Meeting of the Board of NHS Norfolk and Waveney Integrated Care Board (ICB)

Tue 28 March 2023, 12:00 - 16:00

Agenda

12:00 - 12:00
0 min

Meeting Agenda

00. 2023.03.28 NW ICB Public Meeting Agenda.pdf (3 pages)

12:00 - 12:00
0 min

1. Welcome and introductions - Apologies for absence

Chair

12:00 - 12:00
0 min

2. Minutes from previous meeting and matters arising

Chair

02. DRAFT NW ICB Board Part 1 Minutes 24012023.pdf (7 pages)

12:00 - 12:00
0 min

3. Declarations of interest

03. ICB Board Register of Interests - March 23.pdf (4 pages)

12:00 - 12:00
0 min

4. Chair's Action Log

Chair

12:00 - 12:00
0 min

5. Action log – things we have said we will do

Chair

05. ICB Board Action Log March 2023.pdf (1 pages)

12:00 - 12:00
0 min

6. Chair and Chief Executive's Report

06. 2023-03-28 - Chair and Chief Executive's ICB Board report - Final.pdf (4 pages)

12:00 - 12:00
0 min

Learning from people, staff, and communities

12:00 - 12:00
0 min

7. Learning from people, staff, and communities

Patricia D'Orsi

To hear from people, staff and communities in Norfolk and Waveney with lived experience of mental ill health about the support they've received from Wellbeing Hubs, and how this helped them manage their mental health and live well in the community. To discuss and learn. This item will be a video presentation.

12:00 - 12:00
0 min

Items for Sharing and Board Consideration

12:00 - 12:00
0 min

8. Quality Strategy approval

Patricia D'Orsi

- 08. 2023 03 28 Quality Strategy Frontsheet for Board v1.0 (1).pdf (2 pages)
- 08.1 2023 03 17 NW ICS Quality Strategy FINAL DRAFT v0.20.pdf (22 pages)

12:00 - 12:00
0 min

9. Mental Health Collaborative approval

Jocelyn Pike

- 09. Mental Health System Collaboratives ICB Board Mar 23 v2.pdf (6 pages)
- 09.1 CYP Mental Health Collaborative Paper v10.pdf (9 pages)

12:00 - 12:00
0 min

10. Maternity overview and updates

Patricia D'Orsi

- 10. ICB Public Board LMNS March 23 Final.pdf (5 pages)

12:00 - 12:00
0 min

Finance and Corporate Affairs

12:00 - 12:00
0 min

11. Financial Report for Month 11

Steven Course

- 11. ICB Finance Report - Month 11 - Board.pdf (9 pages)

12:00 - 12:00
0 min

12. Update Governance Handbook (TOR changes)

Karen Barker

- 12. Governance Handbook refresh March 2023.pdf (4 pages)
- 12.1 DRAFT GovHand-v1.4-14.03.2023 CLEAN.pdf (236 pages)

12:00 - 12:00
0 min

13. Board Assurance Framework

Karen Barker

- 13. BAF Paper for ICB Board Part 1- March 23.pdf (3 pages)
- 13. ICB Board Assurance Framework (BAF) LIVE V4 2.pdf (49 pages)

12:00 - 12:00
0 min

Committees Update and Questions from the public

12:00 - 12:00
0 min

14. Report from the Quality and Safety Committee

Aliona Derrett

14. 2023 03 28 - Quality and Safety Committee Report to Board v2.0.pdf (7 pages)

14.1.

12:00 - 12:00
0 min

15. Report from the Finance Committee

Hein van den Wildenberg

15. 2023.03.28 - Fin Com Chair Report to Board DRAFT (HW).pdf (4 pages)

12:00 - 12:00
0 min

16. Report from the Primary Care Commissioning Committee

James Bullion

16. 23-03-20 PCCC for ICB Board.pdf (3 pages)

12:00 - 12:00
0 min

17. Report from the Performance Committee

hilary byrne

17. Performance Committee Report to Board - March 2023.pdf (3 pages)

12:00 - 12:00
0 min

18. Report from Patients and Communities Committee

Aliona Derrett

The initial Committee meeting has taken place and the Board will receive update reports from meetings moving forward.

12:00 - 12:00
0 min

19. Report from the Audit and Risk Committee

David Holt

19. 20223.02.09-ARC Report to Board.pdf (5 pages)

12:00 - 12:00
0 min

20. Report from the Conflicts of Interest Committee

David Holt

20. 2023.03.28 - COI Committee Report to Board.pdf (3 pages)

12:00 - 12:00
0 min

21. Questions from the Public. Where question in advance relates to items

Chair

12:00 - 12:00
0 min

22. Any other business

Chair

NHS
Norfolk and Waveney
Integrated Care Board

Meeting of the Board of NHS Norfolk and Waveney Integrated Care Board (ICB)

Tuesday, 28 March 2023, 2.00pm – 4.00pm

(In Public)

Meeting venue The Assembly Room, King's Lynn Town Hall, Saturday Market Place, King's Lynn, Norfolk PE30 5DQ

Our mission: To help the people of Norfolk and Waveney live longer, healthier and happier lives.

Our goals:

1. **To make sure that people can live as healthy a life as possible.**
2. **To make sure that you only have to tell your story once.**
3. **To make Norfolk and Waveney the best place to work in health and care.**

Chair: Rt Hon. Patricia Hewitt

Item	Time	Agenda Item	Lead
1.	2.00	**Welcome and introductions - Apologies for absence**	Chair
2.		**Minutes from previous meeting and matters arising** To approve the part 1 public minutes of the previous Board meeting.	Chair
3.		**Declarations of interest** To declare any interests that board members may have specific to agenda items that could influence the decisions they make. Declarations made by members of the ICB Board are listed in the ICB's Register of Interests. The Register is available via the ICB's website.	Chair
4.		**Chair's Action Log** To receive an update from the Chair on actions taken since the last meeting. There are no Chairs Action to report at this meeting.	Chair
5.		**Action log – things we have said we will do** To make sure the ICB completes all the actions it agrees are needed.	Chair
6.	2.05	**Chair and Chief Executive's Report** To note an update from the Chair and the Chief Executive of the ICB about the work the ICB has done since the last meeting.	Chair and Tracey Bleakley

Item	Time	Agenda Item	Lead
		Learning from people, staff, and communities	
7.	2.15	To hear from people, staff and communities in Norfolk and Waveney with lived experience of mental ill health about the support they've received from Wellbeing Hubs, and how this helped them manage their mental health and live well in the community. To discuss and learn. This item will be a video presentation.	Tricia D'Orsi
		Items for Sharing and Board Consideration	
8.	2.35	**Quality Strategy approval** To receive a copy of the draft ICS Quality Strategy (2022-2025)	Tricia D'Orsi
9.	2.45	**Mental Health Collaborative approval** To approve the establishment of the adult mental health system and a children and young people's system collaborative.	Jocelyn Pike
10.	3.05	**Maternity overview and updates** To receive an update on the progress of the LMNS Programme • Including East Kent Update	Tricia D'Orsi
		Finance and Corporate Affairs	
11.	3.15	**Financial Report for Month 11** To receive a summary of the financial position as at month 11	Steven Course
12.	3.25	**Review of the Governance Handbook** Including proposed changes to the Governance Handbook for Board approval.	Karen Barker
13.	3.35	**Board Assurance Framework** A review of the risks (things that might go wrong and how we can alleviate them) within the Integrated Care system.	Karen Barker
		Committees Update and Questions from the public	
14.	3.45	**Report from the Quality and Safety Committee**	Aliona Derrett
15.		**Report from the Finance Committee**	Hein Van Den Wildenberg
16.		**Report from the Primary Care Commissioning Committee**	James Bullion
17.		**Report from the Performance Committee**	Dr Hilary Byrne
18.		**Report from Patients and Communities Committee –** The initial Committee meeting has taken place and the Board will receive update reports from meetings moving forward.	Aliona Derrett

Item	Time	Agenda Item	Lead
19.		**Report from the Audit and Risk Committee**	David Holt
20.		**Report from the Conflicts of Interest Committee**	David Holt
21.	3.55	**Questions from the Public.** Where questions in advance relates to items on the agenda.	Chair
22.		**Any other business**	Chair
Date, time and venue of next meeting: **Tuesday, 30 May 2023 Via Microsoft teams**			
Any queries or items for the next agenda please contact: **nwccg.corporateaffairs@nhs.net**			

Some explanations of terms used in this Agenda.

Please see further terms defined on our website www.improvinglivesnw.org.uk

Integrated Care System (ICS) - new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

Integrated Care Board (ICB) - an organisation with responsibility for NHS functions and budgets. Membership of the board includes 'partner' members drawn from local authorities, NHS trusts/foundation trusts and primary care.

Clinical Commissioning Group (CCG) – NHS bodies that will be replaced by ICBs on 1st July 2022.

Integrated Care Partnership (ICP) - a statutory committee bringing together all system partners to produce a health and care strategy. Representatives include voluntary, community and social enterprise (VCSE) organisations and health and care organisations, and representatives from the ICB board.

Health and Wellbeing Partnerships (HWP) - are local place-based partnerships work on addressing the wider determinants of health, reducing health inequalities and aligning NHS and local government services and commissioning.

Lived experience - knowledge gained by people as they live their lives, through direct involvement with everyday events. It is also the impact that social issues can have on people, such as experiences of being ill, accessing care, living with debt etc.

NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the meeting on Tuesday, 24 January 2023

PART 1 – Meeting in public

Board members present:

- Rt Hon. Patricia Hewitt (PH), Chair, NHS Norfolk and Waveney ICB
- Tracey Bleakley (TB), Chief Executive, NHS Norfolk and Waveney ICB
- Steven Course (SCou), Director of Finance, NHS Norfolk and Waveney ICB
- Dr Frankie Swords (FS), Medical Director, NHS Norfolk and Waveney ICB
- Patricia D'Orsi (PD'O), Director of Nursing, NHS Norfolk and Waveney ICB
- Hein Van Den Wildenberg (HvdW), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cathy Armor (CA), Non-Executive Member, NHS Norfolk and Waveney ICB
- David Holt (DH), Non-Executive Member, NHS Norfolk and Waveney ICB
- Aliona Derrett (AD), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cllr Bill Borett (BB), Chair, Norfolk Health and Wellbeing Board, and Chair, Norfolk and Waveney ICP (joined at 2pm)
- Dr Hilary Byrne (HB), Partner Member – NHS Primary Medical Services
- Jonathan Barber (JBa), Partner Member – NHS Trusts (Acutes)
- Stephen Collman (SCol), Partner Member – NHS Trusts (Mental Health and Community Services)
- James Bullion (JBu), Local Authority Partner Member (joined at 1.50pm)
- Sue Cook (SCoo), Local Authority Partner Member
- Emma Ratzer (ER), Voluntary, Community and Social Enterprise Sector Board Member

Participants and observers in attendance:

- Karen Barker (KB), Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB
- Mark Burgis (MB), Patients and Communities Director, NHS Norfolk and Waveney ICB
- Jocelyn Pike (JP), Acting Director of Mental Health Transformation, NHS Norfolk and Waveney ICB
- Andrew Palmer (AP), Director of Performance, Transformation and Strategy, NHS Norfolk and Waveney ICB
- Ema Ojiako (EO), Director of People, NHS Norfolk and Waveney ICB
- Ian Riley (IR), Director of Digital and Data, NHS Norfolk and Waveney ICB
- Judith Sharpe (JS), Deputy Chief Executive, Healthwatch Norfolk

Attending to support the meeting:

- Chris Williams (CW), Senior Support Manager, NHS Norfolk and Waveney ICB (Minutes)
- Professor Sally Hardy (SH), School of Health Sciences, University of East Anglia (for item 9)

1.	**Welcome and introductions - apologies for absence**	
	The Chair welcomed everyone to the meeting. There were no apologies from Board members.	

2.	**Minutes from previous meeting and matters arising**	
	Agreed: The draft minutes from the meeting held on 22 November 2022 were approved as an accurate record of the meeting.	
3.	**Declarations of interest**	
	The Chair noted that declarations of interest are kept up-to-date and are available on the ICS's website.	
4.	**Chair's action log**	
	The Chair explained that there were no actions to report at the meeting.	
5.	**Action log**	
	The report was noted.	
6.	**Chair and Chief Executive's Report**	
	The Chair introduced the item by thanking staff working across health and care system in Norfolk and Waveney. She recognised that the pressures were being felt right across system and that we could only address the challenges we face by working collaboratively. TB highlighted key points from the report and explained that the system would be coming out of critical incident status, noting that the situation is still very challenging, but the hard work of staff was having an impact. She also thanked colleagues for their hard work during the recent industrial action. TD'O detailed the significant amount of work being done to improve discharge and flow through our hospitals. She noted that between 14 December 2022 and 23 January 2023, the number of patients with no criteria to reside had reduced from 655 to 593. To put this into context, TD'O noted that in 2018 there were c300 patients in our hospitals with no criteria to reside. She commented that the recent reduction was pleasing, but that there was still much to do. Questions and comments from Board members: • CA asked how staff morale was after this period. TD'O explained that organisations are providing support to staff and that morale was the best it could be given the scale of the challenges. • DH asked what the extra actions are that the system would be taking over the next 12 months to reduce the risks relating to discharge outlined in the Board Assurance Framework. TB highlighted two pieces of work; a review of community services and a focus on improving the health, wellbeing and care of older people. • AD asked if we can segment GP appointments to understand if the same patients are being seen multiple times for the same issue. MB explained it is easier to segment appointment data in acute settings to identify frequent users, it is harder to do in primary care, but some work is being done to address this.	

	• AD asked whether the additional funding we've been given has to be allocated or spent by the end of March. MB explained that there are a number of pots of funding we've been awarded this year and we are waiting for some further information and to see which will be recurrent. The Chair wished LS the best of luck in her new role, and thanked her for the critical roles she played in forming our Integrated Care System and in leading our response to the pandemic locally. The report was noted.	
	Learning from people, staff and communities	
7.	**Learning from people, staff and communities**	
	The Chair thanked the Corbett family for joining the meeting. PD'O then introduced the item, which focused on the importance of having appropriate support for older people to help them live well in the community. Questions and comments from Board members: • The Chair explained that the learning from this Corbett family's experience had helped inform the next item on the agenda about improving the health, wellbeing and care of older people. • TD'O explained that she had received a note from the Norfolk and Norwich University Hospital outlining the actions they had taken. • JBu noted that the learning from this item extends beyond health, to social care and housing.	
	Items for sharing and Board consideration	
8.	**Transforming care for older people**	
	TB introduced the item by explaining that the health and care system already has a lot of projects aimed at improving the health, wellbeing and care of older people; we want to pull them together and have a focus on older people's care. She commented that we could better manage older people's care in the community, and that people could plan better if they were told more about what to expect as they get older and about the conditions they might develop. Questions and comments from Board members: • FS explained that we have pockets of excellence and that when we get it right, we are exemplary, however there is too much variation. • ER noted that the Voluntary, Community and Social Enterprise (VCSE) Assembly is supporting a piece of work led by Voluntary Norfolk to establish a 'Later life network'. • BB endorsed the need for a different approach and whole heartedly supported the paper.	

	• JBa explained that the three acute hospital trusts are working much more closely together to improve older people's care and reduce variation. **Agreed:** The ICB Board agreed to support: • The ambition of working with our partners to transform and better integrate the heath and care for older people in Norfolk and Waveney. • The principle that resources will need to be re-prioritised in 2023/24 and in the longer term in order to achieve this ambition, acknowledging that this will require collective decisions with our partners about priorities and funding allocations.	
9.	**Anchor Programme**	
	TD'O and SH introduced the item by highlighting key points from the paper. Questions and comments from Board members: • ER asked how voluntary, community and social enterprise sector organisations were or could be involved in the programme. SH said that VCSE colleagues would be welcome to join the programme's advisory board and workstreams. • CA asked about the timeframe for the programme. SH explained that the programme has to show outcomes to funders by 2024. • DH asked how the programme could support disabled people not in work and inactive groups like the over 50s. SH explained that there is a workstream on people with a disability and while there isn't a specific workstream looking at the over 50s, there is a lot of work being done on legacy workers. • BB asked what definition of place the programme is working to. SH commented that we want care to be wrapped around citizens; there will be innovation sites in the West at the Queen Elizabeth Hospital, in central Norfolk at Norfolk Community Health and Care, and in the East at the James Paget University Hospital. **Action: ER and SH to liaise regarding the involvement of colleagues from the voluntary, community and social enterprise sector in the Anchor Programme.** The report was noted.	ER and SH
	Finance and Corporate Affairs	
10.	**Financial Report for Month 8**	
	SCou introduced the item, noting that the forecast outturn position for the ICB for the year remained a break-even position in line with our plan. He explained that the forecast outturn position for the Integrated Care System was also break-even as planned, but that the system has a year-to-date	

	deficit position of £10.0m at month eight, which is adverse to our plan by £7.4m. BB welcomed the paper and noted that the language around financial reports needs to be clear and concise. The report was noted.	
11.	**Board Assurance Framework**	
	KB introduced the item by highlighting key points from the paper. Questions and comments from Board members: • DH endorsed the report and recognised it can be hard to manage and communicate risk. He commented that it would be helpful for the Board to understand where the Executive Management Team considers the system may struggle to achieve what they believe is a tolerable risk in 12 months time, particularly for those risks which would have catastrophic consequences. This would enable the Board to either endorse the organisation having to have a tolerance which is higher than the normal level of risk acceptance, or to say the organisation should reallocate some resources to address the risks. • HvdW noted that most of the risks in the paper were system risks and that this is how it should be. He added that a few of the risks were for just the ICB, including regarding the finances of the organisation; he suggested this should be reframed around achieving the financial plan for the all NHS organisations in the ICS. • DH explained that he had organised a meeting with the chairs of the trusts' audit and risk committees to discuss how they could work together. **Agreed:** The ICB Board received and reviewed the risks presented in the Board Assurance Framework.	
12.	**Emergency Preparedness Reslience and Response ("EPRR") Core Standards**	
	SCou introduced the item by highlighting key points from the report. Questions and comments from Board members: • DH asked if the aim was to be fully compliant or whether substantially compliant was a good target to achieve? SC responded by saying that the ambition is to be fully compliant. It is important to understand where the gaps are and how significant they are. There are gaps, but they don't cause alarm. Being not fully compliant is not necessarily cause for concern, as long as we satisfy ourselves that we have a good level of assurance against the standards.	

	• LS explained that she regards these standards as core basics and that the Board's ambition should be to achieve full compliance. She added that it is good the ICB has put more resource into this area. • TD'O commented that it is essential we have EPRR expertise to guide us and that we may need to consider if we have enough resource and whether our succession planning is sufficient. The report was noted.	
	Committees update and questions from the public	
13.	**Report from the Quality and Safety Committee**	
	The report was noted.	
14.	**Report from the Finance Committee**	
	The report was noted.	
15.	**Report from the Primary Care Commissioning Committee**	
	The report was noted.	
16.	**Report from the Performance Committee**	
	HB noted that the committee had examined performance around urgent and emergency care, 78 week waits for elective care, cancer waiting times and mental health 12 hour breaches. She also noted the following risks and issues impacting on performance: industrial action, issues related to reinforced autoclaved aerated concrete (RAAC) planks at the Queen Elizabeth Hospital, pressures on urgent and emergency care, and waiting list payments.	
17.	**Report from the Audit and Risk Committee**	
	The report was noted.	
18.	**Questions from the public**	
	No questions were received in advance of the meeting. The following questions were asked at the meeting: Question: How is technology being used to improve people's care, including to help get people out of hospital and cared for at home? Answer: The Chair noted that this is an important topic and a response would be provided in writing following the meeting. Question: Can NHS trust and foundation trust governors be invited to the Patients and Communitees Committee? Answer: The Chair agreed to respond in writing following the meeting so that the involvement of governors could be considered.	

