October 2022 (time of writing this report), £175,000 of this balance had been received. There was no risk to this balance. It was noted that a risk associated with a GP overpayment by the CCG had been identified. The individual had been contacted multiple times during this calendar year regarding the overpayment totalling £366.54, to which no response or payment had been received. No write-offs had been identified in the period to 30 September 2022. Credit notes had also decreased in month. The aged debt position was reviewed monthly by the Financial Control team to ensure appropriate management of ICB assets. **The Audit and Governance Committee NOTED the report contents regarding the level of aged debt at 30 September 2022.**	

AG/2223/067	**Report of Single Tender Waivers** Chloe Foreman reported that as per the ICB's Scheme of Delegation, Single Tender Waivers were reviewed and approved by the Director of Finance and subsequently reported to the Audit and Governance Committee for oversight. This report informed the Committee of Single Tender Waivers approved from 1 July 2022 – 30 September 2022. Keith Griffiths reported that there had been a lot of STWs, which in the past had been raised as a default, and not by exception. Discussions with Helen Dillistone had taken place about re-emphasising the need for due governance and discipline around procurement rules and not automatically defaulting to STWs. It was noted that processes were to be tightened in the ICB regarding the need to go to market. Keith Griffiths reported that he did not want to give committee the impression that what we had previously done with STWs had not been appropriate, but that we would be more disciplined around what we did in the future. **The Audit and Governance Committee NOTED the report of Single Tender Waivers approved by the Chief Finance Officer.**	
AG/2223/068	**Financial Sustainability Assessment** Chloe Foreman reported that the ICB was instructed by NHSE to engage its internal auditors to commission a review of the Healthcare Financial Management Association (HFMA) checklist – Improving NHS financial sustainability: are you getting the basics right? The ICB (along with all ICBs, NHS Trusts and Foundation Trusts) had completed a self-assessment checklist covering the following areas: • Business and financial planning • Budget setting • Budget reporting and monitoring • Forecasting • Cost improvement / efficiency plans • Board reporting • Financial governance framework • Culture, training, and development. An initial assessment was made for each of these areas, grading between 1 and 5 (1 being never achieved, 5 being always achieved). A detailed assessment was then completed covering 72 questions across each of the areas. Where a grading of 1-3 was concluded, an action plan would be produced. It was noted that a self-assessment of the Financial Sustainability basics had been carried out, which had concluded a number of key	

	actions. The assessment had been submitted to NHSE and would be audited by the ICB's Internal Auditors. The Committee would monitor the process and outcome of the audit. The results of the self-assessment were attached as an appendix to this report. The Chair queried whether the self-assessment had been a bit harsh, and she understood from initial comparative data from other ICBs that it looked like the ICB might have underscored itself. A summary of the derived actions was noted below: • Develop a triangulated operational and finance five-year plan, identifying business cases and cost improvements during the planning process. • Budget managers should attend annual training for financial management, governance, and be able to refer to the Budget Holders Guide policy. Financial management and training of such should form part of the Annual Review/Appraisal process. • Budget managers should maintain an action plan, to be updated on at least a monthly basis to ensure spend is managed within their allocation. • Budget managers should be the driver in forecasting the year end position, reflecting the actions identified alongside other factors. • Cost improvements (CIPs) must be developed from both bottom-up and top-down. These should be identified imminently to deliver the current financial year, and in advance of the next financial year as part of the planning process. • Staff at all levels should be empowered to suggest savings ideas and be aware of the process to do so. • The ePMO project must manage all stages from ideas to the monitoring of KPIs and hence delivery. It was noted that the details were shared with the Executive Team on 5th October 2022 and submitted to NHS England. Developments were already underway to move to delivering the above actions, which included the production of the system five-year plan, redesign of the budget holder reporting, engagement of CIPs through the Joined-Up Improvement Exchange, and budget holder training would be rolled out before the end of the year. Throughout October and November, 360 Assurance were completing their internal audit of the self-assessment. They planned to revisit the above actions to understand the progress made in early 2023. It was noted that 360 Assurance would collate this information and benchmark between organisations in order that we could share and learn from other Providers and ICBs. **The Audit and Governance Committee NOTED the Financial Sustainability Assessment.**	
AG/2223/069	**M6 ICB Financial Position Review**	

	Darran Green reported that this paper presented the financial position of Derby and Derbyshire ICB for period end 30th September 2022. It highlighted the key areas where we had particular I&E challenges, as well as summarising the efficiencies position for Derby and Derbyshire ICB. As of 30th September 2022, the ICB had a forecast break-even position and was committed to delivering break-even for the 2022/23 financial year. Whilst forecasting a break-even result for this financial year, work continued to address the underlying issues in order to achieve the additional savings challenge of £6.95m. The financial position as of 30th September 2022, was a year-to-date deficit of £4.1m and with current run rates the likely, unmitigated projected deficit by 31 March 2023 would be £7m. The repatriation of the £5m community future fund from Derbyshire County Council in 2021/22 had been agreed. The following was highlighted: • The table in Section 2 of the report showed the ICB was not forecasting to meet one of its statutory duties. This was around delegated co-commissioning, where we were forecasting to spend around £.5m more than allocated. This was because of practices being eligible to be paid for more additional roles reimbursements and investment impact fund enhanced services. The practices were eligible to be paid more than the ICB could reclaim. It was noted that we had received 6% of the money up front, and we could claim the other 40% up to the level of delivery. However, that level of delivery would take us above the 100% that we could claim. • The ICB had notified this to NHSEI; their response was that there was a national reserve to cover instances like these and should those practices claim that, then we should in effect be eligible to reclaim more, but NHSEI had not confirmed what that process was yet. • The ICB had an unmitigated forecast outturn of £7m, and this was an improvement from the £13.3m that we had in M5. • Table 3.2 highlighted the efficiencies that the ICB were forecasting to deliver. The ICB was doing more analysis on efficiencies both within the ICB as a statutory body, but also across the system. It was noted that we were trying to analyse delivery against the original plan, and understanding the level of non-recurrent as opposed to recurrent delivery, and the level of unplanned non-recurrent benefit that had been classed as efficiency as opposed to genuine transformation. • Section 3 of the report described the pressures that were currently being seen around CHC fast tracks, mental health Section 117 and prescribing. • Unfortunately, the latest prescribing information we had since writing this report demonstrated that the prescribing position was	

	likely to get worse. This was mainly to do with inflationary pressures and drugs that had to be bought from overseas. • Section 5 of the report described the JUCD position. It was acknowledged that this Committee was only responsible for the statutory position of the ICB, but it was felt useful to give some headlines in terms of the system position. • There was a commitment to break even. • There was an unmitigated forecast outturn of £39.8m. This was an improvement from M5 which had been £55.6m, largely driven by improvements in the ICB position. • The JUCD position at M6 also included a £4.5m contingency that had been developed to support winter pressures that may arise and on top of a £5.5m allocation we had received from NHSEI. It was believed we had got a good level of cover for any pressures that may come throughout winter. • Dr Dhadda reported that with regards to the prescribing position, this was a national issue. Many drugs were now termed as 'out of stock' and alternative more expensive drugs were being used by clinicians. He asked whether national support would be available to offset those additional cost pressures? • Darran Green reported that the ICB had lobbied NHSEI regarding this, and a response was awaited. • Keith Griffiths reported that when the plan had been agreed back in May/June there had been a £65m gap for the System, and the ICB had a share of that gap. • There had been a lot of work done resulting in asking the providers to take on a fair shares basis to resolve the £10m problem that had previously sat on the ICBs books. This had now been shared out across the organisations and system. The figures in this report included our portion of that £10m as part of our challenge this year. • There had also been an arrangement in place to provide cash support for organisations, which effectively meant that organisations had to take on a further pressure in the planning round; one organisation had refused to do that (the others did), and as a result this risk now sits on the books of the ICB, this was intrinsic within the £7m shortfall. This conversation had not been lost and if we were talking about system working and good equity, we could not have 3-4 organisations participating in an agreement and 1 refusing – we all needed to stand together. There was a need to work through this in a mature way to ensure that everybody felt that they were doing their fair share. • Currently the ICB was carrying that liability of £1.1m. • Looking forwards there would need to be different arrangements in place for 2022-23, we were no longer on PBR arrangements. The allocation that comes into the ICB was the allocation we could share out between primary and secondary care, and not a penny more. The approach described in relation to that 1 organisation would therefore not be acceptable anymore. The process would be more open and transparent.	

	• It was noted that there were still a lot of people within the system that still thought and worked in the logic of the CCG, in that if there was a pressure their first port of call was the ICB to ask for additional funding; the reality was that we were not a commissioner in that sense. Those pressures had to be covered and met by the provider organisations. We had to stop the expectation that the ICB could write cheques during this transition process; we did not have the headroom to do it. • It was noted that the ICB had received requests from primary care to help meet the costs of energy bills and a request from a local hospice because their income had plummeted on the back of Covid and austerity. Although we had a degree of sympathy and empathy with these requests, we were also £7m adrift of where we needed to be. • Keith Griffiths and Dave Stevens had offered to go out to one of the hospices to meet with their Finance Director to discuss their finances and review operational business plans to help maximise income from other sources; this had been well received. • Dr Dhadda reported that regards primary care, this was a national issue and we needed to be consistent with our response. If the ICB received national funding to help with energy then we would pass this through, but currently there was no new funding. He felt the issue with the hospice was more complicated. If we were to support the hospice, what would we get for it, and if we were not to support, what would the cost to the system be? We needed this information to enable us to make an informed decision. • It was noted that we had 2 provider organisations within the system that were currently forecasting a surplus, with a further organisation that was currently unwilling to commit due to tactical and political reasons. • It was noted that the ICB also needed to make efficiency savings. This year was tough but next year would be worse as we would not be able to use non-recurrent money to bridge the gap, as we had been able to do this year. The ICB still had a substantial gap to close before the end of the year. • Keith Griffiths reported that national funding was received regarding the Glossop boundary change. The income received exceeded the cost of care by about £2m. Tameside and Glossop had requested that some of that be transferred back to them this year. It was noted that originally, we did have provision in our accounts to make such a payment, but this had now been used in its entirety to help us get towards breakeven. There had been several discussions between Dr Clayton and Tameside, and a view had been taken that we could only pay them if we were in surplus at the end of the year as a one-off goodwill payment; it was noted that currently this was not likely.	

	The Audit and Governance Committee NOTED the M6 ICB Financial Position.	
G/2223/070	**Complaints Report Quarter 2 2022/23** Lisa Butler presented the Quarterly Complaints Report which summarised activity and performance in Quarter 2 2022/23 (1st July to 30th September). It was noted that during Quarter 2, the ICB received 33 formal complaints from its resident population, of which 2 related to the ICB's statutory functions. Overall, this was a slight increase in the total number of formal complaints received in Quarter 1, and an increase on the total numbers received for the same period last year. Complaints attributed to the Nursing & Quality and Commissioning Directorates were the focus of the complaints received in quarter 2 and were consistent with previous reporting periods. The complaint relating to the Continuing Healthcare (CHC) service was around the handling of an assessment and communication with next of kin. These were all recurring themes. The complaints relating to the Medical Directorate were around the difficulties experienced accessing the Medicines Order Line (MOL). This was a recurring theme. Ten cases were closed this quarter, 70% were either fully or partially upheld. The report detailed the learning we had taken on those closed complaints. **The Audit and Governance Committee NOTED the content of the ICB Complaints Report - Quarter 2 (2022/23).**	
AG/2223/071	**Freedom of Information Performance Report Quarter 2** Suzanne Pickering presented this report, which provided details of Derby and Derbyshire ICB's compliance under the Freedom of Information Act (2000) in Quarter 2 of 2022/23. Requests made under the Freedom of Information Act were handled by the ICB's Communications Team. During July - September 2022: • FOI numbers greatly increased, with 64 FOI requests received compared to 47 in Quarter 4 of 2022/23. This is in line with previous years where August has often seen a high number of requests received. • No requests were responded to during this quarter outside the statutory timescale of within 20 working days of receipt. • 62 responses were sent. • 5 responses included exemptions under the Freedom of Information Act.	

	• 1 request for internal review was received and responded to. **The Audit and Governance Committee RECEIVED the quarterly report on the ICB's performance in meeting our statutory duties in responding to requests made under the Freedom of Information Act.**	
AG/2223/072	**Internal Audit Recommendations Report** Suzanne Pickering reported that the Internal Audit Recommendations Tracker detailed 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. It was noted that as at September's Audit & Governance Committee, the Internal Audit Recommendations Tracker identified one outstanding action, all the other recommendations were complete. This one action was in relation to the key financial systems regarding the position of the Service Auditor Reports (SARs). In the Appendix to the report there was an update stating there was no SAR within the contractual agreements for HR transactional services, we needed to agree this recommendation with Internal Audit, and if they were happy that we could report by exception to this Committee, then we could agree and complete that action. The Chair felt this was a reasonable way forward to report by exception; she added that she did not find SAR particularly helpful, they only partially gave assurance. It was far better to have management information coming through on a regular basis; this gives assurance that they were managing the processes as you would expect, and she was not aware that we had any problems with the management information coming through. The Chair asked Suzanne Pickering to feed that back into her discussions with Internal Audit, that the proposed way forward seemed reasonable. **The Audit and Governance Committee NOTED the Internal Audit Recommendations Tracker.**	
AG/2223/073	**ICB Estates Update** Chrissy Tucker reported the following: • The organisation had moved to green phase 2 of our Rag Rated model at the end of September. • Staff no longer had to wear masks on site and social distancing was no longer applicable.	

	• Desks on both sites had still been kept spaced apart for staff comfort rather than infection risk. • Staff had been asked to work on site for an average of 2 days week either at our bases or other provider locations as appropriate to their roles. • As part of the process, we had looked at how much estate we needed to accommodate staff. It had been agreed that we could release one of our spaces at Cardinal Square either on the ground floor or in the east wing. • Discussions were being undertaken with the landlord now regarding this. • Staff had been issued with a survey asking what was important to them in using our office space. • The estate review would be ongoing as hybrid working beds in. • The review would also include Scarsdale accommodation. Accommodation at Scarsdale was also shared with clinical teams, NECs and Arden and Gem CSU. • The ICB was responsible for void costs at Scarsdale, so we would need to find another organisation to take any space available. • Keith Griffiths reminded Committee that we had 258 properties on our patch which included administrative buildings, clinical spaces, hospitals, and primary care; we had an awful lot of estate. When we looked at future models of agile working, we also needed to look at local authority buildings. • There was potential for releasing estate resources which needed to be explored fully. **Audit and Governance Committee NOTED the ICB Estates verbal update.**	
AG/2223/074	**Confidential Conflicts of Interests** The Chair reported that the purpose of this paper was to assure the Audit and Governance Committee, of the confidential register of interests. The confidential register of interests detailed those individuals who did not wish for their information to be in the public domain. All individuals were decision makers – either through being a member at decision-making meetings, or in their role for the ICB. This would mean that their information would be published on the decision-makers register of interests, which was published on the ICB's website. All entries had been approved by the Conflicts of Interest Guardian (Sue Sunderland). **The Audit and Governance Committee RECEIVED the confidential register of interests for the ICB.**	
	FOR INFORMATION	
AG/2223/075	**Pre-Delegation Assurance Framework Moderation Panel Outcome**	

	Chrissy Tucker explained that the Pre-Delegation Assessment Framework for the Pharmacy, Optom and Dental work delegated to the ICB, had been received. The Pre-Delegation assessment had been jointly completed by the regional teams working on this. The following was highlighted: • The assessment framework was circulated through all the relevant functions of the ICB; changes required were made and then sent back in. • The moderation panel had now been held and it was deemed that all ICBs in the region were ready to proceed from April next year to take on those delegated functions. • Work was now underway to undertake all the actions. In addition there was a safe delegation checklist that went with it, which was similar to the one that the ICB received regarding the readiness to operate statement. • The checklist would come to this Committee for us to process, and through to the Population Health and Strategic Commissioning Committee where it related to parts of the service that may change. • It was noted that we had recently received another PDAF which related to specialised commissioning, and we were doing the same process on that; again, there would be a moderation panel to say whether we were OK to proceed. • The PDAF for specialist commissioning was being sent in today. • Darran Green reported that he had been informed that specialist commissioning had been put back 12 months. **Audit and Governance Committee NOTED this verbal update.**	

AG/2223/076	**ICB Committee Meeting Log** Chrissy Tucker reported the purpose of this paper 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 – August and September 2022 • Population Health & Strategic Commissioning – September 2022 • Public Partnerships – July to September 2022 • Quality & Performance – August 2022 At the time of reporting, the discussions and decisions which took place at the September People & Culture Committee were unavailable. **The Audit and Governance Committee NOTED the Committee Meeting Log.**	
AG/2223/077	**Non-Clinical Adverse Incidents** Chrissy Tucker reported that there were no non-clinical adverse incidents to report. It was noted however, that the ICB were doing some resilience and preparedness work across the system relating to energy supply and the possibility of backouts etc. There had been a meeting with EPRR leads across the system and we would be linking into the LRF. Chrissy Tucker reported that MIDSROC had been sending through the SOC, questionnaires about generators in respective organisations. There was a need to do some work around patients at home who relied on electricity for their equipment to keep them safe and what they needed to do if there was an electricity failure. This work would be collated with the EPPR leads and be available in a single report for assurance and incorporated into business continuity plans.	
AG/2223/078	**KPMG Update on 3 Month Accounts** Andrew Cardoza highlighted the following: • After discussions with Donna Johnson and Chloe Foreman it had been agreed that KPMG would start the audit in December. • The Audit Plan would be brought to November Committee for approval. • The Audit would be done as quickly and efficiently as possible; it was noted that KPMG did not have to do a VFM and would be completed by end of January 2023. • The nine-month Audit Plan would be brought to Committee in the New Year. An engagement letter was still to be agreed and signed for this.	AC