	Question: I understand there might be a slight deficit and I wondered how that might impact on providers? Answer: SCou explained that our priority is providing patients with safe, high-quality care within the budget available. He noted that we are looking at a slight deficit in some providers and that we are working with them on financial recovery plans. Our approach will be to work across organisations, as a system, to do address the challenge.	
19.	**Any other business**	
	AD added that the Patients and Communities Committee had met for the first time, it was well attended and a good start for the committee.	
Date, time, and venue of next meeting: **Tuesday, 28 March 2023, 1.30pm – 3.30pm, King's Lynn Town Hall**		
Any queries or items for the next agenda please contact: **nwccg.corporateaffairs@nhs.net**		

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
Patricia Hewitt	Chair, Norfolk and Waveney ICB	FTI Consulting	X			Direct	Senior advisor, FTI Consulting	2015	Present	Since January 2022 I have not undertaken any work on healthcare or life sciences. Will declare at relevant meetings if a risk arises.
		Newnham College Cambridge			X	Direct	Honorary Associate, Newnham College Cambridge	2018	Present	No conflicts have arisen or foreseen
		Oxford India Centre for Sustainable Development			X	Direct	Chair, Oxford India Centre for Sustainable Development	2018	Present	No conflicts have arisen or foreseen
		ORA Choral Ensemble			X	Direct	Chair, trustees, ORA Choral Ensemble	2020	Present	No conflicts have arisen or foreseen
		Age UK Norfolk			X	Direct	Volunteer, Age UK Norfolk	2020	Present	Declaration of interest made in any relevant conversation
Catherine Armor	Non-Executive Member, Norfolk and Waveney ICB	Brundall Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Norwich University of the Arts			X	Direct	Deputy Chair of Council, Norwich University of the Arts	2019	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Evolution Academy Trust			X	Direct	Trustee, Evolution Academy Trust	2022	Present	
		Cambridge University Press		X		Direct	Trustee, Cambridge University Press Pension Schemes	Ongoing		
		East of England Ambulance Service NHS Trust	N/A			Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust	Ongoing		
Jon Barber	Partner Member - Acute, Norfolk and Waveney ICB	James Paget university Hospitals Trust		X		Direct	Director of Strategy & Transformation James Paget university Hospitals Trust	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Broadland St Benedict			X	Direct	Non-executive Director of Broadland St Benedicts – the property development subsidiary of Broadland housing Group	2020	Present	
		Acle GP Partnership			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Tracey Bleakley	Chief Executive Officer, Norfolk and Waveney ICB	Drayton & St Faiths Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
James Bullion	Partner Member - Local Authority (Norfolk), Norfolk and Waveney ICB	Norfolk County Council		X		Direct	Executive Director Adult Social Services, Norfolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.

NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
		Skills for Care		X		Direct	Trustee of Skills for Care	Ongoing		Member prepared to leave any meeting where training and development provision might be likely awarded or recommended to be provided by skills for care
Dr Hilary Byrne	Partner Member - Primary Medical Services	Attleborough Surgeries	X			Direct	GP Partner at Attleborough Surgeries	2001	Present	To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary.
		MPT Healthcare Ltd	X			Direct	Director of MPT Healthcare Ltd	2020	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Norfolk Community Health and Care Trust (NCH&C)				Indirect	Spouse is employee of NCH&C (Improvement Manager)	2021	Present	
		South Norfolk PCN				Indirect	Clinical Director of SNHIP Primary Care Network	2022	Present	
Stephen Collman	Partner Member - Mental Health and Community, Norfolk and Waveney ICB	Norfolk Community Health and Care NHS Trust		X			Chief Executive, Norfolk Community Health and Care NHS Trust	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Sue Cook	Partner Member - Local Authority (Suffolk), Norfolk and Waveney ICB	Suffolk County Council		X		Direct	Executive Director Adult Social Services, Suffolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Steven Course	Director of Finance, Norfolk and Waveney ICB	March Physiotherapy Clinic Limited				Indirect	Wife is a Physiotherapist for March Physiotherapy Clinic Limited	2015	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards March Physiotherapy Clinic Limited
Aliona Derrett	Non-Executive Member, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals NHS FT				Indirect	My son-in-law, Richard Wharton, is a consultant surgeon at NNUHFT	2004	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Hear for Norfolk	X			Direct	I am the Chief Executive of Hear for Norfolk (Norfolk Deaf Association). The charity holds contracts with the N&W ICB.	2010	Present	

NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
		Derrett Consultancy Ltd	X			Direct	I am the Director of Derrett Consultancy Ltd.	2018	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Norfolk and Waveney MIND				Indirect	My husband, Robin Derrett, is the HR Director at Norfolk & Waveney MIND. MIND holds contracts with the N&W ICB	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		MoldovaDAR Ltd	X			Direct	I am Director of MoldovaDAR Ltd	Ongoing		Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
Patricia D'Orsi	Executive Director of Nursing, Norfolk and Waveney ICB	Royal College of Nursing		X		Direct	Member of Royal College of Nursing	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to RCN
David Holt	Non-Executive Member, Norfolk and Waveney ICB	Solebay Health Centre			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Tavistock and Portman NHS Foundation Trust	X			Direct	Senior Independent Director, Tavistock and Portman NHS Foundation Trust	2013	2022	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Tavistock and Portman NHSFT
		Department of Work and Pensions	X			Direct	Non-Executive Board Member, Department for Work and Pensions. Chair of the Audit Committee and Chair of the Health Transformation Programme Board	2019	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Ministry of Defence	X			Direct	Non Executive Director, Audit and Risk Assurance Committee, Ministry of Defence	2022	Present	In the unlikely event that a decision having an impact on either of the declared parties arises, a decision will be made with the relevant chair to assess the risks. Appropriate action will be taken accordingly.
		Newberry Clinic				Indirect	Wife is Consultant Community Paediatrician, Newberry Clinic (Great Yarmouth)	Ongoing		
Emma Ratzer	Partner Member - VCSE	Access Community Trust	X			Direct	I am the Chief Executive Officer of Access Community Trust, an organisation which holds contracts with NWICB	2009	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Community Access Trust

NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
		VCSE Assembly			X	Direct	I am CEO of a voluntary sector organisation operating in NWCCG and Independent Chair of NWVCSE Assembly	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Dr Frankie Swords	Medical Director, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals NHS FT		X		Direct	Honorary Consultant Physician and Endocrinologist at Norfolk and Norwich University Hospitals NHS FT (1 day a week)	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		N/A			X	Direct	Ad-hoc Clinical Advisor of multiple patient charities - Addison Self Help Group - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	
		Long Stratton Medical Partnership			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		British Medical Association		X		Direct	Member of the BMA	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to BMA
		N/A				Indirect	Husband is a counsellor and undertakes voluntary work with 2 VCSE providers in N&W MIND and Emerging Futures	2008	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Ruby Media
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with QEHKL and borough council)	2021	Present	Low risk. If there is an issue it will be raised at the time.

Davey, Heidi
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NORFOLK & WAVENEY ICB Action Log Part 1 - Tuesday 28 March 2023							
No:	**Date of Meeting**	**Description**		**RESP**	**Due Date**	**ACTION / UPDATE**	**Status**
3	22-nov-22	Follow up learning from patient experience	TD'O to bring a report back to the meeting of the ICB Board in January 2023 on learning from the patient experience heard in November.	Tricia D'Orsi	30.05.2023	Item moved to May agenda.	Open
5	22-nov-22	Data Sharing	The ICB Board agreed that the system's Executive Management Team would look at the broader risks around data sharing between partners, identify any barriers since COPI ended, next steps and challenges, and that they would report back to the Board via one of the committees	Ian Riley Stephen Collman	24.01.2023	Ian Riley has met with David Holt to work through the issues and will bring a report around current sharing arrangements (post COPI) in Norfolk & Waveney and work up a new risk around 'partners not sharing data' and report back to the Audit Committee on 11 May 2023.	Propose closure of risk.
6	24-jan-23	Anchor Programme Work	Emma Ratzer and Sally Hardy to liaise regarding the involvement of colleagues from the voluntary, community and social enterprise sector in the Anchor Programme	Emma Ratzer	28.03.2023	ER met with SH on the 17th February and disseminated some information across the Place Networks. ER working with the Assembly around the 14th September event that SH is leading on.	Propose closure of risk.
7	24-jan-23	NHS trust and foundation trust governors re attending meetings of the Patients and Communities Committee	Karen Barker to confirm with Howard Tidman that NHS trust and foundation trust governors can attend meetings of the Patients and Communities Committee	Karen Barker	28.03.2023	The Chair emailed Howard Tidman to confirm that NHS trust and foundation trust governors can attend meetings of the Patients and Communities Committee.	Propose closure of risk.

Norfolk and Waveney
Integrated Care Board

Agenda item: 6

Subject:	**Chair and Chief Executive's report**
Presented by:	**Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Prepared by:	**Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**28 March 2023**

Purpose of paper:

To update members of the Board on the work of the ICB.

Executive Summary:

The report covers the following:

A. System pressures
B. General practice services in Norwich
C. Norfolk and Suffolk NHS Foundation Trust CQC Report
D. The Hewitt Review
E. Visits

Report

A. System pressures

As a result of close collaboration between partner organisations and the hard work of many colleagues, we have reduced the pressure on the health and care system. The

progress is good – we are no longer in a critical incident – and our thanks go to everyone for the work they have done over what has been an incredibly challenging winter. However, services remain under pressure, partly because of the demands on the system, but also because of workforce challenges.

Key actions we have taken over winter include creating additional bed capacity and supporting the timely discharge of people who no longer need to stay in hospital, providing additional support to care homes to avoid unnecessary hospital admissions and redeploying staff and using reservists where help is needed most. In total, we mobilised 528 beds or bed equivalents over winter in order to increase capacity.

A top priority has been improving our discharge arrangements and the flow of patients through our hospitals and back into the community. The additional capacity, coupled with changes to processes, has made a difference. We stabilised the numbers of patients in our hospitals who no-longer needed to be there because they were medically fit enough to leave (in NHS terms patients who have no-criteria to reside). We are now continuing to see a steady decrease in numbers of these patients from the peak in September. It is important that we now build on this, learn from this winter and continue to find new ways to improve discharge and flow.

B. General practice services in Norwich

We want to thank all the people who have taken the time to share their views on the consultation about general practice services in Norwich. We take any changes to services like this very seriously, and understanding the needs, experiences and views of our staff, local people and communities is important to us. Once the consultation is closed on 26 March, it will take some time to analyse and consider the results. This, coupled with the need to mindful of the pre-election period for the upcoming local elections, means that the outcome of the consultation will be shared in May.

C. Norfolk and Suffolk NHS Foundation Trust CQC Report

It was really positive to see the Care Quality Commission (CQC) recognise the hard work and achievements of all staff across Norfolk and Suffolk NHS Foundation Trust (NSFT) in its latest inspection report. As the report says: “The trust has moved at pace to make the necessary changes and significant improvements could be seen at all levels of the trust”.

The new leadership at NSFT has recognised the need to work closely with both the wider Norfolk and Waveney and Suffolk and North East Essex Integrated Care Systems. This has helped strengthen and build upon the excellent work being done across primary care and in the voluntary sector to provide vital support in the community for people who need mental health support.

Despite the improvements so far, there is much more to be done to support mental wellbeing and provide high quality mental health services across Norfolk and Waveney. This is one of the highest priorities for NHS Norfolk and Waveney and we will continue to fully support this journey of improvement, working closely with our

staff, people and communities to ensure people have the high-quality, mental health services they so rightly deserve.

D. The Hewitt Review

It has been a real privilege to lead a high-level review of Integrated Care Systems. I've spoken with many colleagues across the country, shared problems, discussed solutions and drafted a report I hope will be of use to us in Norfolk and Waveney, as well as systems up and down the country. My report will be published at the end of the month and we can discuss it at a future meeting.

E. Visits

We wanted to highlight some the meetings we've attended and visits we've made to interesting local organisations. These have included:

As Chair, in addition to the time I've spent on my review, meetings and visits have included:

- With Tracey, I attended and spoke at the Queen Elizabeth Hospital's Leadership Summit, which focused on bravery, boldness and ambition. It was a great session and an opportunity to explore what leadership means.
- Also with Tracey, I attended the Integrated Care Partnership / Norfolk Health and Wellbeing Board meeting. We had some really good discussions, including about the Better Care Fund and discharge funding, the Director of Public Health's Annual Report and about workforce.
- I gave the keynote speech on national policy at Rewired 2023, a conference that featured pioneering work by local health IT teams and information about new innovations in digital and the use of technology in health services.

As Chief Executive, much of my time has been focused on operational matters, but other meetings and visits have included:

- I took part in joint event organised with colleagues from Suffolk and North East Essex about the essential role of the voluntary, community, faith and social enterprise sector in health and care. It was a really great event co-chaired by Emma Ratzer, Chair of the Norfolk and Waveney ICS VCSE Assembly, and Kirsten Alderson, Chair of the Suffolk and North East Essex ICS VCFSE Assembly.
- With Sam Higginson, Chief Executive of the Norfolk and Norwich University Hospital NHS Foundation Trust, I met with Helpforce, a charity with a mission to accelerate the growth and impact of volunteering in health and care. We discussed being a pilot system for some new work they are doing.
- I met Dr Andrew Llewelyn, a trustee of Heritage House in Wells, which provides day care to disabled and older people. We discussed how the charity could help with enabling patients to leave hospital and continue to receive the care they need at home.
- I also took part in the interviews for the Chief Executive role at the Queen Elizabeth Hospital. I would like to congratulate Alice Webster again on her

appointment; she's been a really positive force since taking on the role on an interim basis and I look forward to continue working with her.

- I attended Healthwatch Norfolk's partner event, which was a good opportunity to hear about some of the work they have been doing over the past year and where they are at as an organisation.
- I also attended the Suffolk Health and Wellbeing Board, in addition to attending the Norfolk board.

Recommendation to the Board:

This agenda item is for information only.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 8

Subject:	Draft ICS Quality Strategy (2022-2025)
Presented by:	Tricia D'Orsi, Executive Director of Nursing
Prepared by:	Evelyn Kelly, Quality Governance & Delivery Manager
Submitted to:	Integrated Care Board
Date:	28 March 2023

Purpose of paper:

To present the Board with a copy of the draft ICS Quality Strategy (2022-2025)

Executive Summary:

The draft ICS Quality Strategy (2022-2025) sets out a strategic direction for how we develop as a system that has a culture of compassionate leadership, with a focus on improving care quality and outcomes and ensuring services are safe and sustainable, for now and for future generations, using insights around health inequalities and population to achieve fair outcomes for the people of Norfolk and Waveney. Quality will support the values of integration, personalisation, and outcomes-based commissioning, to develop local teams, services and communities that promote wellbeing and prevent adverse health outcomes.

Next Steps: Pre-Publication Design and Implementation Plan
With Board approval of the strategy content and direction, the ICB Communications and Engagement Team will lead on pre-Publication design work, to ensure that the document has a strong visual identity, is accessible, and reflective of the people living and working in Norfolk and Waveney. An operational implementation and resource plan will set out governance, progress and success metrics and a rolling schedule of evaluation and continuous engagement. Listening to our public, patients, carers, and staff will be central to the development, delivery and evaluation of the strategy and they will be included in our further developments.

Implementation Timeline

Recommendation to Board:

The Board is asked to:

1. To receive and respond to the content of the draft ICS Quality Strategy (2022-2025) and approve for publication.

2. To receive and support the next steps in relation to pre-publication design and the approach to development of a supporting implementation plan, as detailed above.

3. To consider how the Integrated Care Partnership can support the implementation and monitoring the strategy.

Key Risks	
Clinical and Quality:	The ICS Quality Strategy (2022-2025) supports the collaboration approach to quality across the system.
Finance and Performance:	None
Impact Assessment (environmental and equalities):	None
Reputation:	The ICS Quality Strategy (2022-2025) provides strategic direction for the ICS commitment to quality.
Legal:	None
Information Governance:	None
Resource Required:	The office of the Executive Director of Nursing has led on strategy development and have requested Communication & Engagement Team support with pre-Publication Design.
Reference document(s):	None
NHS Constitution:	The ICS Quality Strategy (2022-2025) provides strategic direction for the ICS commitment to quality.
Conflicts of Interest:	None
Reference to relevant risk on the Board Assurance Framework	None

Improving lives **together**
Norfolk and Waveney Integrated Care System

Norfolk and Waveney Integrated Care System

Quality Strategy 2022-2025

Document Control Sheet

Name of document:	Norfolk and Waveney Integrated Care System Quality Strategy 2022-2025
Version:	Final Draft (v0.20)
Owner:	ICB Executive Director of Nursing
File location / Filename:	*TBC*
Date of this version:	17 March 2023
Produced by:	ICB Quality Governance & Delivery Manager
Synopsis and outcomes of consultation undertaken:	None Undertaken
Synopsis and outcomes of Equality and Diversity Impact Assessment:	None Undertaken
Approved by (Committee):	*Taken to Board for ratification on 28 March 2023*
Date ratified:	*TBC*
Copyholders:	*TBC*
Next review due:	*TBC*
Enquiries to:	ICB Quality Governance & Delivery Manager

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
17/03/23	Final draft taken to Board for ratification on 28 March 2023	TD/KW/EK	v0.20

Approvals

This document requires the following approvals either individual(s), group(s) or board.

Name	Title	Date of Issue	Version Number
N/A	Integrated Care Board		

Contents	Page

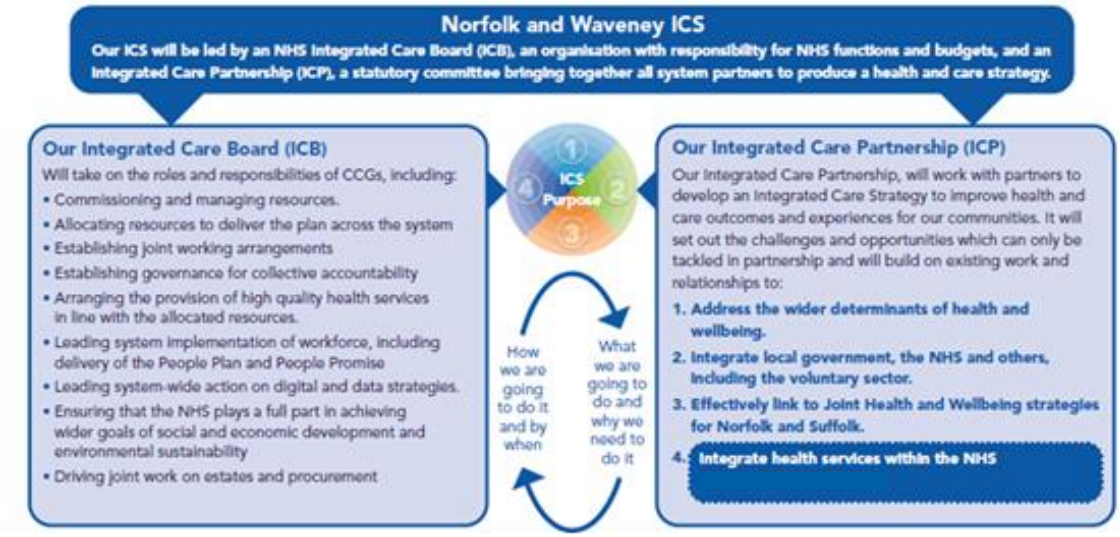
What Should Quality Feel Like?
Throughout this strategy, you will also see sections on how we believe quality touches on the experiences of patients and service users, carers and health and social care staff.

Look out for **Charlie** on page 8, **Nelson** on page 9, the Staff and Service Users at **Canary Care** on page 18, **Ben and his family** on page 20 and **Aaliyah** on page 22…




1.0 Introduction

1.1 Our Integrated Care System (ICS)



The Norfolk and Waveney Integrated Care System (ICS) is made of a wide range of partner organisations, working together, with our local communities, to achieve three main goals for our population:

1 To make sure that people can live as healthy a life as possible.

This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something we must change.

2 To make sure that you only have to tell your story once.

Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.