	• KPMG had won the joint tender procurement exercise for External Audit services for the system. This was being processed by KPMG and procurement currently. • KPMG had agreed to do the Mental Health Investment Standard Audit 2021-22; Richard Walton would lead on this work. A timetable, engagement letter and fee would be agreed for this work in due course. • Keith Griffiths requested KPMGs views/soft intelligence/thoughts on the NHS landscape for next year. Andy Cardoza agreed to provide this at the next meeting in November. **Audit and Governance Committee NOTED this verbal update.**	AC
MINUTES AND MATTERS ARISING		
AG/2223/079	**Minutes from the Audit and Governance Committee meeting held on 13 September 2022** The minutes from the meeting held on 13 September 2022 were agreed as a true and accurate record of the meeting.	
AG/2223/080	**Action Log from the Audit Committee meeting held on 13 September 2022.** The action log was reviewed and updated during the meeting.	
CLOSING ITEMS		
AG/2223/081	**Forward Planner** **The Audit and Governance Committee ACCEPTED the Forward Planner.** It was noted that going forwards (New Year) Audit and Governance Committee's would move to bi-monthly meetings.	
AG/2223/082	**Any Other Business** There was no further business.	
AG/2223/083	**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? **Yes.** • 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? **None.**	

DATE AND TIME OF NEXT MEETING
Date: Thursday 24 November 2022
Time: 2.00PM
Venue: MS Teams

Signed: …… Dated: ……..
(Chair)

MINUTES OF THE AUDIT AND GOVERNANCE COMMITTEE

HELD ON 24 NOVEMBER 2022 VIA MS TEAMS AT 2.30PM

Present:		
Sue Sunderland	SS	Non-Executive Director/Audit Chair
Dr Buk Dhadda	BD	GP
Richard Wright	RW	Non-Executive Director
In Attendance:		
Andrew Cardoza	AC	Audit Director, KPMG
Ged Connolly-Thompson	GCT	Head of Digital Development & Digital Health Skills Development Network Lead
Helen Dillistone	HD	Executive Director of Corporate Affairs
Debbie Donaldson	DD	EA to Chief Finance Officer (note taker)
Darran Green	DG	Acting Operational Director of Finance
Keith Griffiths	KG	Chief Finance Officer
Donna Johnson	DJ	Acting Assistant Chief Finance Officer
Chris Leach	CL	Head of EPRR
James Lunn	JL	Head of Human Resources and Organisational Development
Usman Niazi	UN	Client Manager, 360 Assurance
Suzanne Pickering	SP	Head of Governance
Chrissy Tucker	CT	Director of Corporate Delivery
Kevin Watkins	KW	Business Associate, 360 Assurance
Apologies:		

Item No.	Item	Action
AG/2223/084	**Welcome, introductions and apologies** Sue Sunderland as Chair welcomed all members to the meeting. No apologies were received.	
AG/2223/085	**Confirmation of quoracy** The Chair declared the meeting quorate.	
AG/2223/086	**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/2223/087	**Human Resources Policies** James Lunn presented 6 policies for review by the Committee: **Career Break Policy**: Committee were advised there were no significant material changes to this Policy, only minor amendments/inclusions in terms of ICB branding and a 'lift and shift' from the CCG to NHS Derby and Derbyshire ICB. **Audit and Governance Committee APPROVED the Career Break Policy.** **Disability & Long-Term Conditions Policy**: Committee were advised that this was a new policy for the ICB. The policy builds on best practice, was in line with the NHS People Plan, and had been developed with the Diversity Inclusion network. This policy was looking to align with our system partners and sets out the approach for the organisation to support colleagues with disabilities and long-term health conditions. It introduces a reasonable adjustment passport to help support colleagues with the adjustments that they needed and paid disability leave, which again was something that our partners had in place. This policy would help colleagues with disabilities and long-term health conditions to manage their conditions at work. Richard Wright reported that there may be times where certain disabilities would preclude from certain roles on safety grounds, he asked how we would deal with that; we did not want to expose people to unreasonable risks? James Lunn reported that the primary aim of this policy was to look to make the adjustments to retain the person in the role that they were currently working to. He added that there were probably very few roles within the ICB where there would be risk and a person would not be able to fulfil their role. If, however, we could not adjust their duties, we would then look at whether there was an alternative role within the organisation that would meet their needs and comply with safety requirements. This was a low risk for the ICB given the nature of the work that we did, as compared to maybe the operational roles that Providers had. **Audit and Governance Committee APPROVED the Disability & Long-Term Conditions Policy.** **Disciplinary Policy:** Committee were advised there were no significant material changes to this Policy, only minor amendments/inclusions in terms of ICB branding and a 'lift and shift' from the CCG to NHS Derby and Derbyshire ICB.	

	Audit and Governance Committee APPROVED the Disciplinary Policy. **Maternity, Paternity, Adoption, Shared Parental and Parental Leave Policy**: Committee were advised there were no significant material changes to this Policy, only minor amendments/inclusions in terms of ICB branding and a 'lift and shift' from the CCG to NHS Derby and Derbyshire ICB. **Audit and Governance Committee APPROVED the Maternity, Paternity, Adoption, Shared Parental and Parental Leave Policy.** **Secondary Employment Policy**: Committee were advised there were no significant material changes to this Policy, only minor amendments/inclusions in terms of ICB branding and a 'lift and shift' from the CCG to NHS Derby and Derbyshire ICB. **Audit and Governance Committee APPROVED the Secondary Employment Policy.** **Secondment Guidance and Procedure**: Committee were advised the Secondment Guidance and Procedure was largely a 'lift and shift' with the removal of the restriction on secondments only being within JUCD. This had been a temporary change made in April 2021 to provide a level of stability within the former CCG during the period leading up to the establishment of the ICB. The Secondment Guidance and Procedure had also been updated to provide a more robust process in place for agreeing and reviewing secondments. **Audit and Governance Committee APPROVED the Secondment Guidance and Procedure Policy.**	
FOR CORPORATE ASSURANCE		
AG/2223/088	**External Audit** **External Audit Plan - Month 3 Audit** Andrew Cardoza reported that KPMG were not able to bring the three-month External Audit Plan to this meeting. However, the Plan had been discussed with Darran Green and his team. He explained that it was a timing issue, and that KPMG could not bring the Plan before completing the risk assessments on the file. Andrew Cardoza explained that KPMG were on target to complete the three-month audit, the main nine-month audit, and the MHIS work. Andrew Cardoza referred to an action from the last meeting from Keith Griffiths who had requested KPMGs views/soft intelligence/thoughts on the NHS landscape for next year. A set of slides were produced, and the following was highlighted:	

	• Digital and technology – this was not being adopted fast enough from their point of view. • Looking across the Health and Social Care landscape, there was much investment needed – this challenge would go on for many years. • The long-term finance and productivity targets – this needed more creative thinking. The consultants were working with several organisations regarding transformation and efficiency. • Demand would continue to grow and attracting, retaining, and training of the NHS workforce would be ongoing. • Integrated Care and population health management was one step to providing the longer-term solution – this required complete and radical different models of governance to make it work properly. • Regarding the pandemic, this had caused significant backlogs and the government wanted to push the elective care by 30% to pre pandemic levels with the continuing emergency demand. The consultants had no idea how this could be addressed at this moment in time, as the demand was going up so fast. The providers within the system had not got the staff in place to deliver that. It was also unclear whether funding would be available to facilitate this. • There was a scarcity of skills particularly at leadership level; there were not enough quality managers in the NHS. • The PLACE-based budget care puts greater focus on wrapping services around individuals. This required forward and different thinking to ensure that happened at pace to make it work and more meaningful for people. • Prevention – how would you make this work in a system where people were currently fighting fires, never mind being able to look at the horizon. • Whole citizen required citizen centric approach – this was about outcomes and socioeconomic groups and required the system to improve the access and equity for healthcare. • Key areas were digital and technology, finance and productivity, attracting and retaining staff. • In terms of digital and technology - it was about optimising technology. Using Robotic Process Automation (RPA) to do manual work was being reviewed, but this may also bring about security issues. • Finance and productivity - the move away from the traditional cost improvement model, which was not sustainable. There was a need to find a different and more effective method. • As the ICB moved away from strategic alignment, and NHSEI handed down more responsibility from a governance point of view, how would the ICB ensure that was working across system partners. • In terms of retaining staff, strategic workforce planning was key. Consultants were working across several organisations to help with this. • The Population Health Management (PHM) piece was intrinsic to making it work. It was about challenging and changing the population health needs to make it much more financially sustainable. There needed to be brave and really hard	

	decisions made about where money was spent to make that work into the future. • Significant backlogs and emergency demand would be an issue. Keith Griffiths thanked Andrew Cardoza for this update. He highlighted the problem-solving culture that was needed to generate transformation and reported that the ICB had 4-5 Programme Delivery Boards; he wondered whether we had done any OD with those colleagues around what was needed now, given the scale of the challenge, compared to when those people were put into those roles. He felt there needed to be a different lens now and reported that he would speak with Amanda Rawlings to see what we could do help support those colleagues regarding transformation work to help them rethink their approach to give better results and quicker clarity. **Audit and Governance Committee thanked Andrew Cardoza for his update and looked forward to seeing the External Audit Plan at the next meeting.**	KG
AG/2223/089	**Internal Audit** **Progress Report from 360 Assurance** Usman Niazi presented the progress report from 360 Assurance and highlighted that since the last Audit and Governance Committee they had: • Completed the fieldwork for the NHSE mandated work on financial sustainability and were preparing the draft report. • Completed the fieldwork for Stage 1 of the work programme supporting the Head of Internal Audit Opinion. A draft report was currently being prepared. • Commenced the fieldwork on the Transformation and Efficiency audit. • Agreed the Terms of Reference and timing of the Governance and Risk Management audit. • Held ongoing discussions with the Executive Director of Corporate Affairs regarding utilisation of the allocation in the 22/23 Internal Audit Plan for risk management workshops. • Monitored the Management's response to recommendations made to the ICB's predecessor organisation which remained relevant. 360 Assurance were pleased to report that all recommendations due had been implemented in a timely basis. Usman Niazi reported that following discussions with External Audit colleagues across its ICB client base, they were proposing to supplement the Financial Sustainability checklist review in the Plan with an audit of General Ledger and Financial Reporting controls. It was proposed that this review take place in Q4 and would require 8 days to complete. The reason for completing this work was to give 360 Assurance the opportunity to test controls at a slightly earlier stage in the process. Any issues could then be brought to the attention of External Audit colleagues in a timely manner. Audit	

	and Governance Committee were requested to approve this additional work. The Chair reported that she did not have a problem with this additional work. Richard Wright was interested in the transformation and efficiency report and asked when this would be ready. In addition, he asked whether issues were raised on an ongoing basis with Keith Griffiths and his team during the exercise and prior to the final report? He felt we had some real challenges as an ICB in this area. He went on to ask whether 360 Assurance compared us with other Systems in their client base and whether they could highlight areas where we might fill in any gaps. Kevin Watkins responded that on the first point, 360 Assurance were hoping to complete the work as soon as they could, but it was hoped a draft report would be prepared in the next 2-3 weeks. It was noted that in terms of the issues that the exercise had identified, the ICB's finance team were aware of these from the discussions that had been undertaken, as was Maria Riley. Regarding comparison with other areas, it was noted that 360 Assurance had done a piece of work last year looking at emerging transformation arrangements comparing Nottinghamshire with Derbyshire and highlighting differences between the two. This piece of work would be undertaken in other communities in the next year and 360 Assurance agreed to bring any shared learning from those reviews. Keith Griffiths referred to the transformation work that 360 Assurance were doing and highlighted that the Provider Collaborative was now developing itself and Tamsin Hooton, who was MD of that group, had overall responsibility through Maria Riley for the Programme Delivery Boards. He felt it would be well worth 360 Assurance having a conversation with her as she would be leading on this on behalf of the System through the Provider Collaborative. Keith Griffiths reported that he was getting soft intelligence from people within those teams regarding what they saw their priorities as being, which may not be well rounded in terms of recognising all the ICB's challenges. He felt it would be worthwhile getting 360 Assurances independent view on what people on the ground thought about what they were doing and what their priorities were. That way we could have a clear script as to what we needed to work on; this would add more value to the report when it was finally produced. The Chair referred to the risk management workshop and asked Helen Dillistone for further clarity on the thinking behind this and where it fitted with the risk management side of things.	

	Helen Dillistone reported that the workshop was born out of a conversation with 360 Assurance over the last couple of weeks. It would form part of the programme to tie in the work that we were now undertaking with all the Committees regarding strategic risks having been agreed by the ICB Board last week. The risks had now been assigned to lead Executives and Committees. Work was being undertaken to populate the new BAF ready for presentation to the ICB Board in January. It was noted that we had been developing a new BAF template that was more intuitive and reflective of the approach that we now needed to take, recognising the complexity of the system and the importance of reflecting system assurance in that. This was now ready to be issued, and one to one work with individuals was being undertaken ready for Committee meetings. In support of its development, it was noted that 360 Assurance would have a slot on each of the respective Committee meetings to help position risk appetite and risk tolerance. Helen Dillistone reported that after discussions with John MacDonald, he might still want to work with Deloittes on the BAF, to help keep continuity. In terms of the technical piece around risk management at Committee level, she felt the expertise that 360 Assurance had, could help to assist conversations to develop the BAF. It was noted that a schedule was to be drawn up for 360 Assurance to attend Committee meetings over the next couple of months in order to do that. It was noted that members felt this would be useful and agreed that the timing for this was right. Keith Griffiths reported on a conversation at Finance and Estates Committee earlier this week about the risk register. We needed to recognise the distinction between a risk register for a single organisation and a risk register for the system. Whilst this work was progressing, he welcomed 360 Assurances thoughts about whether what we were designing was tailored to system working or organisational challenge. We had some difficult things to land in terms of owners of risk. It was noted that people who were not part of the ICB, were being asked to take on the risk lead whilst being employed by other individual organisations. We were finding that this was a psychological and accountability challenge for those colleagues; they were being expected to accept responsibility for something which was boarder than their current organisational remit. Helen Dillistone wanted to support that critical point, in essence what the new BAF needed to demonstrate was not to just look through the lens of an ICB. The 9 strategic risks agreed at Board last week were to support the System. It was noted that Kevin Watkins, Usman Niazi and Helen Dillistone may have to regroup to ensure that time in the Committees was given to reflect on some of	

	the points raised to help support and drive some of those discussions to help with that boarder understanding of the System. **Environmental and Sustainability Event – 6 December 2022** Usman Niazi reported that there was to be an environmental and sustainability event on 6 December via MS Teams. The event was aimed at Board members as well as environmental sustainability and climate leads across organisations. Unfortunately, the Chair was unable to attend, but Richard Wright agreed to try and join for part of the event. The Chair thanked 360 Assurance for sharing the initial comparison of the financial sustainability responses. She reported that it was interesting to see that the ICB came up with higher scores around Board reporting but more negative lower scores around cost reduction areas. She felt that this was probably a reflection of the work we knew we had to do around the cost reduction side of things. The Chair reported that she would be interested to see the detail of this audit when it was completed. **The Audit and Governance Committee:** • **NOTED the Progress Report** • **APPROVED the proposed adjustment to the 2022/23 Internal Audit Plan so that it included a separate review of General Ledger and Financial Reporting controls.**	
AG/2223/090	**ICB Financial Position Review – M7** Darran Green presented the ICB financial position review for M7 and highlighted the following: • This report was discussed at length at the Finance and Estates Committee earlier this week. • This paper covers the ICB as a statutory body and the ICB remained committed to deliver a breakeven position as at 31 March 2023. • The paper sets out the YTD reported position of a £1.2m deficit with an unmitigated forecast outturn of £4.4m deficit. This forecast outturn deficit was a continued improvement from £7m deficit seen at M6 and £13.3m deficit seen at M5. • The table in Section 3 sets out the movement between M6 and M7. This was a result of the ICB team reviewing assumptions behind the forecast outturn with budget holders. The challenging of those assumptions continued. • Table 3.2 identified the ICB was forecasting to over deliver against its planned level of efficiencies for this year. However, as reported to SFEC earlier this week, £20m of that delivery was non-recurrent and the over delivery was also part of that £20m non-recurrent element. This was going to impact on the recurrent position of the ICB.	