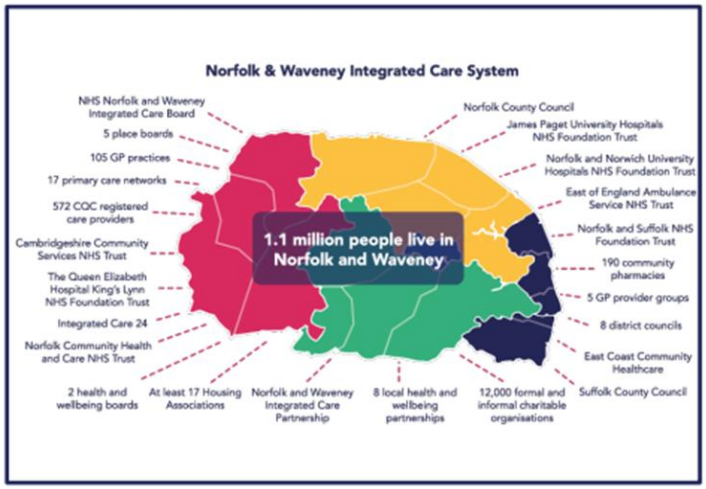
3 To make Norfolk and Waveney the best place to work in health and care.

Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

Like all Integrated Care Systems in England, we will work to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Our system includes:

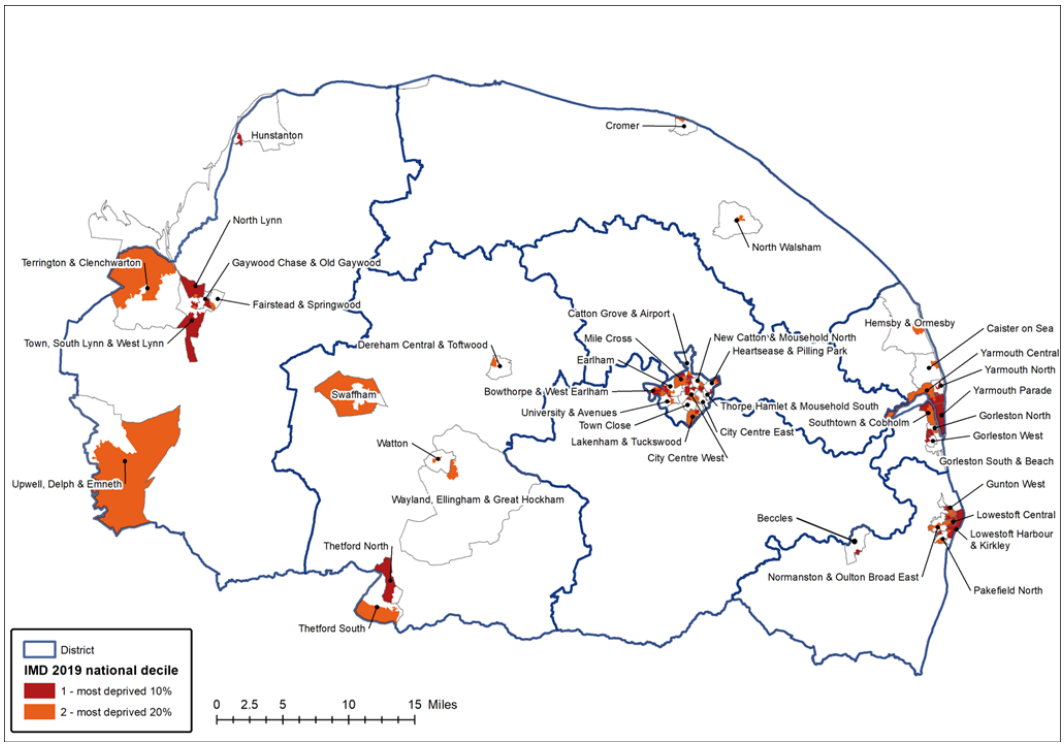


Our communities are rich in different experiences and backgrounds, situated in rural, coastal, and urban geography.

1.2 Population Health and Health Inequalities

The Norfolk and Waveney Public Health Joint Strategic Needs Assessment highlights inequalities present in Norfolk and Waveney and how this is experienced by people, in relation to:

- Healthy life expectancy
- Lifelong health outcomes
- Social, economic, and living conditions
- Healthy lifestyle factors
- Access and quality of health services



There are 42 communities across Norfolk and Waveney where some or all the population live in the 'Core20' of the 20% most deprived areas in England. The largest contributors towards the life expectancy gap between the most and least deprived populations in Norfolk and Waveney are **circulatory**, **cancer**, and **respiratory** diseases.

In addition to social deprivation, there is a strong relationship between service quality, including service user experience and access, and the underlying health needs of our population. This strategy supports key elements of population health medicine, by enabling the delivery of safe, timely and evidence-based care and support, to:

- Impact on demand and need for healthcare and the role of high-quality treatment and support as a prevention for further illness.

- Ensure a healthy standard of living for all, whilst also working to reduce disparities in health outcomes.

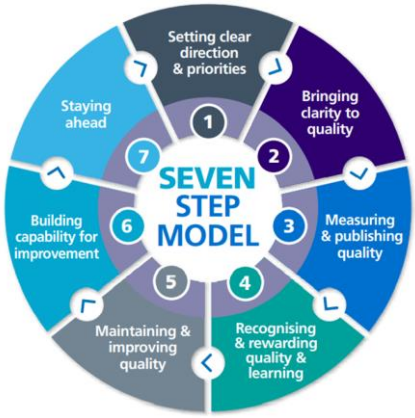
- Look at what improves quality and length of life and influence people's health behaviours, while improving experiences of care and delivering effective public health and primary prevention interventions.

Workforce skills around health coaching and goal setting are a key skillset to help empower service users, to engage with health improvement opportunities and personalise care.

2.0 Strategy Context, Purpose, Values and Priorities

2.1 National Strategy Context

In April 2021 the National Quality Board refreshed its Shared Commitment to Quality, which provides a nationally agreed definition of quality and a vision for how quality can be effectively delivered through Integrated Care Systems. It sets out seven clear steps to achieving a cohesive and collaborative system approach to quality:



The shared commitment uses the following measures to describe what high quality care should look and feel like for patients, carers, and staff; delivered **safely** and **effectively**, with a **positive experience**. It should be **well-led**, **sustainably resourced,** and **equitable** across all communities and populations.

2.2 Norfolk and Waveney Quality Strategy Purpose

The Quality Strategy for Norfolk and Waveney Integrated Care System (ICS) outlines our quality priorities for 2022-25 and makes a commitment to the people of Norfolk and Waveney, to deliver quality, based on what matters most to the people using our services and the insight and expertise of our compassionate, skilful, and innovative workforce. The Strategy is underpinned by continuous development of the Integrated Care Partnership (ICP) and Integrated Care Board (ICB) model for clinical leadership, quality management and assurance, and research and innovation. The delivery of safe, high quality, evidence-based care empowers patients, service users, carers and staff and

must be supported by a quality governance and delivery infrastructure that has influence, impact, and accountability to the people of Norfolk and Waveney.

The Strategy does not replace existing quality assurance and improvement strategies developed by our partners but highlights the importance of quality within our wider system working.

2.3 Norfolk and Waveney Quality Strategy Values

We will always value our people and our communities and keep them central to the focus of our strategy.

We will always treat people with dignity and respect and will encourage compassion and understanding, through our quality improvement work.

We will continue to develop trusted relationships and embrace partnership working, across services, networks, and organisations, including VCFSE and communities.

We will deliver on our strategy commitments and share our progress in a way that is open and transparent, and we will be accountable to patients, carers, and staff.

The ICS Clinical Strategy sets out the following priorities to fully integrate care services and improve population health outcomes, so that people living in Norfolk and Waveney can feel that their NHS sees them as a whole person, is one high quality, reliable and resilient service, works to reduce waiting times, acts early to improve health, and addresses health inequalities. You can find out more about the clinical strategy here.

2.4 Co-Production with Communities

People-centredness is a key part of our quality journey and culture of improvement, acknowledging the value of people's lived experiences as a powerful driver for change. If our co-production work is effective, our people, communities, and ICS partners, will be able to see that:

- People feel listened to and empowered. They can see the difference their views and insight have made.
- The voices of our people and communities are looked for early, when planning, designing, and evaluating services.
- People have shared their story and it has made a difference and been listened to by partners all over the ICS.

We will continue to work closely with all our ICS partners, including Healthwatch, to offer opportunities for a diverse range of voices to be heard and to use patient, carer, and community feedback to improve care.

Case Study: Norfolk and Waveney Carers Identity Passport

Carers, Carers Voice Norfolk and Waveney and health and social care have worked together to co-produce a Carers Identity Passport. It was recognised that Carers need to be respected and valued and an equal partner in the health and care of those they care for. Carers requested a passport so that there is early identification of their caring role by means of a digital card or physical card and lanyard.

From the outset, Carers Voice worked to develop a systemwide project to ensure the Carers Identity Passport is recognised in hospital settings across Norfolk and Waveney and these are distributed by Carers Voice Norfolk and Waveney. To obtain a Carers Identity Passport click here.

What Should Quality Feel Like? Meet Charlie

Charlie, aged 19, has been a family carer for most of her life and a member of Norfolk Young Carers' Forum, supported by the charity Caring Together as part of Norfolk and Waveney ICS. The Forum helps to recognise the lives of young carers and ensure that health, care and education services across Norfolk understand their needs. The Forum has carried out surveys of young carers and ran a conference for people working across the health and care system. Forum members have recorded videos, shared their experiences and reviewed all of the materials which are used in carer-awareness training. Charlie has put a lot into the forum, and got a lot out of it too.

Charlie says: "At first I was surprised they gave a 15-year-old the responsibility of doing the lectures, but I'm used to it now. It's still nerve-wracking but I know exactly what I am doing. I was a shy kid, but when I joined the Forum, I felt a real surge in confidence; it gave me a voice. In the Forum, everyone accepts who you are. Everyone is in a similar boat. They all just get it. I've made a lot of friends that I will be friends with for the rest of my life and pushed me to do what I want to do." Charlie's caring role continues and when she reflects on five years in the Forum, she is positive about the changes that have happened in that time. She remains committed to driving further change for young carers.

Find out more at Working with People & Communities - Norfolk and Waveney ICS (improvinglivesnw.org.uk)

2.5 Our 2022-2025 Quality Priorities

We should all expect to receive timely care and support that is consistently safe, effective, equitable and evidence based.