	• This section went on to describe the pressures we were seeing against the plan we initially set, which were around CHC fast tracks, mental health and S117, and prescribing. • Section 4 identified the risks that we had got to the position. The usual challenges were around spend against CHC and prescribing. • It was noted that the running costs also reflected the increasing energy costs and the difficulty with recruitment. • It was noted that the unfunded investments line was still holding elements that ought to be sat within some of the providers. The intention was that the risks of those things would sit with individual organisations next year and not be held centrally. • Darran Green reported that we would be doing a much more robust planning process and distribution of resources which would meant the ICB would not hold anything like that going into next year. • Keith Griffiths reported that when we achieved breakeven, we would not have only balanced the ICB's books, but we would also have contributed towards the system shortfall, and we would continue to do everything we could to ensure the ICB was in the best possible position to support the broader system challenges. • Keith Griffiths reported on the consequences of the current economic environment. Healthcare organisations, including hospices were coming to the ICB looking for financial support so they could remain viable. When organisations providing frontline care like hospices were asking for financial support, it was a very difficult, ethical, and commercial complex set of values and issues that were having to work with. The last thing we wanted was hospices to close, because they provided a massive amount of support to the families and provided help with discharges from hospitals. Hospices were seeing their costs spiral because of energy and seeing their income fall because people did not have to cash to spend in their charity shops or to support and donate. • It was noted that people felt the ICB and/or NHS were the organisations to seek help from for some of the national problems that we were currently seeing across the country. We did not hold any reserves to deal with those kinds of things and neither could we walk away. We needed to be diplomatic around how we find solutions to some of those things. It was felt this was going to be a continuing challenge for the next couple of years. • It was not just hospices; other partners were facing significant financial challenges that needed to stay solvent to provide the care that we needed for our citizens. It was noted, unfortunately, we did not have the money to support them. • Dr Dhadda asked how we encapsulate the risk around the cost of inflation and the impact it was going to have on our System. With inflation running at around 11% this would add cost pressure to all service providers. The risk was that some	

	providers may have to start cutting back on services to meet that cost. • Darran Green responded that we reported on a regular basis to NHSEI as a System on the impact of inflation and how that was changing on a monthly basis, and details of this were contained within the report that went to SFEC. • Dr Dhadda reported from a primary care perspective, practices were looking at £50-70k of cost pressures, it would not be long before practices would need to start cutting back on services at a time when we needed full engagement from System partners. If we had 1-2 years of this, that could do significant damage in terms of engagement with our System partners and the ability to deliver the agenda over the next 12-18 months. • Keith Griffiths explained that we reported openly on what the cost of inflation was doing in our reports. We may need to add in the risk that was bubbling away behind the scenes, that we could not quantify, but recognising that it could come from other sectors. • It was noted that there had been a discussion on Monday evening with Amanda Pritchard and Julian Kelly, and the inference from that was that we were to plan for a 4.1% inflation for 2023-24. That was a lot less than the 11% we were currently experiencing. • Even if we get funded for the 4%, which was more than what we had received in the past, there would still potentially be a significant problem throughout 2023-24. We needed to wait and see what the formal allocation told us around additional support in year if inflation continued. Keith Griffiths reported that he needed to be calling this out now publicly, as it might impact on the decisions that we had to make collegiately to stand still. • Darran Green reported that the System was reporting a £35m challenge between now and the end of the year to deliver breakeven. We were clear that an element of that was unfunded inflation, unfunded Covid and a more technical issue regarding funding to one of our providers. It was noted that we were making it clear to NHSEI that there were things behind our position that we were trying to mitigate, but that none of those cost pressures were in our initial plan and we were trying as best as we could to mitigate them and deliver a breakeven position. **The Audit Committee NOTED the M7 ICB Financial Position.**	
AG/2223/091	**Board Assurance Framework Update** Helen Dillistone reported that on 17th November the Board approved the ICB's proposed strategic risks, work would commence with the Executive risk owners and relevant Committees to develop and populate the Board Assurance Framework. This would also involve engaging with key system leads and system groups who would also have an important role to play to support the management of the strategic risks.	

	A fully populated BAF would be reported to the public ICB Board on the 19th January 2023. The BAF would be reported quarterly to the ICB board thereafter, and as work continued to develop on the strategy, the strategic objectives may therefore be further refined to reflect any changes. It was noted earlier in this meeting, that 360 Assurance would be offering support to Committees to help with risk registers. Linked to that, but separately presented, was the ICB Operational Risk Register, where we had a number of risks that were ICB focused as an organisation in its own right, which accompanied and complemented the BAF. **The Audit and Governance Committee NOTED the process of the development, future monitoring, and reporting arrangements of the Board Assurance Framework.**	
AG/2223/092	**ICB Risk Register Report – October 2022** Chrissy Tucker presented the ICB Risk Register Report to October 2022 and highlighted the following: • The report this month had been streamlined and simplified. • The report described three risks No 04, 12 and 14 that were approved virtually for closure on 9 November 2022. • This Committee was now responsible for 5 risks on the ICB corporate risk register. • There was one high scoring risk, No 15, which was about the capacity to manage workload arising from the delegation of functions to the ICB. That score remained at 16 as the work was still in progress to understand what impact this was going to have on the ICB. • To add to this risk, since this paper was written, we had become aware that other ICB's had also volunteered to act as hosts as well as Nottingham. It was noted that we intended to amend the wording of that risk for next time. It was noted that there had been a CEO discussion in December, and we may have a confirmed host by the time this Committee met again. • We had 4 remaining risks that were the responsibility of this Committee none of which had changed this month. • Risk 5 was around EPRR capacity and preparedness for CAT1 responsibilities, this remained at a score of 12. The new head of EPRR had joined us this month, Chris Leach, and he would be putting together a programme of work to get us exactly in the right position for CAT1. As a result, we were not ready to reduce this score yet. • Risk 7 related to the secure and consistent storage of staff files, this had been on the register for a while. It was noted that we had a plan developed and were trying to work out how we could get the capacity together to implement that plan. • Risk 11 related to sustainability, this remained at a score of 9. It was noted that we should start to see a reduction in this risk once we made some headway towards the targets in our green plan for 2022-23.	

	• Risk 16 related to potential staff anxiety and wellbeing relating to the transition into an ICB. There was continued promotion of supporting mental health and staff looking after themselves and various well-being activities. It was noted that structures were being reviewed and that could cause some uncertainty for staff, as a result that score would not be reduced yet. • The Chair reported that she was happy with the style of this report but had a query on Risk 11 about the green plan. She had reviewed the forward plan for this Committee but could not see anything which indicated that the green plan was being scheduled for discussion. She asked whether the green plan could be added as one of our deep dives to see how we were progressing. Chrissy Tucker agreed to get this scheduled on the planner. • The Chair was happy to close the risks that had been identified for closure. **The Audit and Governance Committee:** • **RECEIVED the risks responsible to the Committee** • **NOTED the virtual approval received for the CLOSURE of Risks 04, 12 and 14.**	CT
AG/2223/093	**Emergency Planning Resilience & Response (EPRR) Update** **EPRR Core Standards Self- Assessment 2022** Chris Leach presented EPRR Core Standards Self-Assessment 2022 report and highlighted the following: • This had been a slightly longer process than in previous years. • There had been a lot more challenge from NHSE regarding the information and data we needed to provide, not only from us but also our providers. • Derby and Derbyshire ICB would come out as being non-compliant this year against the core standards. We needed to become compliant on 6 more standards to move up to partial compliant status. • We would work with NHSE over the next year to make sure our own resilience could be upgraded. • Some of our providers status had also changed and they had dropped down standards where normally they would have achieved green status. • Providers would be taking part in a piece of work as a System over the next 12 months to get them to the status they needed to be. • Chris Leach would be working closely with one of our providers who was, unfortunately, going to attain non-compliant for the second year running. This would be managed by the Local Health Resilience Partnership (LHRP) chaired by Dr Weiner, the Accountable Emergency Officer, to help improve their status. • The Chair asked whether this ICB was an outlier for being non-compliant on this self-assessment.	

	• Chris Leach reported that it was a fairly standard position across the board for most ICBs. Some were non-compliant or only partially compliant. • Chris Leach reported that there were 6 standards that he felt would be quick wins for the ICB, but the other standards may take slightly longer. • It was noted that the entire work plan for this year would be very holistic in its nature. There were also other pieces of work that were not necessarily linked into the core standards that were critical for us to tie into the CAT1 status. • Chris Leach reported that he would bring the work plan to the next Committee meeting, which would show very clear time scales. He added that theoretically we would have done them all by the next time core standards comes round, but he wanted to err on the side of caution stating that there were some which would take a little bit longer to embed in the organisation and the System. **Business Continuity – Power Outage and Industrial Action** Chris Leach highlighted the following: • There had been extensive work done nationally regarding preparations for power outages. • Providers had now submitted information requested by NHSE, and the ICB had also assessed this information. It was noted that a few actions were still open, and these were being worked on in relation to community resilience eg patients on dialysis machines at home. We needed to ensure that these patients were known and that we could keep these patients at home in the event of power outages. • The ICB were meeting weekly with providers and an action log was being kept open to manage these potential events. • We had done a deep dive into our resilience for electrical outage for the ICB. It was important to ensure that the IT servers were running so that staff could access what they needed. NECs had a very resilient plan for this, and it was noted that we had multiple servers in multiple areas of the country, and it was unlikely that we would be affected by the loss of service due to power outages and we would be able to continue working as an ICB. • Regarding possible industrial action, weekly meetings had been arranged to review preparation for industrial action across Derbyshire. A submission was due to NHSE and the ICB next Monday detailing our preparedness. **Operational (System) Control Centres** Chris Leach highlighted the following: • We were currently working with the UEC team to ensure we had an Operational Control Centre from 1 December.	

	• This was to ensure that we could manage escalated activity, and if need be, understand whether we needed to escalate into a critical and/or a major incident. • We were working with the UEC team to ensure that we could respond to an EPRR incident with this system in place. • The control centre would work 8am-8pm 365 days a year with very senior oversight. • It was noted that this approach had come about from the learning during Covid. **Operation Arctic Willow** Chris Leach highlighted the following: • Arctic Willow was briefly linked to industrial action and utility disruption and was a facilitated tabletop exercise across the UK. • We were expected to have delivered on this a couple of weeks ago, but due to a national flooding exercise, region have had to rethink how we deliver it. • Next Wednesday, Thursday and Friday we would be holding 1½ hour sessions with each of the providers, in a facilitated session, the exercise pack sent to ICBs and then feeding back to NHSE. • It was noted that the scenarios were useful from a business continuity perspective. Learning that we get from our providers would be used to dictate our health emergency system planning approach to build what we do with our emergency planning officers across the patch and to deliver the business continuity piece of work. **Incident Response Plan** Chris Leach reported that the Incident Response Plan was meant to come to this Committee for sign off. However, following reassessment there were several aspects that were still missing out of it for the CAT1 status. The Plan had now gone out for comment today across the on-call team that would be using it, and to the provider emergency planning officers, as it was also a system plan. The Plan would be brought to the next Committee meeting for sign off, as it would have gone through the consultation by that point. **Audit and Governance Committee thanked Chris Leach for his comprehensive update.**	
AG/2223/094	**Information Governance Assurance Report** Ged Connolly-Thompson presented the Information Governance Assurance report and highlighted the following: • The purpose of this report was to provide assurance to Committee that the IG function of the organisation operated effectively regarding communication of key decisions/reporting of issues. • Decisions made at the recent Information Governance Assurance Forum were to review and revise the role of Information Asset Owners, and Information Asset Administrators	

	within the organisation. The IG team was currently pulling an SOP together and once agreed would be presented to SLT for approval. • It was noted that training courses would be reviewed, and we were looking to outsource to supplement some in-house training to ensure that appropriate support was in place. • This would also pick up some of the assurance role by Helen Dillistone as SIRO, around the leavers/joiner's process, together with things around shared mailboxes, and access to resources. • In the more complex world of NHS mail and Office 365 there was a lot of work needed to be done in relation to understanding the risks around that. • Some of our data was stored on NECs infrastructure, but some was now held in the cloud and in other organisations. Work was being done to ensure that appropriate access was given, and inappropriate access removed as people moved roles within the System or left the organisation. • This work tied in closely with the ICB's responsibility under the data security protection toolkit, as a result IG teams would be supporting data mapping exercises, access to shared resources, etc. • The IG team would also be supporting the new Data Protection Officer and the Deputy Data Protection Officer. • As with the CCG, the IG team would undertake the investigation. and do a lot of the background work and present a case to Keith Griffiths as DPO and to Darren Green as Deputy DPO respectively and ensure that the DPO, SIRO and Caldicott Guardian had oversight in line with their responsibilities within the organisation. • We were also linking in with the DSPT; the audit criteria had been released and the team had contacted 360 Assurance to start those initial conversations. • We were assured that our NECs IT provider were able to meet the CAT1 requirements. We had reviewed those with them, and we were assured that there should be no outstanding issues from that respect. • It was noted that the team continued to be involved in ICS work, regional and national meetings. They were there to represent the ICB, horizon scan and feed information back to the appropriate people within the ICB and the wider system. • Local Authority Data Access: It was noted that the forum discussed the recent communications from NHSEI regarding Local Authorities having the same rights of access as the ICB to data from the NECS DSCRO service. Rather than having a separate agreement with NECS, the ICB would look to support an extension of their existing contract to incorporate Local Authorities, as this would be more cost effective for the System and remove duplication of effort.	

	• The forum agreed the ICB would seek to extend their contract, pending discussions with the ICS data group and identification of data requirements from Local Authorities. • Regarding mandatory training, Data Security Awareness (Level 1) Training fulfils the requirements in relation to the Data Security Protection Toolkit and gives a level of understanding of responsibilities relating to data security. The ICB was required to meet the percentage of 95% of all staff trained for the period 1st July 2022 to 30th June 2023. • The IG Team received a monthly training report from ESR so that training compliance could be monitored throughout the year. • Keith Griffiths reported that he thought from memory we were about 75% met, but that meant one in four of our colleagues were not compliant with mandatory training. The definition of mandatory was everyone. • We required some polite messaging to staff from HR regarding the importance of mandatory training. • Keith Griffiths reported that there would be some financial training coming out in due course which would also be branded as mandatory training. **The Audit and Governance Committee NOTED the Information Governance update for August to October 2022.**	
AG/2223/095	**Digital and Cyber Security Report** Ged Connolly-Thompson presented the Digital and Cyber Security report and highlighted the following: • The ICB remained assured on the quality of services that NECs were providing to primary care and corporate services. • At the Contract Management Board yesterday, NECs had achieved all but one of their 12 KPIs with reasonable justification presented, which was a much-improved picture than 12-18 months ago. • The network and connected services remained stable. October saw a marked increase in attempts of web downloads. There had some issues with Microsoft Edge Web browser trying to download executables. But it was reassuring to know that this was addressed, and no one was able to install executable applications onto our devices. • Previously ICB's deployed Cisco ICE which was used to look for ghost equipment on the network. We had a very extensive wide network across our primary care and that was linked into our corporate network. This gives us numerous attack vectors where people could put devices on the network and could use those for malevolent purposes. • Cisco ICE was looking across the network and identifying any kind of items that should not be there and that would then start a conversation with primary care, PCNs and corporate colleagues if anything was found.	

	• The team has sought assurance from NECs that no services would be affected because of this, and Communications Directorate would inform people what we were doing. We needed people to understand, that they were part of our cyber defence. • It was noted that there was an ongoing programme of work across corporate and primary care to address legacy issues with access to NHS mail accounts. There was an increasing number of cloud-based services attached to NHS mail, it was no longer simply a mail account, there was all kinds of Office 365 and other access on the back of that. These could present additional attack vectors into the organisation. • The teams were working with HR, NECs, ICB and GP practices to move accounts into NHS mail containers to close accounts or to support organisations setting up their own containers within NHS mail. • Assurances had been given that this would not affect any service delivery. But there were timescales to manage this process, it was something like six weeks to three months for organisations to move, with a multiple of 7-9 contacts on the NECs service desk to ensure what was expected of them. • Any accounts that did not respond would be closed and put through the levers process. • It was noted that we had received two complaints so far from primary care, that was predominantly around the literature and having to redo their literature. They had been an extension of between 3-6 months, so they had time to update all their information. We would then make sure their current account still worked as we transitioned across into the amended one. • This work had seen the release of a number of Office licenses back into the pool, which had given an £11k saving. • From an estates perspective the team were supporting hybrid working and working from home together with occupational health issues. We were in the process of procuring more equipment to make more desks usable at HQ sites and we were also responding to occupational health requests for people with adaptive devices and other things that helped them to either work at home or in the office. • From a transformation perspective, the team continued to work on projects at a local and regional level. We were collaborating with Notts County Council and Department of Culture, Media, and Sport on the Gigabit broadband programme. We were looking to deliver improved access speeds to 25 of our rural GP practices and this should save us around £30k per site, an investment of £750k, which the ICB did not have to find because the money was coming from other areas. • It was noted that about a quarter of our estate that was already up to speed. That did not mean to say that those in urban areas were going to be going to be left out. The ICB had committed	

	to install Gigabit ethernet in all our sites and we would continue to increase bandwidth as and when required. • GP IT resilience funding would use to make sure that there was appropriate connectivity into practice sites. • An update regarding the Derbyshire Pathfinder application was given. It was noted that the investment that had been made in the core infrastructure would give us opportunities in other areas. • The notable one was Lister House Surgery. The contact from the community there had reported that online consultation (the submission of forms to Lister House Surgery in the PCN), did not work for 40% of the community. English was not their first language, and even for those for whom English was their first language, the literacy, and the complications together with the complexity of the system did not work. • It was noted that we had been asked by the community to enter into a co- development opportunity, and we had done that. • We had spoken to the developers of Derbyshire Pathfinder, and they were putting a couple of project managers and a business analysist in to sit down with the community to see how we could work with them. • It was not only about investment in technology, but also about looking at other applications and where we could start to maximise the return and utilise what we already had. • A conversation had taken place yesterday with primary care leadership group around budgetary constraints, we were not looking to remove functionality and would ensure they had the same access experienced during the pandemic, but we would need to look at scale across primary care. • It was expected that there would be some potential issues with that, and we were going through a quality impact assessment on all the options that we were presenting, and they would be taken through appropriate Boards and Committees to reach a consensus, and in line with LMC and the ICB working together. • Dr Dhadda asked whether we had any PCN level data in terms of uptake and usage of the Derbyshire Pathfinder. He understood some practices used it very sparingly, but he found it to be a very useful clinical tool, which he enjoyed using. • Ged Connolly-Thompson reported that we did not have any data on this unfortunately. • Dr Dhadda felt that practices did not realise the potential of Derbyshire Pathfinder. He found it very easy to use and was time effective. • The Chair asked whether we had links into practice training time through the PCNs to make sure that they were fully aware of potential benefits of using all the systems that were available. • It was noted that we were starting to move into training needs analysis work, and we were trying to reach out to practices to give them an idea of what could be provided.	