Our experiences of this should be positive and personalised, empowering us to make informed decisions about our needs and how we access timely care and support, both at home and in care settings and communities, throughout our lives. To achieve this, we commit to delivering a systematic and consistent approach to quality care, delivered in a way that is:

- Well-led through a culture of compassionate leadership.
- Focussed on improving care quality and outcomes.
- Using insights around health inequalities and population health to achieve fair outcomes.
- Ensuring services are safe and sustainable, for now and for future generations.

To achieve this, we will develop the Norfolk and Waveney system's approach to collective quality assurance, embedding a strong culture of collaborative learning and continuous improvement, delivered by confident, empowered, and motivated staff, students and volunteers who have the right tools and skillsets. We will continue to support a 'research-positive' culture in our health and care organisations so that we benefit from having strong evidence behind our treatment and care interventions and encourage and enable opportunities for evaluation and innovation. We will ensure that we examine patient experience and outcome metrics and will enable patients, service users, families, and carers to be involved with quality improvement in a way that is meaningful.

What Should Quality Feel Like? Meet Nelson

Nelson lives in Norfolk & Waveney. He has accessed lots of different health and support services over his lifetime, from childhood right up to now.

For Nelson, quality feels like being able to make informed choices so that he can stay well and do the things in life that he cares about. It means being able to access the right services and tools to help prevent ill-health and manage any emergencies or long term conditions, promptly and safely. It means being able to access the right care and support at the right time, at the right place; at home, in the community or hospital. Wherever care is delivered, Nelson has a right to privacy, dignity and safeguarding from harm. He wants to be involved in planning his care and this relies on open, transparent and clear communication. It means being able to build relationships with the professionals that support him, and only having to explain his story once. It means having a personalised approach which works for Nelson, and support that can step up and down depending on his changing needs and decisions about what matters most to him, his values and beliefs. If something goes wrong, quality means that Nelson can expect an open and honest apology and explanation, and to be involved in learning from what happened, to help prevent it happening again in the future. When services change or develop, quality means that he is kept informed and has an opportunity to contribute his views.

Quality will support the values of integration, personalisation, and outcomes-based commissioning, to develop local teams, services and communities that promote wellbeing and prevent adverse health outcomes, equitably, for all people who live in Norfolk and Waveney.

3.0 Delivery

3.1 Building a Quality Partnership

The National Quality Board Shared Commitment to Quality defines how the partnerships that form Integrated Care Systems need to work in order to deliver high quality care to their local populations, starting with a single understanding of 'quality' which is shared across services, networks and organisations, which allows partners to work together to deliver shared quality improvement priorities and have collective ownership and management of quality challenges and risks.

Quality improvement priorities should be based on a sound understanding of the local population's needs, variation and inequalities and meaningful engagement, with patients, carers, and staff. While ownership of quality within services, networks, and organisations, needs to start internally, the partnership should be able to facilitate quality management at scale when required, to improve safety, health and wellbeing for the local population and share learning and good practice. Clear and transparent accountability and decision-making is essential across services, networks, and organisations; particularly when serious quality concerns are identified.

Our key partners in quality include:

- Provider organisations, professionals, and staff
- People and communities, including service users and carers
- Commissioners and funders
- Voluntary, Community, Faith, and Social Enterprise sector
- CQC, Healthwatch and other regulators
- Education, research, and innovation partners

3.2 Quality System Pillars

The following six pillars set out the core foundation for a system infrastructure that will enable us to deliver our quality priorities over the next three years:

3.3 Data and Evidence

Our commitment to delivering quality is underpinned and driven by good use of evidence and data, which enables us to identify risks and problems early and focus our resources they are needed most. Our main sources of data include, but are not limited to:

3.4 Risk Management

The way we manage system-level quality concerns and risk aligns with the national guidance on Quality Risk Response and Escalation in Integrated Care Systems. Key components include:

- **Effective risk profiling;** timely, triangulated data identifying healthcare concerns and risks, with commonly agreed metrics to measure quality and an active list of quality risks at each level.

- **Rapid quality management response;** sharing of intelligence to 'diagnose' and profile risks to develop actions to address immediate concerns and formulate a plan for longer term change or improvement.

- **Robust, collaborative action and improvement plans;** plan, co-ordinate and facilitate the delivery of mitigating actions, with clear action owners, timescales, and success criteria, and which reflect contractual requirements and regulatory frameworks. Where multiple commissioners are involved, this must join up.

Alongside the management of risk, we also look for opportunities. This means that while identifying and responding to risk, the ICS and its partners also seek out proactive, positive quality improvement opportunities that might otherwise not come to light.

The components described approach are delivered through the development of a 'whole system' approach, including agreed system risk appetite statements, common language and scoring, and risk

frameworks which clearly link to associated accountability and governance frameworks, and which cover quality alongside other risk frameworks (e.g., performance and finance, equality, and sustainability).

3.5 Quality Oversight Forums

Our key oversight and governance forums that support quality surveillance, escalation and improvement include:

The ICB Quality and Safety Committee has accountability for scrutiny and assurance of quality governance and internal control that supports the ICB to effectively deliver its strategic objectives and provide sustainable, high-quality care. It maintains assurance that ICB statutory duties are being met. Ensures that risks are addressed, and improvement plans are having the desired effect. It has delegated authority to approve ICB arrangements and policies to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes including arrangements for discharging the CCG's statutory duty associated with its commissioning functions to act with a view to securing continuous improvements to the quality of services.

The ICS System Quality Group enables routine and systematic sharing of intelligence and insight across the system, to identify ICS quality concerns/risks. It provides a forum to develop actions to enable improvement, mitigate risk and measure impact. Facilitates the testing of new ideas, sharing learning and celebrating best practice.

The ICS Quality Management Approach Hub facilitates a systemwide approach to quality management. Through its Quality Faculty, it brings system partners together to share insight and good practice in quality improvement (QI). Staff from across the ICS can access shared QI training and resources via the Hub to support cross-organisational and system-wide QI. A similar system approach will be taken to sharing quality control best practice. The Hub has led on the development and roll-out of a prioritisation matrix to support the system with quality planning and is supporting co-production of QI programmes across the ICS.

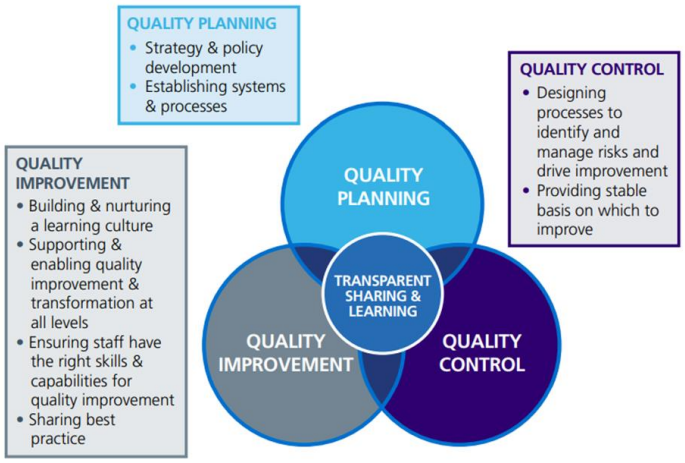
Key relationships with regulatory and monitoring bodies, including CQC and Healthwatch, are also central to the early recognition and response to warning signs and opportunities for improvement. Escalation from these forums go through our NHS System Oversight Framework, NHS England Regional Team, Regional Quality Group and Regulators.

3.6 Quality Management Theory

To deliver good quality outcomes, there are three core quality 'functions' that need to be delivered by systems, described in the **Juran Trilogy**, a quality management approach that is based on international best practice. When delivered effectively, these functions work together in an integrated way to ensure that systems can:

- Identify and monitor early warning signs and quality risks.
- Plan and coordinate transformation locally and at a system level.
- Deliver ongoing improvement of quality experience and outcomes.

These functions of quality management are fundamental to our approach in Norfolk and Waveney and are supported by ongoing collective quality assurance and a culture of learning and continuous improvement. The following diagram from the National Quality Board Shared Commitment to Quality (April 2021) illustrates how this is operationalised through organisational culture, processes, and policy:



[Find out more at Quality Management Approach (QMA) - Norfolk & Waveney Integrated Care System (ICS) (improvinglivesnw.org.uk)]

3.7 Research and Innovation

According to the National Institute for Health and Care Research (NIHR), encouraging a 'research-positive' culture in health and care organisations can lead to better quality outcomes for service users and staff:

J Eval Clin Pract. 2020 Feb;26(1):203-208. doi: 10.1111/jep.13118. Epub 2019 Feb 19.

Patients admitted to more research-active hospitals have more confidence in staff and are better informed about their condition and medication: Results from a retrospective cross-sectional study

Leon Jonker [1], Stacey Jayne Fisher [1], Dave Dagnan [1]

In Norfolk and Waveney, Research and Evaluation Teams work collaboratively across academic networks, health, and social care partnerships and Healthwatch, to deliver the following priorities:

- Research Development
- Research Management and Support
- Public and Patient Involvement
- Evidence and Evaluation

Case Study: Public & Patient Involvement in Research Project: this initiative brings together volunteers and community groups across Norfolk and Suffolk to collaborate with local researchers and health care professions working in research in Primary Care. In 2020-21, PPIRes supported 61 volunteers' involvement in 20 NIHR grant applications and developed and delivered training for volunteers supporting funded research studies.

An exciting priority for the year ahead is the co-production of a system Research, Evaluation, and Innovation Strategy, broadening opportunities for staff and communities in Norfolk and Waveney to participate in and benefit from, evidence-based, innovative care and support.

4.0 Focus Areas

4.1 Primary Care and Place

Primary Care includes a range of community-based services that are often people's first and main point of contact with healthcare, delivering preventative health care, education, advice, and treatment. These services are constantly evolving, and developments need to be made to offer patients with diverse needs a wider choice of accessible, high quality, personalised primary healthcare. This will be a priority for the system and includes:

- General Practice
- Dentistry
- Pharmacy
- Optometry (eye care)

Place-Based Partnerships

Working as a 'place' brings together the NHS, local councils and voluntary organisations, residents, people who access services, carers, and families, to design and deliver integrated services in their local area. The Norfolk and Waveney system benefits from a number of community 'champion' roles and VCFSE support, which helps to coordinate conversations about pathway transformation within local communities and signpost people to the right services.

In Norfolk and Waveney, the five ‘places’ (Norwich, South Norfolk, North Norfolk, West Norfolk and Great Yarmouth & Waveney) have collectively set the following system priorities for improving people’s experiences of care:

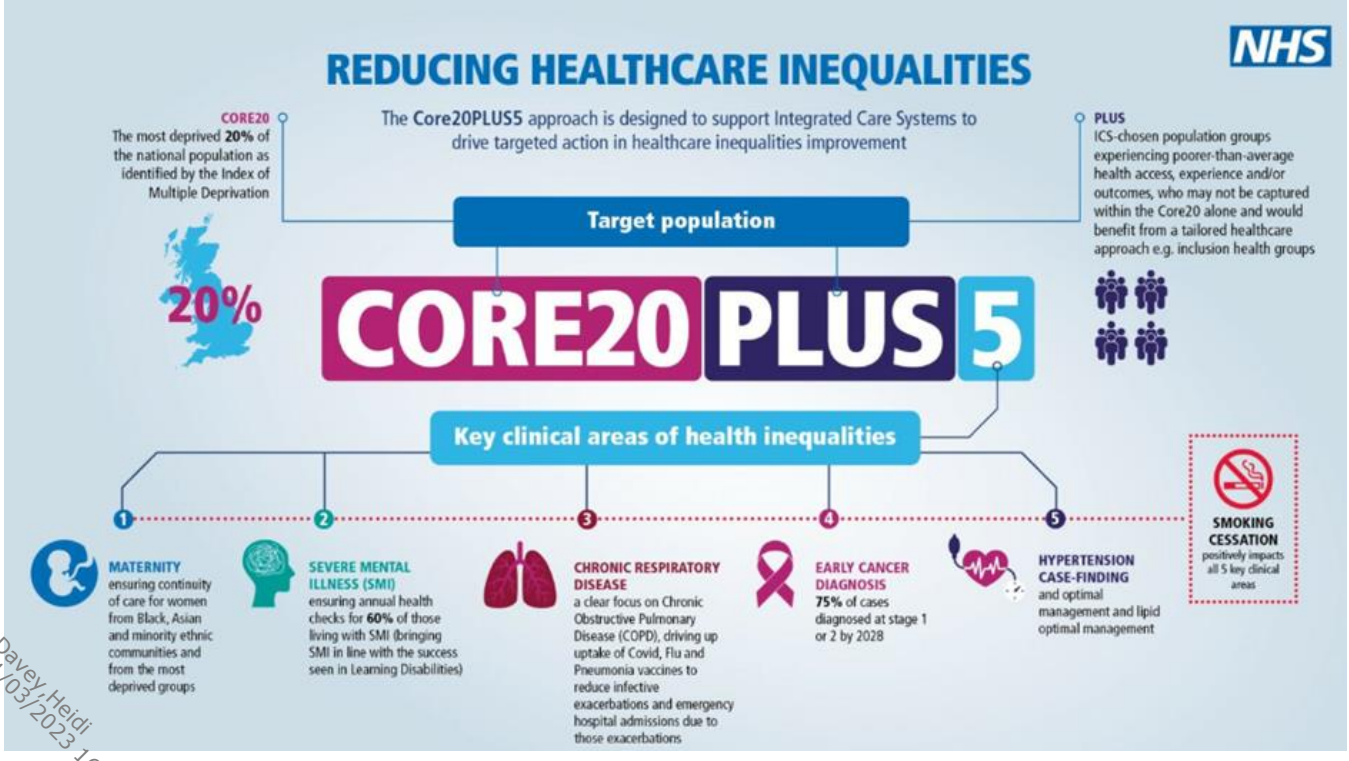
Long Term Condition Management	Personalisation	General Practice Resilience	Urgent & Emergency Service Pressures

4.2 Prevention and Health Inequalities

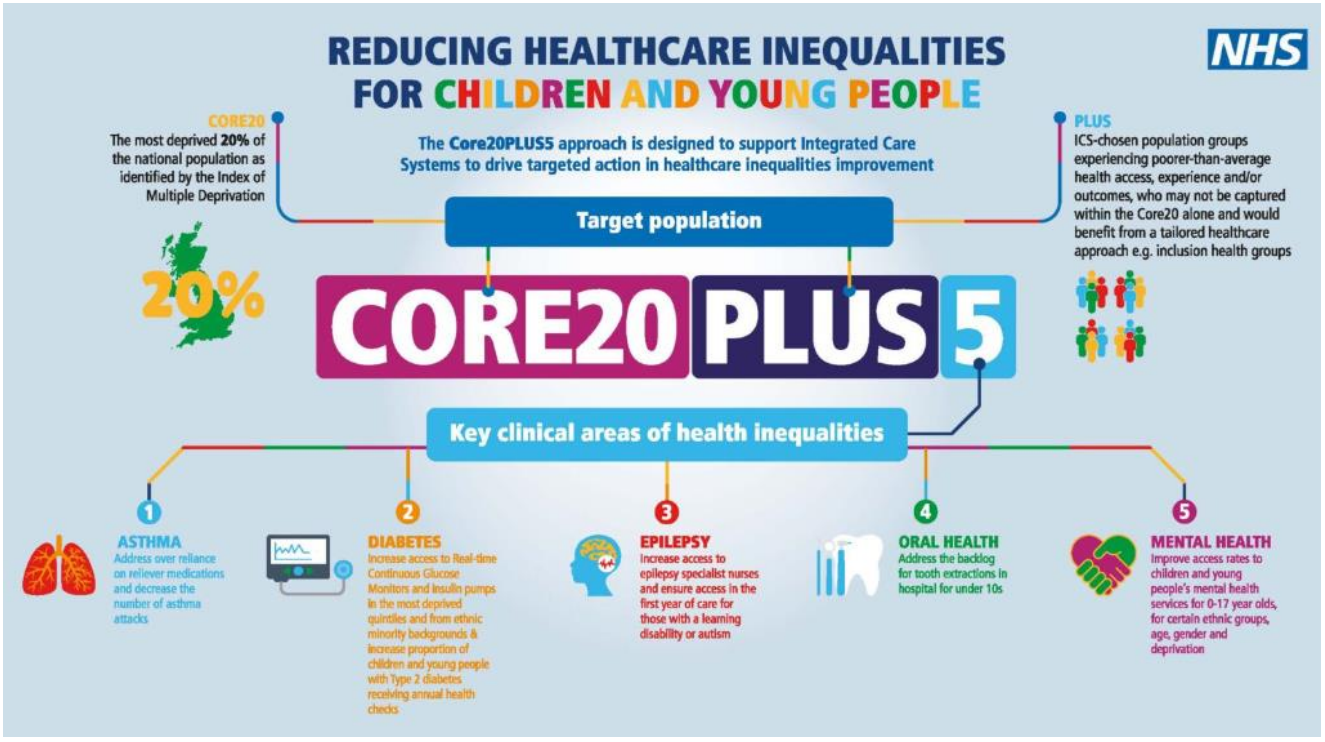
According to Norfolk Insight, health inequalities are “preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies”.

Core20PLUS5 is the national NHS England approach to inform action to reduce healthcare inequalities at a national and system level, by defining ‘Core20’ and ‘PLUS’ population groups, which include people who have additional inequality risk factors and include ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others.

Core20PLUS sets out 5 focus clinical areas requiring accelerated improvement:



Initially, the approach focused on healthcare inequalities experienced by adults but has now been adapted to apply to children and young people too:



Inclusion Health Groups
Inclusion health groups include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the criminal justice system, victims of modern slavery and other socially excluded groups.

4.3 Infection Prevention & Control

Infection Prevention & Control (IP&C) is key to keeping service users and staff safe and well, and making sure services are resilient and we work as a system to ensure that we can work collaboratively, to maximise the skills and knowledge of professionals working in Infection Prevention & Control workstreams across the system, particularly around intelligence and learning, research development and innovation, and education, practice improvement and support.

Current IP&C system workstreams and projects include:

- Antimicrobial Stewardship
- Gram-negative Bacteria and Clostridioides Difficile Reduction
- MRSA Pathway
- Overuse of Gloves in Healthcare Settings
- Hydration and Urinary Tract Infection Prevention

As a system we undertake **surveillance** of community and hospital healthcare associated infections, including Gram-negative bacteria, Clostridioides difficile, Escherichia coli, Pseudomonas aeruginosa, Klebsiella species, Staphylococcus aureus and Surgical site infections.

We have **oversight** of infectious illness prevalence and quality of diagnostic and treatment services, including Seasonal, Pandemic and Avian Flu, Tuberculosis, COVID-19, and novel infections.

We provide **management** and enhanced support for care and non-care community settings experiencing outbreaks of infectious illness.

4.4 Mental Health

The continuous development and transformation of our local mental health services is underpinned by the core values of improving patient experience and access to high quality treatment and support. We develop skills and confidence across our entire workforce to consider a person's mental health alongside their physical health needs and valuing and listening to our mental health staff, to enable them to provide the best quality care.

As a system we need to identify opportunities for early support, to engage people in the right care, which is holistic, person centred, and appropriate for their mental health needs. Bridging the gap between primary and secondary care with excellent communication so that a person's care is seamless and appropriate to their level of need.

We must ensure that people experiencing mental health distress tell their story once, with single trusted assessments and patient identified goals at the heart of their care and that the views of our experts by experience and their carers are listened to, guiding the development of our mental health services and pathways.

Our Mental Health Transformation priorities include:

- Prevention and Community
- ‘Front Door’ and Access
- Children and Young People
- Crisis Support and Admission Avoidance
- Reasonable Adjustments for Neurodiversity
- Addressing physical health inequalities for people living with Severe Mental Illness

4.5 Learning Disability and/or Autism

Norfolk and Waveney ICB has a number of priorities in relation to improving the quality of provision for people with a learning disability and/or autism or other neurodiverse conditions, living within Norfolk and Waveney:

- To improve the number of annual health checks and health action plans being delivered by Primary Care for people with a learning disability.
- To build our care and support community models for the learning-disabled population and those people with autism.
- To improve the adult autism diagnostic offer across Norfolk and Waveney with reduced waits.
- To build capacity across the system in specialist health services for people with learning disability and/or autism to help prevent admission to inpatient hospital services (Transforming Care Programme).