	• The ICB continued to document additional uses for this application and component elements, it was the intention to present to the ICS Data & Digital Board and ICS Design Authority to share learning and gather further use cases. **The Audit and Governance Committee NOTED the Digital and Cyber Security Report.**	
FOR INFORMATION		
AG/2223/096	**ICB Estates Update** Chrissy Tucker highlighted the following: • As stated, at the last meeting, the ICB had now moved to Green Phase 2 of the hybrid working model. • Members of staff had been asked to come onto site on average 2 days per week. • The review of estate was underway. • A staff survey had been undertaken with a view to obtain views of what staff thought were important factors in the working environment with a view to looking at potential savings. • It had been agreed that notice would be given on 1st floor east space at Cardinal Square. This space was divided into office space and meeting rooms. Notice would be given on this space next week. • There were two safe-haven offices on that 1st floor east, and we would be looking to re-provide these two offices on either 1st floor north or the ground floor. • There had been no formal review of the accommodation at Scarsdale yet. Desk bookings via the booking app were being reviewed to see if there were any specific rooms that we currently occupied that could potentially be released to other tenants in the building. **Audit and Governance Committee thanked Chrissy Tucker for the ICB Estates update.**	
AG/2223/097	**Non-Clinical Adverse Incidents** Chrissy Tucker reported that there had been no non-clinical adverse incidents to report. However, we were preparing for a variety of potential events that may happen in the future such as strikes, or adverse winter weather events etc. **Audit and Governance Committee thanked Chrissy Tucker for this update.**	
MINUTES AND MATTERS ARISING		
AG/2223/098	**Minutes from the Audit and Governance Committee meeting held on 27 October 2022** The minutes from the meeting held on 27 October 2022 were agreed as a true and accurate record of the meeting.	
AG/2223/099	**Action Log from the Audit Committee meeting held on 27 October 2022.** The action log was reviewed and updated during the meeting.	
CLOSING ITEMS		

AG/2223/100	**Forward Planner** Deep Dive - Derbyshire Green Plan to be scheduled on the planner. **The Audit and Governance Committee ACCEPTED the Forward Planner.**	CT
AG/2223/102	**Any Other Business** There was no further business.	
AG/2223/103	**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? **Yes.** • 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? **Yes, Green Plan to be scheduled.** • What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? HR policies were approved. Change in Audit Plan Expected EPPR self-assessment to be non-compliant, but there were plans in place to move this forward. Assurances received regarding IG and digital Mandatory training – importance to be flagged to staff.	
DATE AND TIME OF NEXT MEETING		
Date: Thursday 22 December 2022		
Time: 2.00PM		
Venue: MS Teams		

Signed: …… Dated: ……..
(Chair)

RATIFIED MINUTES OF THE ICB PEOPLE & CULTURE COMMITTEE (ICB PCC)

HELD ON WEDNESDAY 07 SEPTEMBER 2022, VIA MICROSOFT TEAMS, 0900-1100

Present:		
Gildea, Margaret	MG	ICB Non-Executive Manager and Chair of ICB PCC and Non-Executive Director DCHS
Bayley, Susie	SB	General Practice Taskforce Derbyshire – Medical Director
Blackwell, Penelope	PB	Place Board Chair and NHS Derby and Derbyshire CCG Governing Body GP
Burnett, Kaye	KB	DCHS Non-Executive Director and Chair of PCC
Dawson, Janet		NED DCHS and Chair of PCC
Garnett, Linda	LG	Programme Director, People Services Collaborative
Knibbs, Ralph	RK	DHFT Non-Executive Director and Chair of PCC
Lowe, Jaki	JL	DHFT Director of People & Inclusion
Moore, Liz	LM	Derby City Council, Head of HR
Rawlings, Amanda	AR	ICB and UHDB Chief People Officer
Sharma, Vijay	VS	EMAS, Non-Executive Director
In Attendance:		
Booth, Lorraine	LB	Derbyshire County Council Head of HR Operations – on behalf of Emma Crapper / Jen Skila
Bradley, Faye	FB	CRH Interim Deputy Director of HR & OD – on behalf of Caroline Wade
Cooke, Nancy	NC	ICB System Workforce Planning Lead
Cooper, Helen	HC	DCHS Deputy Director of People Services and Organisational Effectiveness – on behalf of Darren Tidmarsh
Spray, Susan		JUCD Programme Lead – on behalf of Beverley Smith
Thompson, Helen	HT	Executive Assistant to Amanda Rawlings
Apologies:		
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
Smith, Beverley	BS	NHS Derby and Derbyshire CCG, Director of Corporate Strategy & Development
Street, Joy	JS	UHDB Non-Executive Director and Chair of PCC
Tidmarsh, Darren	DT	DCHS Chief People Officer / Deputy Chief Executive
Wade, Caroline	CW	CRH Director of HR & OD
Wight, Jeremy	JW	CRH Non-Executive Director and Chair of PCC

Item No.	Item	Action
PCC/2223/14	**Welcome, introductions and apologies** Attendees were welcomed to the meeting, introductions were made and apologies were noted as above.	
PCC/2223/15	**Confirmation of quoracy** The meeting was confirmed as quorate.	

PCC/2223/16	**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 DECISION	
PCC/2223/17	**ICB People & Culture Committee Terms of Reference (ToR)** ICB PCC noted that draft ToR had been submitted to the inaugural ICB PCC meeting held on 17 June 2022. Committee members provided very helpful and comprehensive feedback and with the help of the ICB governance team, the ToR were refreshed and circulated via email on 21 August 2022 for further comments. RK suggested that it would be helpful to list the 10 people functions for the ICS within the ToR to show the clear boundaries of the committee. AR agreed to amend. **Subject to the amendment above, the ICB PCC APPROVED the terms of reference.**	AR
	PEOPLE PERFORMANCE	
PCC/2223/18	**Workforce Oversight, including annual plan and agency spend target** ICB PCC received the report which provided a summary of the Derbyshire workforce position along with agency staffing targets, including detailed information to describe the current trajectory against the plan and the associated challenges with achieving the plan. ICB PCC was informed that each NHS provider has been required to submit a workforce plan on an annual basis. In previous years there has been little focus on this plan whereas this year there is an expectation to triangulate the system workforce plan with finances and activity. This approach is good practice that we strive to achieve. However, it is proving difficult to deliver this year due to the financial cost envelope associated with the ICB submitting a plan to achieve a balanced budget. ICB PCC were informed that with regard to agency spend, ICBs are expected to achieve a cost saving of at least 10% on their agency spend from the previous year. JUCDs target equates to a 32% reduction on the previous year's figures. ICB PCC were asked to receive the workforce plan for JUCD and month 4 agency expenditure/annual target, understand the current pressures and associated actions being undertaken within individual providers and the wider system partners and discuss the role of the PCC in overseeing the workforce plan. ICB PCC discussed strategic objectives of retention and growing establishments and noted that extensive recruitment will be required. AR confirmed that following a recent regional meeting,	

	the Midlands region is short of what submitted, retention is a big issue, and the supply gap is enormous. Vacancies nationally sit at around 13,000 which does not include local authorities or social care. AR advised that there is huge expectation that will not meet targets by the end of the year due to workforce supply. This is why a national workforce strategy is required around workforce supply is required and hopefully underway. ICB PCC were advised that will be appointing a system recruitment lead, as have been given national funding to employ someone for a year to assist on retention strategies. The retention strategy will be across all professions, pathways and organisational boundaries etc. A suggestion was made to utilise multidisciplinary leads across the system to obtain information and to assist understanding on what needs to be done and what they can do to help. FB noted that it is the hard to recruit posts rather than the retention side that is creating most of the issues. For example, there are some really key medical posts where they are considered a shortage occupation which are the ongoing challenge in certain areas, e.g. ED, Urology, Microbiology. HC highlighted that one of the important things to note is that are not recruiting to attrition as a system, and so regardless of broader targets to grow our own workforce in the plan, the fact that there are more people leaving than people coming in is a real challenge. This is one of the first things that needs to be addressed through recruitment campaigns. AR confirmed that there is a national steer on what the retention leads need to do, but would also look at this as being a co-creation and co-involvement across the whole system around what works, what doesn't work and what works in different settings, different professions etc. and needs to be clinically led. The post will be advertised amongst our own system in the first instance. ICB PCC were informed that due to the time it will take to recruit the system lead and then for the lead to commence engagement, may potentially not see much in the ways of results this year. A suggestion was made to obtain feedback from the multidisciplinary leads prior to the retention lead commencing in post. JL noted that the retention lead will be helpful, but also noted that alignment of recruitment and retention work is already underway, led by Beverley Smith and assured ICB PCC that are not waiting for the retention lead post before anything is done. Examples were given of opportunities where roles and be created that can be used across the system, and also not thinking about issues with workforce on just an organisational level but as a system challenge and focussing on those things which will make the biggest impact on the bottom line position here this year. JD noted that in some cases the workforce is there, but is working for agencies or on various banks. The challenge should be on how creative is the NHS being about trying to take people out of agencies and is enough being done to make the NHS a competitor	

	with agencies by offering the flexibility that agencies can offer. AR agreed this was a good suggestion, e.g. how do we look at the different categories of workforce and what might need to be done differently. AR agreed to take away to review. MG noted that does go back to third strategic aim of trying to move people from agency to bank, if not into permanent roles. KB noted the opportunities to work as a system and really focussing on hotspot areas and sharing best practice. KB also noted the age profile of organisations and the significant numbers of people who are looking to retire or go part time and noted the need to ensure the right 'stay' conversations are taking place across the board. The quality of conversations that managers are having with their staff is critical, and so equipping people with the skills to have really person centred conversations to understand what is happening and the link into leadership development is key. MG noted items from the meeting chat as follows :- • Reflection on the bank versus substantive and how valuable that might be looking at different rotas for portfolio careers which feeds into the flexibility point. • Idea that if we look at how much of our agency spend on medical staff could come from bringing them in, that would spark some fresh thinking and then a lot about sharing. • Retention is the key and working as a system offers great opportunities to make this work. There are key areas of focus in terms of specific professions/specialties, and also less than 2 years' service and the age profile of our workforce. Link to health and wellbeing is critical! ▪ Would be useful to track the results of the retention framework, and to see how the interventions make a difference In respect of improving agency spend, HC confirmed that all ICS were written to at start of the year indicating that there was a national expectation to reduce agency expenditure by at least 10% with a stretch target of 30% on the previous year. As a system, Derbyshire were given a target of 32%. HC advised that unfortunately are unable to change that target now and that equates to a target for the system of £22.4m. HC explained that at the end of month, have spent £12,000 and coming up to £13,000, so over half before reached the winter period, so obviously this is a real cause for concern. However, are tracking positively against expenditure last year, so would be on trend to come in similarly to spend of last year. HC advised will continue to review and track at both the 10% and 32% to review progress. KB queried what the implications would be for the ICB if targets are not met and to achieve the target what would be implications be for the system and for the sovereign organisations. MG noted that are not clear what implications would be for the system. MB advised would need to escalate the people element of this to the ICB. MG summaried discussions as follows :-	MG

	▪ There appears to be a good handle on data which is encouraging, particularly the health part of the system. ▪ There is a genuine willingness for people across the system to think we could do more by working together as a system. ▪ There are already examples of good practice and it must be quicker to build on things that already doing than it is to start rethinking and reinventing. AR advised of a System Planning Time Out taking place on 16/09/22 involving system CFOs, COOs, CPOs and Strategy Leads to look at what can do between now and year end with this submission, and also the relationship between our finance and activity plans to see what can recover and do differently and then to revamp the process of how this is done in short term and long term as will be asked to do another annual plan. AR also advised that HEE and NHSE are going through an integration process. There are around 5000 people in HEE and approximately 800 in the People Directorate and have indicated approximately 30-40% less staff through this process. AR explained that are working on something called an operating model, which will be what is done at centre, region, ICB and trust level and are consulting on that. Consultation sessions are also taking place with CEOs and CPOs, AR explained that running in parallel to the whole restructure and operating framework is also the development of a workforce plan at national level. Was called a strategy but will now be a plan. It is out for 10 years but it is all around strategic intent. Will possibly not have numbers attached to it in the first round. The plan will have four sections; transforming roles; workforce supply; education reform, and staff experience including pay terms and conditions. AR noted that the plan should come out in early October and will then start to think of our system response and system plan. AR advised that at present it is health centric but believe the ICB plan must be much broader around who we are as an ICS and that includes in our future workforce planning and submissions. There is a broader supply issue for all of our parterns and how we work jointly together. AR noted intention to take what comes out nationally and work with all colleagues to understand that and what that means for Derbyshire. Will also expand that to include what it means for our system and all partners and beyond just the health remit. **ICB PCC noted the report and actions as above.**	
WORK PROGRAMMES UPDATES		
PCC/2223/19	**People Services Collaborative 7x5 Work Programme Update** ICB PCC were reminded that NHS HRDs had agreed to focus on seven areas of focus with five priorities to support 'One Workforce'. The seven focus areas included:- ▪ Workforce Intelligence & Planning ▪ Resourcing & Recruitment ▪ Workforce Development & Transformation	

	▪ Digital & Data / Information ▪ Leadership / Management Development & Talent Management ▪ Equality, Diversity & Inclusion ▪ Health & Wellbeing ICB PCC were reminded of the 5 top priorities for 2022:- ▪ Develop a collaborative recruitment and resourcing hub. ▪ Develop a JUCD induction programme – local organisational inductions to continue. ▪ System wide aligned mandatory training (embedded into passport) include the training required for the care sector. ▪ Commence HR / people management policy alignment. ▪ Envolve our MOU to enable effective movement of people across the system. ICB PCC received updates update as at September 2022 on progress with the workstreams, as outlined in the papers. In response to a query, JL confirmed that work on ICS networks will be led by the networks themselves and EDI objectives have been embedded into all of the 7 focus areas. AR confirmed assurance that colleagues are working as hard as can on the focus areas. **ICB PCC noted the report.**	
PCC/2223/20	**Project Derbyshire – Digital Work Programme** ICB PCC were advised that as a member of the National Workforce solutions programme (replacement for ESR by 2025), AR confirmed that following a request, supported has been agreed for Derbyshire to develop digital road map and to help Derbyshire to be ready for the replacement ESR system. Expert support has been secured from the NHS Business Authority, for two years, to develop the 'as is' and a road map to transform the people digital space across the Derbyshire ICS. ICB PCC received slides which presented; introduction, strategic context, drivers, outputs, scope, resources – technical, resources – project plus and next steps. In response to a query, AR confirmed that the system will be procured nationally and will be a brand new system, which is currently out for tender. Further information will be provided as and when known. Unfortunately AR confirmed that the rostering system will be a separate system and in addition there is a risk due to separate finance and people systems which may not talk to each other. **ICB PCC noted the report.**	
SYSTEM PARTNERS UPDATE		
PCC/2223/21	**Workforce Priorities in Local Authorities / Social Care**	

	ICB PCC received an update from both Derby City and Derbyshire County Councils on their workforce priorities as follows:- ▪ Still have focus on all key points discussed by NHS partners – mainly recruitment and retention challenges and in particular home first services. ▪ Continuing to work with colleagues in terms of recruitment approach. ▪ Need a fresh look at talent management. ▪ Need to reflect on workforce planning, not only in relation to social care but more broadly across organisation. ▪ Need to review and introduce remain and new starter conversations. ▪ City and County Councils very much wish to be included in this space but recognising internal discussions happening first. ▪ Note recognition that pandemic has left lots of workforce challenges with a significant number of vacancies and still losing employees to other organisations. ▪ Have transformation programme underway, with priorities to refocus, realign, drive and shape services so can be well equipped to deliver, review actions and activity to drive that culture of continuous improvement. ▪ Risk flagged earlier regarding availability of home care services. ▪ Take system wide approach to health and social care. ICB PCC discussed leadership, management development and talent management and examples were provided of the importance of the quality of the conversations between managers and staff; the need for a personalised conversations and flexible doable jobs. The heart of what our leadership development should focus on, so all leaders see their job primarily as motivating, empowering and supporting people, not managing money and services. AR asked LG to build the quality conversations into our leadership induction as soon as possible **ICB PCC noted the update and thanked LM/LB for their input.**	
MINUTES AND MATTERS ARISING		
PCC/2223/22	**Minutes from the ICB PCC Meeting held on 17 June 2022** The minutes of the meeting held on 17 June 2022 were accepted as a true record.	
PCC/2223/23	**Action Log** The action log was noted and KB suggested including a deadline for items.	
CLOSING ITEMS		
PCC/2223/24	**Any Other Business** **Potential Industrial Action –** FB advised that the only ballot out at present is from the RCN, to commence mid-September. The earliest date that strike could potentially take place is 28 October and could then strike again at any point within six months. FB advised that the RCN are only voting on strike action and not action	

	short of strike or work to rule. Organisations will be notified as soon as possible after the ballot has closed and will be given 14-days notice of strike action. Each organisation will be working very closely with union colleagues to discuss exception of services and lists are available that have been used previously. FB advised that the expectation is that will be managed through ICB's and ICB's will have a good overview of action being voted, responses and sitrep returns. Further information will be available at the end of September. FB advised that UNISON will be going out to ballot in October. The deputies network will be working very closely together on this. **Meeting Effectiveness –** agreed that the meeting had been effective, but if anyone has any comments, please let MG know. **Future Meeting Dates –** MG noted that it had previously been agreed that ICB PCC meetings would be quarterly, however queried whether this would be sufficient.	
DATE AND TIME OF NEXT MEETING		
Wednesday 07 December 2022, 0900-1100, via Microsoft Teams		

MINUTES OF THE PUBLIC PARTNERSHIPS COMMITTEE

DEVELOPMENT SESSION
HELD ON 20 SEPTEMBER 2022, 10:00 – 12:00
VIA MS TEAMS

Present:		
Julian Corner	JC	Non-Executive Member DDICB **(Chair)**
Steven Bramley	SB	Lay Representative
Michelle Butler	MB	Senior Engagement & Community Officer, Healthwatch Derby
Helen Dillistone	HD	Executive Director of Corporate Affairs DDICB
Karen Lloyd	KL	Head of Engagement DDICB
Jill Kendrick	JK	Deputy Lead Governor Derbyshire Community Health Services NHS Foundation Trust
Harriet Nicol	HN	Engagement & Involvement Manager, Healthwatch Derbyshire
Tim Peacock	TP	Lay Representative
Margaret Rotchell	MR	Lead Governor Chesterfield Royal Hospital
Jocelyn Street	JS	Lay Representative
Sean Thornton	ST	Deputy Director Communications and Engagement DDICB and Joined Up Care Derbyshire
In Attendance:		
Lucinda Frearson	LF	Executive Assistant DDICB (Admin)
Apologies:		
Beth Fletcher	BF	Strategy and Engagement Manager, Healthwatch Derby
Kim Harper	KH	Chief Officer, Community Action Derby
Chris Mitchell	CM	Public Governor Derbyshire Dales and High Peak Derbyshire Healthcare NHS Foundation Trust
Beverley Smith	BS	Director of Corporate Strategy and Development, DDICB
Sue Sunderland	SS	Non-Executive Member ICB
Lynn Walshaw	LW	Deputy Lead Governor Derbyshire Community Health Services NHS Foundation Trust

Item No.	Item	Action
PPC/2223/15	**Welcome, Introductions and Apologies** Julian Corner (JC) as Chair welcomed members to what was to be the first Development Session of the Committee. Apologies were received from Sue Sunderland, Beth Fletcher, Kim Harper, Chris Mitchell, Beverley Smith and Lynn Walshaw.	
PPC/2223/16	**Confirmation of Quoracy** The meeting was confirmed as quorate.	

PPC/2223/17	**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 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.	
	FOR DISCUSSION	
PPC/2223/18	**Discussion around the Development, Role and Purpose of the ICB Public Partnerships Committee** The point of today's meeting is for the Committee to think through what it is they are here to do and how. This was now the Public Partnerships Committee not the Engagement Committee with a whole new regime and system, new prioritises and ambitions and there was a need to think afresh without losing the good things from the system being moved away from. The Committee is here to serve the goals of the ICS and these are: • To improve outcomes for population health and healthcare. • Tackle inequalities in outcomes, experience, and access. • Enhance productively and value for money • Assist the NHS in supporting broader and economic developments. How will public engagement support those goals? There are 2 functions: - • To take assurance that necessary public engagement is occurring to support those goals. Some are clearly statutory but there is a wider assurance needed – **Reactive** • To promote, develop, and sustain a system of engagement across the ICS and that we create the conditions across the ICS for that engagement to happen in the first place - **Proactive** JC highlighted the relevance of Karen Lloyd's (KL) Governance Guide to today's discussion which outlines what is required of the committee and which KL was asked to take members through. Following which a discussion would take place around what was required for things to happen. JC outlined 3 possible stages: -	

	Stage 1 – We understand what is required of us in terms of public engagement. **Stage 2** – We work out what we need to do to develop a system to deliver that. **Stage 3** – We work out what form this Committee needs to take in order to achieve that. Steven Bramley (SB) pointed out that himself and other lay members had stated previously that a complete list of projects with public involvement would be most helpful in understanding what was happening within Derby and Derbyshire – which fitted into stage 2 of the above. Jocelyn Street (JS) commented that the best ways to get a feel around how you achieve what you want to achieve is achieved through practical examples whilst looking at the theories.	
PPC/2223/19	**Governance Guide Testing (KL)** KL felt the Engagement Model to be the heart of the Governance Guide. The guide explains how engagement should take place within the ICB and in the wider system therefore a good foundation for the Public Partnerships Committee to seek assurance on. It was felt important that everyone on the Committee was aware of the contents. The main stages of the model being: • Planning and Preparing for Change • Building a 'Case for Change' – The Why? • Pre-Engagement – The What? • Options Development and Appraisal – The How? • Formal Public Consultation • Decision Making Process – how it considers the feedback. <u>Planning and Preparing for Change</u>: Highlights the legal and moral requirement to public engagement. Not all the stages of the engagement model are needed for every service change. Our legal duty requires us to inform, involve or formally consult. Not all changes need formal consultation, but we have a duty to look at them. It is the role of the Public Partnerships Committee to then assure the level of involvement. The first step is the Patient and Public Involvement Assessment and Planning Form (PPI Form) which is used to start to assess the level of involvement required in the change process. <u>Building the Case for Change</u>: This section is about the evidence, why are we thinking of making that change, and helps build a consensus around the key issues. It is important to note at this stage these are not proposals but why services need to change. At this stage the Public Partnerships Committee needs to start to have sight of the service change. The case for change is the most important section to get across to all decision makers and it is important the engagement team and Public Partnerships Committee get to know about projects at this stage.	

	Pre- Engagement Stage: This is about testing that case for change and developing plans to solve those issues. This is where proposals for possible changes are pulled together and should include stakeholders including patients and members of the public and is about checking the evidence gathered, encouraging ideas around possible solutions and information who may be impacted and how. Options Development and Appraisal Stage: The pre-engagement insight needs to feed into this process. It's about deciding between different options to identify which are viable and which will address the issues identified in the original case for change. There is little patient and public involvement in this stage at the moment. Decision Making Process: All the information is fed into the pre-consultation business case stage, and this is where assurance should then again be gained particularly if moving towards formal consultation. There is a need to be transparent how decisions have been made and show how the decisions have been influenced. Comments and questions raised: - • Margaret Rotchell (MR) asked if the Trust internally was considering a service change to how the Trust delivers a particular service would there be a need to go through this process, as not wanting to stifle the processes already in place. KL advised that through the guide it is being advised that all follow this process but not all changes will be required to go through the whole process. • MR highlighted the need for cultural change with all service providers being required to follow the process if there is to be a change to service. • Tim Peacock (TP) asked regarding GPs, KL advised the guides had been sent to all GP practices as they provide NHS services so are subject to the same law. The duty has always been there, but it has not always been applied. • SB asked around a mechanism to follow through post change. Once the service has changed was there process to see what the impact to the service has been. KL replied that at the end of the engagement model there is a requirement to assess impact but could not actually answer where that assurance may sit. • JS asked if there was a legal duty to act on the results of the consultation as there did not use to be. • JS agreed it was a change of ethos across the board and if achieved the outcome would be great asking regarding the Local Authority. KL was promoting across all partners but the law in the Governance Guide relates to NHS.	

	There were 2 elements emerging from the discussion: • Question of what should we be taking assurance on? • How do we create the conditions for public engagement? **Members went into breakout rooms to discuss the above 2 questions.** <u>Feedback from Room 2</u>: • Recognition of how vast and complex the agenda is. • Wish to make the Committee meaningful but conscious of the size of the task. • Where does the Committee come in, part or whole of the process? • Touched on the importance of looking forward as well as back, historically it has been about what has happened before. • What level of complexity does the Committee get involved in. • Importance of the log which informs the work of the committee, which was complex in set up and difficult to follow. Could be used to enable deep dives and be used to shape business and forward plan. • Subgroups – where colleagues may be more interested in particular aspects of the task and perhaps having an assurance committee which takes an overarching responsibility. - 3 sub-groups: approach to continuous engagement working with delivery boards and across the system. - Infrastructure – online engagement platform and citizen's panel. - Legal duties process. - Maybe 4th – system items <u>Feedback from Room 1</u>: • Key question – is there a good process in place – Yes • Already have risk around this – is the process resourced ok • Will the providers have the resources? • The general public, what enthusiasm is there for all the engagement. • Are all the changes going through the process – the log will be the starting point. • Do we know if a process of engagement is any good, and what represents good engagement? • How can we measure this engagement, we need something in place and again the log seems a good start? • Should there be targets • What sort of progress and review mechanisms will there be? • If we can do all these things than we shall be fulfilling our remit. **Action: A proposal to be developed for the next development meeting.**	**HD/ST/ JC**

CLOSING ITEMS		
PPC/2223/20	**Any Other Business** No further business was raised.	
DATE AND TIME OF NEXT MEETING		
Date: Tuesday 18 October 2022		
Time: 10:00 – 12:00		
Venue: MS Teams		

MINUTES OF THE PUBLIC PARTNERSHIPS COMMITTEE

HELD ON 18 OCTOBER 2022, 10:00 – 12:00

VIA MS TEAMS

Present:		
Julian Corner	JC	Non-Executive Member ICB **(Chair)**
Michelle Butler	MB	Strategy and Engagement Manager, Healthwatch Derby
Helen Dillistone	HD	Executive Director of Corporate Affairs DDICB
Karen Lloyd	KL	Head of Engagement Joined Up Care Derbyshire
John MacDonald	JMc	Chair Designate, JUCD
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
Margaret Rotchell	MR	Lead Governor Chesterfield Royal Hospital
Jocelyn Street	JS	Lay Representative
Sue Sunderland	SS	Non-Executive Member ICB
Sean Thornton	ST	Deputy Director Communications and Engagement DDICB and Joined Up Care Derbyshire
Lynn Walshaw	LW	Deputy Lead Governor Derbyshire Community Health Services NHS Foundation Trust
In Attendance:		
Beth Fletcher	BF	Involvement Manager, DDICB
Lucinda Frearson	LF	Executive Assistant DDICB (Admin)
Sue Higginson	SH	Patient Experience Manager, DDICB
Hannah Morton	HM	Engagement Specialist, DDICB
Victoria Whittaker-Stokes	VSW	Senior TCP Case Manager, DDICB
Apologies:		
Steven Bramley	SB	Lay Representative
Beverley Smith	BS	Director of Corporate Strategy and Development, DDICB
Peter Steedman	PS	Governor University Hospitals of Derby and Burton NHS Foundation Trust
Maura Teager	MT	Lead Governor University Hospitals of Derby and Burton NHS Foundation Trust

Item No.	Item	Action
PPC/2223/21	**Welcome, Introductions and Apologies** Julian Corner (JC) as Chair welcomed all to the meeting, introductions were made around the virtual room. John MacDonald, (JMc), ICB Chair, also attended the meeting. Apologies were noted as above.	
PPC/2223/22	**Confirmation of Quoracy** The Chair confirmed the meeting as quorate.	

PPC/2223/23	**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 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 <u>Declarations of interest from today's meeting:</u> Victoria Whittaker-Stokes (VWS) presenting item PPC/2223/28 LD Short Breaks wished to make members aware that as an autistic person with autistic family members received these services. The item was for information only and VWS was presenting from an expertise perspective. The Public Partnerships Committee **ACCEPTED** VWS was making members aware.	
FOR DECISION		
PPC/2223/24	**End of Life (EoL) Strategy** The Public Partnerships Committee are recommended to **NOTE** the JUCD End of Life Care, Patient Experience Report and **AGREE** proposals for continuation of the work. Sue Higginson (SH) presented the report which set out the findings of engagement work carried out as part of the JUCD End of Life Delivery Plan, and which makes recommendations for continuation of the work to build on good practice, improve services and develop a Single Point of Access (SPA) for end-of-life patients and their families and carers. Funding to the sum of £3k had been provided by NHS England for the work. It was found locally that care was disjointed with some lack of understanding from patients not knowing what was available with a lot of scope for improvement, this was not necessarily around the quality of the care. It was found that there were a number of different workstreams that were not talking to each other. The findings will be taken to the EoL Programme Board in November to facility some joint reporting. The Committee offered the following questions and comments: - • Jocelyn Street (JS) felt this to be a really good report adding that the SPA was a brilliant idea. • Lynn Walshaw (LW) commented on the good overview and how the report resonates what was being heard from local communities, they were not bad experiences, but the experiences could be better.	

	• Sean Thornton (ST) highlighted the understanding of the interrelation with the patient experience work and the direction of it. • JMc advised he was currently looking at strategic objectives and trying to integrate more across health and agreed this was something that should be taken forward. • JC pointed out these surveys provide an impressive amount of data but when it comes to ethnicities, people may have different needs depending on their background and they could potentially get lost in the overall picture. SH advised that she had been working with the compassionate communities' workstream, there were also other ways to target but the workstream had received some funding to produce a leaflet and information for people whose English was not their first language. • Helen Dillistone (HD) commented on the good report highlighting that peoples' experiences pre, during and post Covid could be very different and could lead to some interesting feedback. SH emphasised that the report had been done at a specific point in time. The Public Partnerships Committee **SUPPORTED** the report requesting an update following Programme Board.	
PPC/2223/25	**Glossop Services Engagement Approach – Update** ST verbally updated Committee advising regular engagement sessions were still taking place with the Glossop community and were very popular as people wish to know what was happening. A piece of work was undertaken to compare service lines and on using that information differences had been found. The Scrutiny Committee have requested further checks take place to ensure the position is correct. Work is underway with commissioning to get a complete and accurate list of what the services are and then to look at governance and support with a full engagement approach. A commitment had been made not to make any changes in Glossop for 12 months but there is a need now to start looking due to timescales. The Committee offered the following questions and comments: - • JS believed one of the difficulties was getting the information as Glossop's systems did not align to ours and asked if we were now getting the accurate information to be able to make the correct decisions. HD verified that we did now have information to the questions which had not always been clear. • HD also commented that the ICB was one of 10 areas in total were boundaries were changed and at the time it was	

	not considered there would be risks as outlined. It was not just about the Glossop population but also about the Derbyshire population and could be more complicated than thought. It was believed to be an area of risk that we need to be cognitive on. The Public Partnerships Committee **NOTED** the verbal update.	
	FOR DISCUSSION	
PPC/2223/26	**Eating Disorders – Briefing on the procurement Process** Hannah Morton (HM) presented the report to Committee for information only following a previous presentation to Committee in August 2022. With no option to extend the contracts there was a need to go to procurement. HM emphasised the new contract was an opportunity to build upon what we already have in Derby and Derbyshire and ensure that the service specification includes the thoughts and views of previous, current, and future users of the services. People have been offered various ways to get involved including an online survey, a workshop, an online engagement platform, a project contact and as standard, a contact by email and telephone. It was felt information should be made available in as many places as possible as well as talks in schools and with families and carers. Next steps will be to let those know that provided feedback what information was gathered and what was being used. The report will be shared alongside the procurement document as it has influenced and developed a number of the questions within the process. The Committee offered the following questions and comments: - • Tim Peacock (TP) asked around the numbers of people who use the engagement platform, emails and telephones and when will the information be fed back to those that took part as there were some really good ideas, and it would be good for those people to know what influence they have made. HM was unsure of the figures but would check and feed this back. Feedback had been sent to those that had requested a copy. Those that attended focus groups were explained to that their feedback had informed the service specification. **Action: HM send figures to LF for circulation.** • Sue Sunderland (SS) queried whether this type of information could be built into a common part of any report where consultation has been used as it gave an understanding around what would influence the specifications and where we cannot, due to lack of resource, etc, and that could also be fed in.	**HM/LF**

	• JS commented on a really good piece of work and the terrific way of looking at influencing, JS also asked around lay representation during the tendering process. **Action: HM to follow up and provide a reply.** • JC asked around ethnic diversity and how it is being catered for in the process. HM explained in terms of engagement they had linked into the BAME Forum in the County and various links within the City. Although not huge numbers there was a small number in the feedback who commented on cultural differences and information around how some in different communities will hold back and not reach out and do not understand what an eating disorder is but there is not a wealth of responses from diverse backgrounds, but the aim is to reach as many as possible. The Public Partnerships Committee **DISCUSSED** and **NOTED** the report.	**HM**
PPC/2223/27	**Insight Framework** This item was discussed after item PPC/2223/28 on the agenda. The ICB Public Partnerships Committee are recommended to **DISCUSS** the framework as a way forward for more effective and systematic involvement of people and communities in ICS decision making and offer **ASSURANCE** to the author that this framework should be pursued, and next steps agreed, including adequate resourcing. Karen Lloyd (KL) presented explaining that the Place Partnerships Committee wished to have a new and innovative approach to working with people and communities and wished to access those voices that were not normally heard during the engagement process. In the first instance a framework was produced that contained 5 phases, set out below: - 1. Put the voice and lived experience of people and communities at the heart of what we do in Place. 2. Enable local people to take action to promote good health and wellbeing in their place. 3. Promote a culture of listening, learning, and taking action on that voice together. 4. Create a long-term and continuous process, not a one-off conversation. 5. Create an approach that is seen as a 'must have' not a 'nice to have'. Next step is to look for resources to carry out a proof-of-concept project. There are projects out there that already have certain phases in place but are struggling with the sense making process in the middle, so KL believed it would be good to do some work with them.	

	The Committee offered the following questions and comments: - • JS commented there was a difference between patient and lay experience, both very important parts when engaging with the public. This is a good and complex piece of work but would like to see more stress on involving lay or patient representation at every stage of the process. Any one paid for their services has in some way an influence on what they do. • JS would also like to see some emphasis on training for anyone who is being consulted or involved as lay representation. • LW liked the framework approach and thought it to be an excellent report which gave clarity around everyone involved and consistency all the way through, if people conform. LW also asked what mechanisms were in place for those that wished to come forward, some coaching or guidance to get their voices involved. • JMc agreed with the comments made, pointing out that most will go through place and the emphasis on communities is important. The Local Authority and voluntary sector are very helpful, and the Local Authority are better at engaging communities than health so we should learn from them, and the voluntary sector know a lot about people's daily lived experiences. It is how we change the culture in some of the NHS organisations to adopt this approach suggesting it be socialised with the Board for them to take forward. • KL stated that the framework had been developed with a lot of sector input and recognised the culture change required with people having phases 1-3 in place but not listening at phase 4. The cultural change will be a huge part of the proof of concept. There will also be a peer leadership programme for people with lived experience of using services and long-term conditions which is a 3-tier training programme which helps them to become peers. • SS agreed this to be a really good report and an innovative way to make use of the information gathered from people and an actual conversation not a one off. In terms of getting sign up from other partners for some service changes they may have to do some specific consultation but actually there may be insights provided from the wider dialogue to inform any structured or statutory consultation needed and so more meaningful as a consequence. JC asked around thoughts to implement, replies included: - • Michelle Butler (MB) felt it was good there was a process, and the insight can be used to work with the groups to build on.	

	• JC commented that some very senior level robust conversations were required around what this will take and will require consistent leadership and realism around resourcing. • LW asked about the funding, as this will take a huge amount of resourcing to move forward, are we confident it will be funded effectively. KL believed there was not a need for a huge amount of resource as some of this work is already underway, but help was required to move on and was not sure until the proof-of-concept had been completed. • JC felt there needed to be dedicated resource to this. Capacity of the comms team was on the risk register but there was a need to be aware of the whole system. • JMc advised of funding in national pots and the requirement to bring together or we could be working in silos. The Public Partnerships Committee **SUPPORTED** the framework.	
PPC/2223/28	**LD Short Breaks** **This item was discussed prior to Item PPC/2223/27** The Public Partnerships Committee were recommended to **NOTE** the progress made in re-initiating the NHS LD Short Breaks review and **PROVIDE** comment as necessary on the proposed approach. VWS presented the paper, the purpose of the report was to bring the NHS Learning Disabilities (LD) Short Breaks review programme to the attention of Public Partnerships Committee and seek comment on the proposed approach for delivery. A total of 69 users would be affected and although a small amount it was a significant change for these people and for those coming forward for the service. In 2018 there were 5 services but now there are just 3 services and no decisions have yet been made due to being right at the beginning of the process. The Committee provided the following questions and comments: - • SS asked if the Local Authority had now completed the review of their in-house services as this had caused the initial delay, and did it have an impact. VWS answered that the review had been completed and there had been changes which were likely to have an impact as services are oversubscribed. • LW commented on the good piece of work highlighting that although it was low numbers the work being done going forward was also about family members and looking at the impact of losing that service and the impact on the family members and their health and wellbeing.	

	• Chris Mitchell (CM) endorsed everything that had been said and as a carer himself pointed out that services for people with learning disabilities had been getting worse and if this particular suggestion resulted in a deterioration in people's services beyond the kind of nominal amount of support that people are getting already then it was deplorable. • JS advised that a report had been received at an earlier Committee recommending a reduction in the number of places provided and due to Covid and other circumstances it seems that this had been achieved but with the start of the process again will there be the possibility of restoring and creating more facilities for short breaks than we have now. • JC believed the service requires looking at systemically rather than in isolation The Public Partnerships Committee **DISCUSSED** and **NOTED** the report.	
	COMFORT BREAK	
FOR CORPORATE ASSURANCE		
PPC/2223/29	**PPI Assessment Log** The Public Partnerships Committee are asked to take **ASSURANCE** that forms are being completed appropriately and engagement is fair and appropriate for each project. There were 4 projects reviewed and added to the PPI assessments log since the last meeting. Only one had an engagement element, the Asthma Services Review and the interviewing of patients and families was currently in progress. There were no risks directly arising from the content of this report, however, it had been noted that no PPI Assessment Forms were submitted for review during the second half of August or the whole of September. There will be an audit against emerging content on the electronic programme management office system (ePMO) where the forms are included as a gateway document prior to the commencement of any detailed project work. The audit will seek assurance that projects are not progressing without the completion and sign-off of the forms. The Public Partnerships Committee **NOTED** and was **ASSURED** forms were being completed appropriately and process was being followed.	
PPC/2223/30	**Risk Report September 2022** The Public Partnerships Committee are recommended to **DISCUSS** and **APPROVE** the opening risk responsible to the Committee.	

	HD highlighted 2 risks overseen by the Public Partnerships Committee: - **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. **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.* Risk 17 was a new risk added to the register. A further risk around Glossop had been noted and will be added to the risk register. HD advised that at the time of writing the report in September all executives had been looking at budgets and structures, where there might be significant areas of risk or gaps in structures these could be looked at and may be addressed therefore risk 13 and 17 may be further mitigated by those conversations. The Public Partnerships Committee **APPROVED** the risks responsible to the Committee. The Public Partnerships Committee **APPROVED** the addition of Risk 17.	
MINUTES AND MATTERS ARISING		
PPC/2223/31	**Minutes from the meeting held on: 02 August 2022** The Public Partnerships Committee accepted the minutes as an accurate meeting.	
PPC/2223/32	**Action Log from the meeting held on: 02 August 2022** The action log was reviewed and is to be updated for the next meeting.	
CLOSING ITEMS		
PPC/2223/33	**Forward Planner 2022/23** The Forward Planner was **ACCEPTED** by the Committee.	
	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? **YES** • 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? **Not at this time.** • What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? **No recommendations to put forward.** Feedback on today's meeting from members: - LW commented on it being a good meeting, chaired well with ample opportunity for good discussions and will go away thinking that she has a good sense of assurance that topics covered are covered effectively. JS also felt this had been a good meeting, the timeframe worked well, not struggling to fit in any of the discussions but would have been better had someone from social services attended. CM seconded JS's comment, rating what this committee and the NHS are doing but not so much social care and would appreciate an explanation why non-attendance. ST advised the committee had been set up to report into the ICB which may be sending out the wrong signal to the Local Authority, this will be discussed to at the next development session to try to resolve.	
PPC/2223/34	**Any Other Business**	
DATE AND TIME OF NEXT MEETING		
Date: Tuesday 29 November 2022 (Development Session)		
Time: 10:00 – 12:00		
Venue: MS Teams		

MINUTES OF THE ICB QUALITY & PERFORMANCE COMMITTEE HELD ON

27TH OCTOBER 2022 MS TEAMS, AT 09:00AM

Present:		
Dr Buk Dhadda (Chair)	BD	GP and Chair
Kay Fawcett	KF	Non-Exec Director – ICB
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:		
Craig Cook	CC	Chief Data Analyst - DDICB
Pauline Tagg	PT	independent director of quality patient safety and transformation _LLR ICB
Jo Hunter	JH	Director of Quality - DDICB
Jo Pearce (minutes)	JP	EA to Brigid Stacey - ICB
Apologies:		
Robyn Dewis	RD	Director of Public Health – Derby City Council
Zara Jones	ZJ	Exec Director Of Strategy And Planning – DDICB
Simon Stevens	SS	Director of Public Health – Derbyshire County Council
Sheila Newport	SN	Non-Exec Director – DDICB

Item No.	Item	Action
Q&P/2223 /041	**Welcome, Introductions And Apologies**	
Q&P/2223 /042	**Confirmation Of Quoracy** It was noted that the meeting was not quorate as there were no representatives from the Local Authority.	
Q&P/2223 /043	**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 /044 /045	**Integrated Performance Report**
	Ongoing discussion around the development of the Integrated report
	
	CC took the report as read. The report paints a challenging picture across the programmes of care. in terms of the metrics the position is as at the end of September and a more current position has been given where possible. The main points to note are:
	
	• From an urgent care perspective, the key structural issue underpinning poor flow across our hospitals is exit block – with around 200 patients at any one time ready to be discharged but aren't. Excessive long stays (21 day+ or more) are of a particular concern – with two-thirds of patients waiting for discharge to assess support.
	
	• The effect of exit block on the front-end aspects of the urgent and emergency care pathway within the hospital are significant – with the older person who needs to be admitted waiting between 8-14 hours to access a bed and around 36 hours of lost ambulance crew time per day due to handover delays.
	
	• From a general planned care perspective, the month-on-month reduction to the size of the 78+ weeks waiting list that we were seeing during the spring has plateaued through the summer and into the early autumn – with the non-admitted part of this cohort having increased in recent months. The diagnostic position remains in a difficult state – with around 40% of the people waiting for a test having done so for longer than 6 weeks.
	
	• From a cancer perspective, we have seen referral rates return and for some cancer types exceed pre-pandemic levels. However, the long wait (62 day+) position is some way off where we planned to be – although we are seeing a reduction.
	
	• From a mental health perspective, the number of people experiencing psychosis being seen within 2 weeks of referral is delivering to target but there are concerns in relation to:
	
	  • The time it takes for children and young people with an eating disorder to access services.
	
	  • The size of the gap between the observed diagnosis rate for dementia and the expected rate
	
	  • Access to IAPT services is also on a worsening trajectory.	

JH gave an update from a quality and safety perspective and noted the following

Maternity

Workforce pressures have led to risks to the delivery of transformation including Equity & Equality plans, Personalised Care, Tobacco Dependence and Continuity of Carer. It is expected that there will be an improving picture with mitigations in place, by the end of Quarter 2.

Discharges

Significant gap in provision of Pathway 1 in Derbyshire County leading to discharge delays and patients being discharged to private care packages rather than a reablement and recovery offer or being placed into a residential home. No one accessible IT system to support patient flow leading to lack in clarity as to patient outcomes and no consistent approach to 'strength based' conversations.

Pathway 3 – covid outbreaks, staffing issues, home closures/de-registration and provider capacity is resulting in delayed discharges to both Nursing and Residential care homes. Use of residential care because of gap in P1 provision impacts upon capacity for genuine need for P3 residential care.

Critical Services Review

The Critical Services Review was scheduled for October 2022 to be attended by Executive leads of neighbouring trusts (CRH, UHDB, STH, Kings Mill, Stockport, EMAS), ISDN's, ICB Executive leads and NHSE.

Having discussed this situation locally and with NHSE Midlands, a wider discussion is to take place, to include partner organisations affected by flows of patients from within our community. It is proposed that this could then lead to the necessary next steps for consideration across the network of patient services.

KF asked about the pressures affecting people being able to take people back to their own homes or to residential areas. JH confirmed that there are challenges with P1 in particular in North Derbyshire where P1 beds are difficult to access. There are also financial pressures in Derby City and County. Discharges to nursing and residential homes has challenges around staffing. Continued covid outbreaks is resulting in bed closures. Work is taking place between DCHS and CHS to look at supporting discharges out of UHDBFT and CRHFT. CRHFT are looking at length of stay and opportunities around integrating health and social care with the aim of assisting the system, if successful it will roll out in the high peak and dales areas.

Key partners are looking at P1 and how they can unblock delays which forms part of the 100-day challenge. Work has also been done around looking at a single unified tool to work on flow and the IT support associated. UHDBFT have been looking at a strength-based approach to work across medical wards.

Some D2A beds have been spot purchased however there are still the same issues around staffing and covid bed closures. There is also a project to block purchase some extra beds across the system.

JH added that care homes are continuing to close due to financial sustainability which is impacted by the cost-of-living crisis and the providers ability to offer packages that are financially viable.

CC informed the Committee that the system is looking at the possibility of a retention premium to encourage carers to stay in their employment. There is also the opportunity to open beds at Ilkeston community hospital and London road community hospital.

CF felt it would be helpful for the report to be assurance focused and raised a point around the lens of the Committee in terms of quality and safety risks. CF added it would be helpful if there was regional or national guidance around assessing harm and the actions being taken. CF felt the risk to quality and safety should be the dominant feature of the IPR. BD confirmed that discussions are taking place around harm reviews and risk stratification and a more detailed paper will come to this Committee in January 23. CC agreed with the comments raised and noted that the clinical transformation programme and work that is taking place at a program level needs to be incorporated into the IPR.

RW spoke about flow in and out of the acutes and effectiveness, RW raised a question around patients coming back into the system after they had been treated and asked if this was an issue. RW suggested this is an area that could be taken forward. BS referred to the difficulties over the last 6-8 months around not being able to move patients out of hospital in a timely manner. BS informed the Committee that work is taking place on an operational and strategic level between the ICB Chief Executive and the Local Authority around how the system might utilise the £500m which was promised for social care and discharges. BS then referred to outflow being the biggest area of concern and reminded members that it was agreed that part of the role of this Committee would be to undertake deep dives into specific areas to gain assurance. BS suggested a deep dive around outflow come to the next meeting in November. BD agreed with the suggestion.

JS agreed with the suggestion of a deep dive and noted the importance of having an operational and strategic layer included in the deep dive. JS noted her interest in the impact on patients when they are not discharged on the original planned pathway, which is a cost to the system as well as a poor outcome for the patient.

CW then referred to page 14 of the Committee papers and noted the data around length of stay. CW explained how a patient can potentially require moving to a different pathway if they remain in hospital longer than they initially need to. CW noted the 100-day challenge and the ask around reviewing failed discharges as a critical incident. CW then spoke about the Bristol Push model which is being looked at in Derbyshire. Another element which needs recognition is virtual wards which is being rolled out at scale across Derby and

	Derbyshire. JS referenced the Bristol Push model and asked how the system can take a "stop" moment when looking at other models of care. CC responded and informed the Committee of work that is taking place. At Royal Derby Hospitals FT, the frailty assessment team operate at the front door setting however more resource is required in this area and UHDBFT will be investing in the FEAT team this winter. CW then spoke about EMAS for which Derby and Derbyshire ICB hold the contract on behalf of the whole of the East Midland's footprint. On 19th October 22 representatives from all ICS across the footprint met to review their data and performance around ambulance turnaround and to share what systems were doing to improve performance on a local level. A further meeting is taking place and systems have been asked to bring back their top 3-5 interventions that need to be systematically rolled out across the east midlands. MG commented that the issued identified in the IPR have been excellently articulated however the actions that are being taken against the issues and the impact it has on the data is important. KF asked how the system is managing messages to the general public about these significant quality issues so that they can be in control of their choices. BD noted the comments raised by Committee members that assurance needs to be included in the IPR. BD asked that the next IPR is written to reflect these requests. BD stated that he will be having discussions around the inclusion of Primary Care data in the IPR so that the IPR shows an overview of the system.	
Q&P/2223 /046	**Response to the Quality and Safety of Mental Health, Learning Disability and Autism Inpatient Services Letters 30/09/22 and 18/10/2022** This paper is presented to provide the Committee with assurance as to the actions taken within the Derby and Derbyshire system to ensure that this very vulnerable group of patients and service users are receiving the quality of care that they deserve. Letters were received from Claire Murdoch National Director, Mental Health and Simon Harris, Director of New Care Models, East Midlands Collaborative for CAMHS & AED following the airing of a BBC panorama programme which showed patients being abused while in the care of an NHS Trust. Responses are required and JH will be leading on providing a response within the timeframes. At the time of writing this paper neither DCHS or DHCFT have had the opportunity to submit their action plans to their respective quality Committee or Trust Boards, however the paper states that this is planned into the work schedules and the output of the work will be presented back to this committee to provide assurance. The System Quality and Performance Committee are recommended	

	to **DISCUSS** the paper and **AGREE** the level of **assurance** provided against the details of the letter. The Quality and Performance Committee approved the level of assurance provided.	
MINUTES AND MATTERS ARISING		
Q&P/2223 /047	**Minutes from the meeting held on 29th September 2022** The minutes from the meeting held on 29th September 2022 were agreed as a true and accurate record.	
Q&P/2223 /048	**Action Log from the meeting held on 29th September 2022** The action log was reviewed and updated as necessary. BD noted that all actions have been closed. The Committee have agreed to undertake a deep dive into discharge and outflow at the meeting in November.	
CLOSING ITEMS		
Q&P/2223 /049	**Any Other Business** **Kirkup Report** CW informed members of the national publication of the Kirkup report which is the independent investigation into East Kent around their maternity and neonatal services. CW raised at this meeting as there are expectations of the system. One of the expectations is that each Trust Board take the Kirkup Report to their next board meeting for review and action. It is expected to be listed on the ICB Board agenda in November and partner organisations have been asked to list on their board agendas to formally acknowledge. Over the following months work will take place around how the recommendations within the report are built into the work plan for the LMNS for Derby and Derbyshire. **Internal Changes** BS informed the Committee of internal changes within the ICB. As BS has now taken on the Deputy Chief Executive role, portfolios have been reviewed and changes have been made. CW is now the Executive Lead for Maternity Services and Executive Lead for Quality on the EMAS regional contract. **Vice Chair** BD noted this Committee does not currently have a nominated Vice Chair. BD has asked Christine Fearns to take on the role of Vice Chair for the System Quality and Performance Committee. BD asked for Committee members approval. The Committee members approved.	

Q&P/2223 /050	**Forward Planner** RW noted the omission of the Risk Register and BD confirmed the Risk Register will be a standing agenda item going forward. JH is leading on a piece of work to review the Risk Register. A draft of the Risk Register is being presented at the SQG meeting on 1st November and once agreed it will be presented to System Quality and Performance Committee. BS referred to the work that is being done around the strategic risks and BAF. BS has agreed with the governance team that System Quality and Performance Committee will hold responsibility for the BAF risks. CC suggested a paper around the Winter plan is presented to the November meeting.	
	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: 27th November 2022		
Time: 9:00am to 10:30am		
Venue: Florence Nightingale Room, Cardinal Square, DE1 3QT		

MINUTES OF THE ICB QUALITY & PERFORMANCE COMMITTEE HELD ON

24TH NOVEMBER 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
Margaret Gildea	MG	Non-Exec Director – DDICB
Sheila Newton	SN	Non-Exec Director – DDICB
Brigid Stacey	BS	CNO & Deputy Chief Exec - ICB
Chris Weiner	CW	Chief Medical Officer – DDICB
Richard Wright	RW	Non-Exec Director – DDICB
In Attendance:		
Craig Cook	CC	
Jo Hunter	JH	Director of Quality - DDICB
Phil Sugden	PS	
Joanne Goodison	JG	Senior Commissioning Manager
Jo Pearce (minutes)	JP	EA to Brigid Stacey - ICB
Apologies:		
Christine Fearns	CF	Non-Exec Director - UHDBFT
Kay Fawcett	KF	Non-Exec Director – ICB
Jayne Stringfellow	JS	Non-Exec Director – CRHFT
Zara Jones	ZJ	Exec Director Of Strategy And Planning – DDICB
Gemma Poulter	GP	Deputy Director of Public Health – Derbyshire County Council

Item No.	Item	Action
Q&P/2223 /051	**Welcome, Introductions And Apologies**	
Q&P/2223 /052	**Confirmation Of Quoracy** It was noted that the meeting was not quorate as there was no representation from the Local Authority. It was therefore agreed that any decisions would be made virtually outside of this meeting.	
Q&P/2223 /053	**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 /054	**Deep Dive around Discharge and Outflow** JH and JG shared a deep dive presentation around discharge and outflow with the Committee members and noted there will be a further deep dive around the transformation element which will come to the meeting in January 2023. The main focus of todays presentation is in relation to the work around Virtual Wards and the Discharge to Assess (D2A) nursing bed project. The main highlights if the presentation were: • Best practice and principles • System highlight report is submitted to NHSE on a monthly basis. • Trajectory is to have 110 Virtual Wards beds by December 2022. • Actual capacity is 190 and there are currently 84 which is 44%. Majority of these are implemented by DHU. It is expected other providers will commence implementation by end Q3. • Recruitment of staff to the virtual wards has commenced. • CRHFT have recruited ACP to the frailty and cardiology wards. • The digital enabler procurement process is coming to an end. 7 providers submitted bids. • Virtual wards are included in the 22/23 Winter plan. • There is a plan in place around staff recruitment, engagement and campaign. Providers have received a lot of interest around the roles associated with virtual wards. • All providers have access to Foundry, the NHS data platform. SOP development and QEIA process are near completion by providers. • Virtual Wards Programme manager is due to commence in post in January. • Key challenges are around interoperability at UHDBFT as they are looking at using Lorenzo to support virtual wards. • Trajectories for the 10 virtual wards are unlikely to be met due to the challenges listed. • A governance structure was included in the presentation. Questions raised by the committee were: SN asked about the size of the expansion. BS replied to say the expansion is equal to approximately 3 normal size wards however the rigour and governance attached should enable the system to deliver. Recruitment is the biggest issue and there is concern in the system that this will be an attractive role and therefore the HRDs are closely monitoring the recruitment process to ensure this does not result in recruitment gaps elsewhere. MG noted the importance of allowing managers to recruit into areas where they expect to need staff rather	

	than where there are current vacancies. CW noted the importance of the cultural transformation that is required for the delivery of the Virtual Wards beds. A large proportion of the beds are for step down care and the value of the Virtual Wards beds will be around the prevention of people going into hospital by means of delivering secondary and tertiary prevention into the system. BS noted the positive element that 44% of virtual ward beds have already been implemented. SN asked how the outcomes of the Virtual Wards will be assessed. BS responded to say that it will be the improved outcomes for patients. One of the key drivers nationally for Virtual Wards is the prevention of patients being admitted into acute hospitals, getting delayed and decompensating. CC shared a graphic with the Committee which gave context into the 5 types of demand into the acute settings over winter. Highlighting the extent, the Virtual Wards programme is aiming to impact the demand into the acutes through reducing length of stay and admission avoidance. RW noted the IRP states 200 patients are currently delayed in beds so why is the project aiming for 110 Virtual Wards beds. BS confirmed that there are additional elements of the winter plan which will contribute to the 200 beds, including D2A and initiatives around transformation around the discharge process. RW commented on the rising costs of travel and the risk that this may be a limiting factor when staff are considering applying for these jobs. BS confirmed that there has been a 6% uplift to all providers of Domiciliary Care and Care Homes to reflect these increases. RW observed that the Virtual Wards will be assisting the care system and asked if the Local Authorities were engaging in the Virtual Wards and offering any resource. CW commented on the potential of the Virtual Wards programme and the added value could be such that it would be beneficial in the long terms to risk having staff move into these roles and leaving gaps elsewhere. SN commented on the importance of considering the impact that the Virtual Wards will have on Primary Care and that the engagement element with Primary Care is vital. JH then continued to talk to the presentation for the D2A nursing bed element which is for people eligible for a CHC assessment to identify how their care is funded. • The project is seeking to procure 40 nursing home beds with the option to expand to 52. • Daily reporting into an ICB flow coordinator by all providers. • Agreement that the CSU will complete a CHC assessment within 10 working days of admission to the nursing home.	

	• Interim funding period will end after 28 days. • Provision for spot purchasing nursing homes beds – the impact and outcome of the patient will be monitored. • Regular partnership meetings will take place. • The project is in the procurement phase and is hoped to commence in February. • Care provision provided to patients is quality assured. • Use of beds will be monitored and evaluated. • Project has clear lines of accountability and responsibility. • Metrics, reporting template and how data will be collected has been agreed. SN asked if there is thought around looking forward to next winter if the project is successful. JH confirmed that the project will run for 12 months with evaluation at month 6. Any escalations identified prior to the evaluation will be made as required. RW asked how this is going to improve the issue around those 200 patients that are experiencing a delayed discharge from hospital. CC replied to state that although the spot purchase of beds will relieve some of the pressures it will not resolve the fundamental gap. The system has acknowledged that not all of the patients delayed in hospital will be able to be discharged. BS added that although there is not a solution, the system has a robust winter plan which details the risks and mitigations that are being put in place. The system quality leads have assessed the winter plan from a quality and safety perspective and the findings will be presented to this Committee in December. BS went on to say that as a result of implementing this process YTD to end September the total costs avoided is circa £7m. It is anticipated once the structure is in place this amount will increase as well as increasing flow out of the acute beds. MG asked what capacity is required in the long term to ensure this is a permanent solution. JH clarified that these beds are for a specific cohort of people who are eligible for CHC funding and the assessment shows that between 40 and 52 beds are required. CC added that the current view in gaining some stability is to double the amount of P1 bed capacity. The Committee noted the contents of the presentation.	
Q&P/2223 /055	**Integrated Performance Report and Ongoing discussion around the development of the Integrated report** The report was taken as read. CC referred to the performance element of the report and highlighted the following: The amount of time which is being released due to a reduction ambulance delays has increased specifically at Royal Derby Hospital. Royal Derby Hospitals were reporting approx. 43 hrs worth of lost ambulance crew time per week and this has reduced to 12 hrs, which	

	is one of the by-products of the push model that has been employed. The same improvements are not being seen at CRHFT however it is thought they may be using a different model. The 78 week wait position – the admitted part of wait list is slowly reducing the non-admitted long wait position is increasing and the reasons behind this are not fully understood. Once the reasons are understood conversations will take place with providers around reducing the waiting list. CC noted that there are some specialities which are driving the position such as Dermatology. CC noted a final point in relation to the IPR around it not including a view on the clinical transformation programme. CC did however give the Committee assurance on all the actions that are being taken in response to performance issues. JH added the team are looking at how the quality aspect is embedded in each area along with actions. JH then went on to sight the Committee on an issue raised at the Learning Disability Autism and Mental Health Board around the capacity and capability of providers to support people with a LD who have complex and challenging health and social care needs safely in the community. Majority of these people are cared for in the community and have complicated care packages which are very fragile and often break down. The LDA MH Board are working with providers to look at resource that can provide a holistic approach to the care of the individuals. RW asked about the Panorama Manchester Mental Health expose. Initial indications reported there were no problems relating to Derbyshire patients and RW asked if this was still the position. BS responded to say that the ICB have submitted the report to the NHSE regional Team as requested, which shows it is confident with the actions being taken by providers. JH will share the submission with the Committee. SN added that there is a stream of work being carried out by DHCFT around ongoing scrutiny and assurance around this. The Committee noted and approved the contents of the report.	
Q&P/2223 /056	**Winter Plan** CC noted the paper has been presented at the ICB Board. The reason for it coming to this Committee is due to the issues around community capacity. CC highlighted two areas: The issues around ambulance turnaround and the connection with EMAS ability to respond to CAT 2 calls. The recent innovation of the new Push model in the acutes should bring some benefit in terms of reducing handover delays. Cancer long waits – there is a plan to reduce the number of long waits month on month, and it is expected for the numbers to be lower by the end of the winter period.	

	CC then spoke about how the risks are managed in a proactive way and how to build in quality review and surveillance into the infrastructure. BD noted the winter plan feels balanced and realistic and has a recurring theme that can be built on. CC highlighted there is information around the Social Care monies that is expected. There are conditions attached in accessing the monies and a plan on how the monies will be utilised has to be submitted in December. The Committee noted the contents of the report.	
Q&P/2223 /057	**Risk Register** JH updated the Committee on the discussion from the last System Quality Group. The format of the system risk report has been agreed for the high risks within the system. There is Primary Care engagement and there are risks coming through from both local authorities. A position on how the risks can be regularly reviewed to ensure they are up to date has been agreed. It is hoped that a report will come to this Committee in January.	
MINUTES AND MATTERS ARISING		
Q&P/2223 /058	**Minutes from the meeting held on 27th October 2022** The minutes from the meeting held on 27th October 2022 were agreed as a true and accurate record.	
Q&P/2223 /059	**Action Log from the meeting held on 27th October 2022** The action log was reviewed and updated as necessary.	
Q&P/2223 /060	**Any Other Business** **Minutes Of Meeting On 27th October Confidential Session** BD noted there is no confidential session this month and that the minutes of the confidential meeting on 27th October 2022 had been circulated for virtual approval. BD noted the Committee had approved the minutes of the confidential meeting on 27th October 2022. **Meeting Effectiveness And Assurance** MG asked the Committee to reflect on whether the Committee is making a difference on the questions and challenges. SN suggested a review where honest reflections on the effectiveness on the meeting are shared.	

	Sheila Newton leaving the Committee. SN informed the Committee that this will be her last meeting and confirmed that her successor will be Lynn Andrews who was previously DoN at CRHFT.	
CLOSING ITEMS		
Q&P/2223/061	**Forward Planner** There were no additional items added to the forward planner.	
	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: 22nd December 2022		
Time: 9:00am to 10:30am		
Venue: Florence Nightingale Room, Cardinal Square, DE1 3QT		

MINUTES OF NHS DERBY AND DERBYSHIRE ICB BOARD PUBLIC MEETING

Thursday 17th November 2022

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
Helen Dillistone	HD	Executive Director of Corporate Affairs
Margaret Gildea	MG	ICB Non-Executive Member
Keith Griffiths	KG	ICB Executive Director of Finance
Carolyn Green (representing Ifti Majid)	CG	Director of Nursing and Patient Experience Deputy Chief Executive
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
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:		
Chlinder Jandu	CJ	Corporate Administration Manager
Suzanne Pickering	SP	Head of Governance
Fraser Holmes	FH	Interpreter
Sam Waters	SW	Interpreter
Sean Thornton	ST	Deputy Director Communications and Engagement
Apologies:		
Andy Smith	AS	Strategic Director of People Services, Derbyshire County Council (Local Authority Partner Member)
Dr Buk Dhadda	BD	ICB Non-Executive Member / Vice Chair of the ICB Board
Ifti Majid	IM	Chief Executive DHcFT & Provider Collaborative at Scale (NHS Trust & FT Partner Member for Mental Health)

Item No.	Item	Action
	Introductory Items	
ICBP/2223/036	**Welcome and apologies** John MacDonald (JM) welcomed Jim Austin, Chief Information and Transformation Officer to the meeting. JM thanked Ifti Majid (IM) who will be leaving at the end of this month to take up his new post at Nottingham Healthcare. JM thanked IM both personally and on behalf of the Board. The Mental Health Trust is in the process of recruiting a new Chief Executive, interviews are due in December with a start date in the new year. Apologies were noted as above.	
ICBP/2223/037	**Confirmation of quoracy** It was confirmed that the meeting was quorate.	
ICBP/2223/038	**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/ No declarations of interest were noted.	
ICBP/2223/039	**Questions received from members of the public** No questions were received from members of the public.	
	Strategy and Leadership	
ICBP/2223/040	**Chair's Report** JM made the following comments on his report: • with the new government coming into place we have received the announcements of the autumn statement that will set out some important parts of the financial outlook for the NHS; • we are seeing a continued drive nationally on elective recovery on ambulance waits and the financial position as we move towards the end of this year; • in regards to the Operating Framework, the new restrictions on finance and the increase in details	

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	required about elective recovery have been identified. It is important to work in partnership, in collaboration, and support each other and replicate this when talking to regional and national colleagues, and the general public; • the Board held a development session towards the end of October to begin to outline the strategic framework as part of our organisational development. The first version will be brought to Board in December with further work before March. JM aims to bring to the Board a high level overview of how the system is operating and how effective it is. This is important in terms of the Board being able to discharge their responsibilities, particular around the strategy and performance aspects. JM thanked everyone right across the NHS and social care for the huge amount work that has been carried out on planning for winter, for putting in contingency plans in place in the event of a strike, problems with power and energy and delivering on the ground on a day-to-day basis JM did not underestimate the time, effort and resilience that is needed in what is a very difficult time. **The Board NOTED the Chair's report.**	
ICBP/2223/041	**Chief Executive's Report** Chris Clayton (CC) provided an update on the key messages and developments relating to work across NHS Derby and Derbyshire Integrated Care Board (ICB) and the Integrated Care System (ICS). CC covered different sections of the report as follows: • Section One - taken as read; • Section Two - provides information on the work CC carries out on behalf of the ICB. CC will be looking at making the report more bespoke and welcomed feedback; and • Section Three - CC highlighted items that were not mentioned in the report, such as industrial action and how the ICB support the system during this time. CC made the Board aware of the following changes in staff: • Mark Cuban, NHS England will be moving on in the new year to be Chief Executive of Manchester University; • Sarah Jane Marsh, Midlands Chief Executive will be taking over from Dame Pauline Phillip as the Urgent Emergency Care National Director and Lead; • Berenice Groves, Chief Operating Officer will be leaving Chesterfield Royal Hospital in December and will be replaced by Michelle Veitch; and • Jim Austin, Chief Digital and Information Officer is working in an integrated post for the ICB and DCHS.	

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	Comments Richard Wright (RW) raised a question relating to High Street Pharmacists treating thousands more people for minor illnesses, which signifies a real change in the way that people access the NHS and how we can offer community support to people in primary care. CC explained that this was not a new approach. When working in general practice the value of community pharmacies is well understood. Over the past decade the prominence of pharmacies has increased in many ways. **The Board NOTED the Chief Executive's Report**	
ICBP/2223/042	**NHS Derby and Derbyshire Clinical Commissioning Group Annual Report – April 2021 to March 2022** **Link to report:** https://joinedupcarederbyshire.co.uk/publications/annual-reports/ Avi Bhatia (AB) reflected on the past and the intelligence gained working initially with the four Derbyshire Clinical Commissioning Groups (CCG) and then as a single CCG. The introduction of Primary Care Networks (PCNs) helped with the integration of care and joined up care. AB thanked all staff/colleagues working on the ground and the CCG for all their hard work. CC gave his appreciation to AB for remaining on the Board following his previous role as CCG and Governing Body Chair, as this has aided with the continuity of work for the ICB. With regards to the report CC wanted to highlight that whilst this is looking back, it is also in the context of looking forward and stated that although the statutory functions of the CCG have now moved into the ICB, other duties have arisen which the ICB has a definite view on wanting to work differently on. It also sets out the opinion of the work and what the CCG had been engaged in. CC assured the Board that the accounts are fully audited internally and externally, and the audit opinion gave assurance that the report was reviewed by the CCG and the governance and audit committees. **Comments** JM thanked AB and CC and stated that this has provided a good basis for moving forward and is very much a part of shaping the system. **The Board NOTED and APPROVED the NHS Derby and Derbyshire Clinical Commissioning Group Annual Report – April 2021 to March 2022.**	

Item No.	Item	Action
	Items for Decision	
ICBP/2223/043	**Confirmation of the Chairing Arrangements for the Commissioning for Individuals (CFI) Panel** Brigid Stacey (BS) presented the paper and set out the background. Back in 2019 BS's team undertook a review of the CCG funding decision pathways around ensuring the CCG had the appropriate governance in place for the commissioning, funding and review of packages for individuals for which the CCG had statutory responsibility for. As a result of that review, the 'commissioning for individuals panel' was established which looked at high risk, high cost and complex patients' individual packages. This was a weekly panel which was chaired by one of the CCG Lay Members to ensure requests were fair and transparent and the decisions made were based on best evidence and commissioning principles. In 2021/22 the panel considered a total of 459 cases, 256 were high cost, high risk CHC cases and 203 were very complex cases, which were the ones reviewed by the panel. Following the transition to the ICB, a further review was requested on the chairing of the panel. The outcome provided several options which were presented to the Executive Team, who made the recommendation to continue with the established Lay Chairs on the CFI Panel. BS requested approval from the Board on this recommendation. **Comments** CC acknowledged the work that the Lay Members did for the CCG and highlighted the spectrum of commissioning that the ICB does and supported BS's proposal. RW stated this is an example of how we can examine our back-office functions and streamline. **The Board APPROVED the continuation of the Lay Chairs to Chair the Commissioning for Individuals Panel.**	
ICBP/2223/044	**Derby and Derbyshire Integrated Care Partnership Joint Committee Terms of Reference** Helen Dillistone (HD) presented the Joint Committee Terms of Reference for the Integrated Care Partnership (ICP) for formal approval by the Board. The ICP has an important role in that it will work alongside other organisations and members of the voluntary sector, as well as the two Derbyshire Health and Wellbeing Boards. In terms of the primary focus, the committee is there to act in the best interest of the communities across Derby and Derbyshire and across the system.	

Item No.	Item	Action
	The Terms of Reference set out what the function is to establish the ICP, and the additional actions that the ICP will undertake. These terms of reference have already been agreed and approved through Derbyshire County Council and Derby City Council, and has received Cabinet approval from both local authorities. The ICP meeting will be led by the Chairs respectively on a rotating basis of the two health and wellbeing boards and the ICB Chair, JM will act as the Vice Chair. **The Board NOTED and APPROVED Derby and Derbyshire Integrated Care Partnership Joint Committee Terms of Reference.**	
Items for Discussion		
ICBP/2223/045	**ICB Winter Plan: November 2022 – March 2023** Zara Jones (ZJ) confirmed that this paper is presented to the Board for assurance, and to seek the Board's support to deliver the plan. A number of the actions will give some headroom into the 2023/24 financial year and how we manage our operations collectively. ZJ discussed the following: • winter plan – how the ICB is to mitigate some of the risks we expect to experience over the next few weeks and months; • system pressures: ○ our emergency departments and the flow through our hospitals out into the Community; ○ support to people with mental health issues, learning difficulties and thinking about how support is given to people in crisis; and ○ particular challenges in primary care and general practice; • prevention – particularly some of the secondary prevention and initiatives that need to be considered and actioned over winter. There has been some targeted work, for example COPD, on how can we support people in the community, to ensure they say as well as possible at home and do not exacerbate in terms of their conditions. ZJ highlighted the following areas of focus: • Derbyshire is making good progress on the flu and Covid-19 vaccination front; • supporting people in their own homes; • mental health; • urgent response. • online appointments; • transformation work on delayed discharges from hospital; • delayed referral to treatment and surgery times, especially in regards to cancer.	

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	Comments Carolyn Green (CG) commented on the clarity of the papers in terms of what we are doing and the impact, and will take it back to her organisation and partners to make them aware of the outcomes. CG thanked colleagues for the work that has been carried out. Tracy Allen (TA) commented that we need to be keep a focus on the very high levels of risk that remain whilst recognising this is a much more comprehensive integrated winter plan than our systems ever managed to produce before. It does not completely mitigate the risks, but it is a significant step forward. CC stated to the Board to recognise this is the winter plan. This is what is we are going to deliver and is an important position statement for the next six months and by agreeing to it we are setting what we will endeavour to achieve and the support for it is very much appreciated. **The Board DISCUSSED the ICB Winter Plan: November 2022 – March 2023.**	
ICBP/2223/046	**Summary of the Independent Investigation into East Kent Maternity and Neonatal Services (The Kirkup Report, October 2022)** Chris Weiner (CW) presented the national report stating that it is saddening and one which should challenge the way we think about our maternity and neonatal services going forward. I should drive improvement in the way we operate these services across the entire country. The key findings of the report were: • the services lack compassion and kindness to service users; • a multitude of opportunities were missed to deliver high quality services that were safe for their local community. The report will be picked up in November through the Local Maternity Neonatal System Board (LMNS), who will work with partners and overall organisations delivering our maternity services across Derby and Derbyshire to ensure there is a key focus on: • gaining assurance that safety and performance is being monitored across Derbyshire; • good standards of clinical behaviours; • effective teamworking; • good organisational behaviours to help drive quality services going forward;	

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	It was noted that the national report is also being presented across the Derby and Derbyshire system this month in other Boards, as an initial opening briefing document. **Comments** BS informed the Board that hopefully in the spring of next year there will be a national agreement. The Board noted that BS has reported previously on Ockendon 1 and Ockenden 2 with seven recommendations and further recommendations following the Kirkup report. The national team will bring the three reports together and this will be a maternity transformation assurance piece which we will work to as a system. BS confirmed that there is an audit trail of all the outstanding actions from each of the maternity reviews and they will be incorporated into the national and local framework. CW also provided reassurance that outstanding actions will be picked up through the LMNS Board. CW informed the Board that the individual organisations do have responsibility and accountability for the quality of services that they deliver. CG commented on the four key areas of focus above are applicable to all service areas, and queried whether the Clinical Professional Reference Group will look at how they can be applied to all. CG also mentioned that a lot of the papers discussed today talk about receiving feedback but do not indicate how this feedback is responded to. CG asked whether a 'you said' 'we did' mechanism could be looked into in some of those areas. BS responded that in terms of the assurance for the Board, all these reports have been presented to System Quality Group where they are considered by the Executive and then reported to the System Quality and Performance Committee for assurance. CW commented that CG is correct and there is a need to ensure the triangulation of information to help us drive real quality improvement from our communities and in our services. **The Board NOTED the Summary of the Independent Investigation into East Kent Maternity and Neonatal Services (The Kirkup Report, October 2022).**	
Corporate Assurance		
ICB/2223/047	**Month 6 System Financial Position Review** Keith Griffiths (KG) presented the financial position of the ICS for the period ending 30 September 2022, and reminded the Board that when the financial plan was set at the beginning of 2022/23 there was a 3% efficiency ask that every organisation	

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	committed to. Assuming this was delivered, there was still a residual £65m gap to achieve financial breakeven for 2022/23. KG reported that at the end of month 5 the £65m gap reduced to £55m, and has reduced further to £39.8m during month 6. The month 7 position has improved by a further £4m, and the commitment to achieve breakeven remains. Boards across Derbyshire have committed to delivering the breakeven target and also a surplus, whilst acknowledging the fact that there are significant underlying issues in a few of our providers. KG emphasised the connection to the national priorities and immense challenge in driving financial efficiency and transforming care when the system is under significant pressure, both culturally and from a leadership perspective. **Comments** RW commented on the five year plan and that ensuring we are in the right position this year to enter those five years is just as important as how we achieve this year. JM thanked colleagues for all the work that is being done and reiterated the messages he has heard not only from the Board but also from the Financial Non-Executives in the Trusts, as they feel there is some really good collaboration work developing. **The Board NOTED the Month 6 System Financial Position Review.**	
ICB/2223/048	**Audit and Governance Committee Assurance Report – July to October** Sue Sunderland (SS) summarised the report as follows: • a vast amount of policies were reviewed and approved to ensure the ICB has policies in place as a new organisation; • assurance on control in a number of areas was received, and the committee were happy that the general controls and governance are working well. Risk management is an area seen as a work in progress, and work is underway with Executives to move this forward; and • an opportunity was identified to review the use of estates, particularly given the hybrid working position. **Comments** JM thanked the Chairs of all ICB corporate committees and stated that they are the engine room of the Board. The volume of work which is going through these committees should not be underestimated and the transition from the CCG to the ICB has involved a huge amount of work.	

Item No.	Item	Action
	The Board NOTED the Audit and Governance Committee Assurance Report – July to October.	
ICB/2223/049	**Derbyshire Public Partnership Committee Assurance Report – August and October** Julian Corner (JC) reported that the committee continues to deliver positive work on scrutinising public engagement in new initiatives and service changes, whilst balancing and utilising the experience of long standing and highly experienced members. The committee are currently developing their role to look at wider duties and responsibilities under the ICB through: • engagement governance –building on best practice across the whole system and ensuring there is a clearer understanding of how public engagement is improved throughout the ICP's work; • coproduction – ensuring community insight to improve services and the insight framework that is currently being researched and developed is utilised. Taking on board the new context of the ICB, many of the things the committee focuses on overlap with social care, therefore the committee need to look at how the public is integrated with the ICB, local authority public engagement work and querying whether the committee should have a stronger relationship with the ICP. **The Board NOTED the Derbyshire Public Partnership Committee Assurance Report – August and October.**	
ICB/2223/050	**People and Culture Committee Assurance Report – June** Margaret Gildea (MG) highlighted the importance of the workforce and that one of the risks is not having enough people in all the right places because of a combination of: • retention issues; • people moving out of the NHS and the local authority sectors into private sector; • people retiring completely; or • difficulty in recruiting into some key roles. MG reported that Amanda Rawlings (AR) has established a group for Chief People Officers of the Trusts with local authority involvement. A program has been developed which includes seven work streams to develop one system workforce which will focus on: 1. workforce intelligence and planning; 2. resourcing and recruitment and retention; 3. workforce development and transformation;	

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	4. digital and data information; 5. leadership, management; 6. development and talent management; 7. equality, diversity and inclusion and health and wellbeing. The five top priorities of the group are: 1. a collaborative recruitment and resourcing hub – ensuring energy and efficiency is not wasted through replication; 2. a JUCD induction program with local organisations; 3. system-wide mandatory training – a training passport so staff do not have to repeat mandatory training if they move between organisations; 4. aligning the way we address people issues across all our areas within the NHS; and 5. becoming more effective at moving people across the system so that we can move people to where they can be most valuably used. Following a meeting in September it could be seen that some progress was being made. It is a big challenge, and it is reassuring to see that all the organisations, both in local authorities and in the various other organisations from the NHS, are working together to try and address the challenges. **The Board NOTED the People and Culture Committee Assurance Report – June.**	
ICB/2223/051	**Quality and Performance Committee Assurance Report – July to October** BS presented the paper on behalf of Dr Buk Dhadda, and highlighted the following: • the Quality & Performance Committee Terms of Reference were approved; • BS discussed the Panorama programmes, which many colleagues will have seen regarding the treatment of patients and individuals in some institutions. The national team wrote to all ICSs asking for assurance on the quality and safety of mental health, learning disabilities, and autism inpatient services. A response was presented to the System Quality Group, and the system Quality and Performance Committee for assurance. The committee was assured of the actions being taken. • Christine Ferns, Non-Executive Director at UHDB and UHDB Quality & Performance Committee Chair has agreed to be Vice Chair of the System Quality & Performance Committee; • internal changes to the Executive portfolio – BS will be undertaking the Deputy Chief Executive role and CW will take on the Executive Lead for Maternity Services	

Item No.	Item	Action
	and Executive Lead for Quality on the EMAS regional contract. **Comments** JM noted that this is another good example of cross system working with Christine Ferns taking up the role of Vice Chair. **The Board NOTED the paper Quality and Performance Committee Assurance Report – July to October.**	
ICB/2223/052	**Population Health and Strategic Commissioning Committee Assurance Report – July to November** JC reported that the committee is in the process of developing a delegation of responsibilities to the Mental Health System Delivery Board, to allow for delegated decision making in regards to budgets and is in line with the delegation to the Primary Care Sub-Committee. This will enable the committee to focus on more strategic matters. JC also reported that the committee has been reviewing health inequalities and the clinical governance model; considering how to track health inequality impact across all areas and what information is required on health inequalities to assess whether all of the individual commissioning decisions that are made across the system ultimately create step change in health inequalities for the population. The clinical governance model that AB and colleagues have developed will allow a more streamlined process of clinical input and scrutiny in the run up to commissioning decisions being made. **Comments** AB confirmed that the Clinical Pathway Model will be brought to the Board for information. HD will add this to the Committee's forward planner. **The Board NOTED the Population Health and Strategic Commissioning Committee Assurance Report – July to November and AGREED the RATIFICATION of decisions made by the Committee.**	**HD**

Item No.	Item	Action
ICB/2223/053	**Draft Strategic Risks and update on Board Assurance Framework progress** HD presented the paper for assurance on the proves of the BAF's development, and also requested approval of the ICB Strategic Risks to enable the development of the full Board Assurance Framework (BAF). HD took the report as read and highlighted that the ICB's risk management arrangements consist of two key elements: strategic risk management; and operational risk management. Development workshops have been undertaken with corporate committees from the end of the summer into early autumn to discuss the strategic risks and recognise the complex risks facing the ICB which have arisen from working in a complex system. The paper set out the nine strategic risks and how these are assigned to and discussed at each corporate committee – recognising that each ICB committee will have oversight of the strategic risks but will need to seek and gain assurance that mitigations and controls are in place from some of the system partners. **Comments** RW thanked HD for the finance risk D on sustainability which emphasised how we best spend our £2.9b. It is a big cultural shift for the ICB and focus is needed on how this money is sufficiently utilised for the people of Derbyshire. CC fully supported the paper and noted that risks E and F in regards to workforce are different but still similar, and wondered if they could be aligned. SS commented that the ICB has moved on a long way from where we started at the beginning of the ICB and is supportive of the direction of travel. SS suggested looking at how as a system we take ownership of the BAF and come up with the mitigations and controls to ensure that it is not just seen as something that the ICB is responsible for, but that as a system working together we have got more chance of mitigating these risks, particularly around the workforce and those areas that are causing huge problems in terms of our operational delivery. JM thanked SS for overseeing the BAF as the Chair of Audit and Governance Committee. **The Board NOTED and APPROVED the paper Draft Strategic Risks and update on Board Assurance Framework progress.**	

Item No.	Item	Action
ICB/2223/054	**ICB Corporate Risk Register Report – October 2022** HD took the paper as read and highlighted that the paper sets out the ICB's corporate risk register which details 18 corporate risks that the ICB manages. The Board are requested to approve the closure of four risks, risks 4, 8, 12 and 14, which have all been discussed and closure recommended by the committees. **The Board NOTED and APPROVED the risk closures of risks 4,8, 12 and 14.**	
The following items are for information only and will not be individually presented		
ICB/2223/055	**Health and Wellbeing Board Minutes** • Derby City – 8.9.2022 • Derbyshire County – 7.7.2022 **The Board NOTED the Health & Wellbeing Board Minutes.**	
ICB/2223/056	**Ratified Minutes of CCG Meetings:** • Derbyshire Engagement Committee – 21.6.2022 • Governance Committee – 23.6.2022 • Primary Care Commissioning Committee –22.6.2022 • Quality & Performance Committee – 30.6.2022 **The Board NOTED the ratified minutes of CCG meetings.**	
ICB/2223/057	**Ratified minutes of ICB Committee Meetings:** • Audit and Governance Committee – 19.7.2022/25.8.2022/13.9.2022 • Public Partnership Committee – 2.8.2022 • People and Culture Committee – 17.6.2022 • Quality and Performance Committee – 28.7.2022/25.8.2022/29.9.2022 **The Board NOTED the ratified minutes of ICB Committee meetings.**	
Minutes and Matters Arising		
ICB/2223/058	**Minutes from the meeting held on 21 July 2022** **The Board AGREED the minutes from the previous meeting as a true and accurate record.**	
ICB/2223/059	**Action Log from the meeting held on 21 July 2022** No actions noted.	

Item No.	Item	Action
	Closing Items	
ICB/2223/060	**Forward Planner** Nothing further was noted on the forward planner.	
ICB/2223/061	**Any Other Business** No further items were discussed.	
	Date and Time of Next Meeting	
Date:	**Thursday, 19 January 2023**	
Time:	**9am to 10.45am**	
Venue:	**via MST**	

ICB BOARD ACTION LOG 2022-23

Item No.	Item Title	Lead	Action Required	Action Implemented	Due Date
21.7.2022 ICBP/2223/024	Joined Up Care Derbyshire ICS Green Plan	Helen Dillistone (HD)	HD agreed to bring back progress updates on the Green Plan to the Board bi-annually.	Added to the Forward Plan	January 2023
17.11.2022 ICBP/2223/052	Population Health and Strategic Commissioning Committee Assurance Report – July to November	Avi Bhatia (AB) Helen Dillistone (HD)	AB confirmed that the Clinical Pathway Model will be brought to the Board for information. HD will add this to the Committee's forward planner.	Added to the Forward Plan	January 2023

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								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