What Should Quality Feel Like? Visit Canary Care

Canary Care* is a home care provider. It is a big local employer that provides opportunities for its staff to develop skills for caring, working as compassionate professionals who help to keep people healthy, happy and independent, in their own homes.

For the **staff at Canary Care**, quality feels like being able to provide care in a joined up system, with clear communication and processes shared with other partners, like hospitals, discharge teams and GP surgeries. It means that there are career pathways at all levels and recognition of social care talent and skills. Quality means taking pride in your work and having the right values, tools and resources to meet the needs of your service users. It means being part of a professional and well managed company that values and rewards your work.

For **Canary Care service users**, quality feels like being safe, healthy and having personal needs met by people that you can trust. It feels like being able to keep connected with friends, family and community and be a part of planning and decision making about your own life; from 'what's for dinner' to 'where do I live'. Quality means feeling safe, respected and involved in choices about your care. It means having equal access to a healthy, active lifestyle and a rich and fulfilling life.

4.6 Local Maternity and Neonatal System

The Local Maternity and Neonatal System (LMNS) has a continued commitment to maintaining safe and personalised maternity care, in order to support the transformation required by NHSE, for our pregnant women and people, families and staff, as detailed in Better Births, Ockenden Review and NHS Long Term Plan. The system partnership that the LMNS provides, brings together the Integrated care Board (ICB), providers, and service users to focus on maternity transformation priorities that will improve safety and experiences of antenatal, birth and postnatal care.

Our LMNS priorities include:

- System transformation, continuity of care and community hubs
- Safety, learning from incidents and sharing good practice
- Local response to the national Ockenden and Kirkup Reviews
- Perinatal mental health support
- Digital and data technology
- Prevention including Perinatal Pelvic Health Projects
- Neonatal Critical Care Review and Action Plan
- Workforce Development including Training and Education
- Equality and Equity Strategy

The LMNS also supervises and oversees the Norfolk & Waveney Maternity Voices Partnerships, (MVP) who are also aligned to the three Acute Hospitals in Norfolk and Waveney.

The MVP creates and maintains a co-production forum for maternity service users, service user advocates, commissioners, service providers and other strategic partners to ensure that service user voice is incorporated into in the development, review and updating of maternity guidelines, procedures, surveys and patient information, and the Maternity Transformation Programme.

4.7 Babies, Children, Young People and Families

Types of family services involved across the system include Maternity Services, Health Visitors, Children's Services , NHS Continuing Care, the Voluntary, Community, Faith, and Social Enterprise sector, parent peer and sibling support, hospital Children's Wards, Community Paediatricians and education teams in the local authority.

Norfolk and Waveney's quality vision is that every baby, child, young person, and family will FLOURISH (Family, Learning, Opportunity, Understood, Resilience, Individual, Safe and secure, Health).

This is the quality vision of the collective system in Norfolk for babies, children, and young people (CYP) and their families, through the CYP strategic partnership board. In every decision we undertake we will ask ourselves where the FLOURISH opportunities lie and what good looks like. Norfolk County Council's (NCC) 'vital signs' priorities and Suffolk County Council's (SCC) 'every child will have the best start in life' priority align and support FLOURISH to ensure quality. No child or young person will be excluded, and we will strive proactively to reach out to groups that may have previously been unseen or recognised to offer equitable quality services to all.

Find out more about FLOURISH here.

Our priorities for Babies Children and Young People (BCYP) include:

- Prevention and early help
- Mental health and emotional wellbeing
- Special Educational Needs and Disabilities (SEND)
- Addressing gaps in learning following the pandemic
- Improving the experience of all BCYP and families
- Improving health and reducing health inequalities
- Providing timely support for neurodiverse CYP
- Providing quality integrated support, personalised to the needs of each individual

We will think 'whole family, whole system' working to support BCYP in a way that is outcome and quality focussed and 'right time, right place'. We will adopt a strength orientated and personalised approach and work in partnership with BCYP, parents, carers, and communities. Safeguarding underpins all planning and delivery, and we will make the best use of collective resource based on population need and best available evidence.

What Should Quality Feel Like? Meet Ben and his Family

"When I was born, my parents and the professionals supporting them assumed that I would be a challenge, even though I hadn't had the opportunity to show them any of my skills!

I couldn't co-ordinate my tongue and swallow, so I have my milk through a tube. My parents were shown how to do it, and that 'quality' action helped me to thrive. We are four years into my journey, and busy planning my first day at school, how 'quality' is that?! Sometimes my parents need some extra reassurance, but I am teaching everyone to focus on **me** and not my extra chromosome. Oh yes, I forgot to mention I have a super power called Down's Syndrome! I happen to have a disability, but it doesn't define me. We are enjoying the journey, together and everyone is learning along the way, another part of 'quality' for me. Yes, the path is different, but it's my individual path to a full, happy and active life. Of course they still have the days when they worry or think too far ahead, but I like to teach them to slow down and take each day as it comes. I am showing them how I learn and what I need. They seem to be having a lot of fun too! I will never forget the look on my sister's face the day my parents brought me home. The way her face lit up when she saw me, showed me unconditional love. We bonded in that moment and she gets me better than anyone. She gets to have fun with other children who are lucky enough to have siblings with super powers too. I am glad that happens as she deserves that extra 'quality' time too."

4.8 Safeguarding

The Integrated Care Board has a statutory responsibility to ensure that all organisations commissioned to provide health and care services provide a safe system that meets the statutory requirement to safeguard and promote the welfare of children and adults.

It represents Health as a statutory partner at the Norfolk and Suffolk Safeguarding Adult and Children Partnerships, along with the Local Authorities, Police and wider partner agencies and voluntary sector.

Safeguarding Children Priorities

- Protecting Babies
- Child Exploitation (including Online) and 'At Risk' Adolescent Groups
- Preventing and Addressing the Impact of Neglect
- 'Build Back Fairer' Child Poverty and Health Inequalities
- Looked after Children and Care Leaver's Care and Support
- Children Seeking Asylum

Safeguarding Adults Priorities

- See Something, Hear Something, Say Something Campaign
- Domestic Abuse and Sexual Violence
- Modern Slavery and Human Trafficking
- Statutory Serious Violence Duty

Joint Priorities for Children and Adults: Domestic Violence, 'Think Family', transition into adulthood and developing 'trauma informed' awareness and skills across the health and social care landscape. Standards, equity of access and experiences of care for people with learning disabilities and autism, within community and inpatient settings. Safety-netting people while waiting for services, improving mental and emotional well-being through prevention, co-production and delivering ethical commissioning approaches.

4.9 #Wecaretogether Workforce

In August 2020 the local #Wecaretogether People Plan launched across the ICS; supporting the key system priority to ensure that Norfolk and Waveney is the **best place to work in health and social care**. Our local workforce priorities align to the national NHS People Plan.

Have you seen our photo documentary on social media?

This captures and celebrates our local people, working together to deliver compassionate care.

Follow and like it here:
#wecaretogethernw

As a system, we will also work with VCFSE sectors to develop opportunities for volunteers and help smaller organisations to access training and support.

What Should Quality Feel Like? Meet Aaliyah

Aaliyah is a Norfolk & Waveney healthcare professional. From a young age, she felt passionate about having a career that helped people and made a real difference to her community.

For Aaliyah, quality feels like being encouraged to pursue a rewarding and satisfying career, starting at school and continuing into adulthood and lifelong learning. It means access to education and training pathways that are high quality and tailored to her individual needs, experiences and values. It means working in a system that invests in its staff; developing skills and confidence, recognising and rewarding successes, retaining experienced colleagues and growing new talent. A clear and accessible career pathway is important so that clinical and non-clinical staff are able to thrive and the diversity of health and social care means that this could be in advanced practice, education, leadership and commissioning roles and more.

Quality means that Aaliyah feels listened to, working in a just culture that makes it easy to speak up and ask for help or flag concerns about standards of practice if needed. It means that she can access the right skills, tools and support to take action if they see an opportunity to improve services, in a way that is evidence-based, safe and sustainable. It also means taking a clear zero tolerance approach to abuse and discrimination.

5.0 Our Quality Journey

5.1 Next Steps

March 2023	May 2023	July 2023	December 2023 ➔
Strategy Publication	Implementation Plan	Resource Allocation	Monitor, Evaluate and Refresh
Share aspirations and making a commitment to staff, patients, service users, families and carers to deliver our strategic priorities.	Define key performance indicators. Plan delivery activities, milestones and outcome measures, being clear about who will deliver what, by when.	Allocate resources required for the system to deliver, monitor and evaluate the impact of the strategy.	Monitor delivery to ensure that the strategy is effective. Recommit to the existing direction, or stop, reflect and refresh if needed.

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 9

Subject:	Establishment of the Mental Health System Collaboratives
Presented by:	Jocelyn Pike, Acting Director of Mental Health Transformation
Prepared by:	Anne Borrows, Associate Director of Special Projects
Submitted to:	ICB Board
Date:	28 March 2023

Purpose of paper:

The ICB Board is asked to:

- Agree to the establishment of the adult mental health system collaborative and a children and young people's system collaborative from April 2023.
- Endorse the direction of travel set out in this paper.

<u>Context</u>
Discussions over collaboration across mental health (MH) in Norfolk and Waveney (N&W) have been a focus for several years. In 2019 both the adult, and children and young people's (CYP) MH strategies respectively placed integration at the heart of their service models moving forward.

The 2022 Health and Care Act established the legislative framework to promote better joined-up services. This includes a duty for all health and care organisations to collaborate to rebalance the system away from competition and towards integration.

Working in this way should mean that health and care providers, including voluntary sector organisations and primary care, will organise themselves around the needs of the population rather than planning at an individual organisational level, in delivering more integrated, high-quality, and cost-effective care.

During 2022 the formation of system collaboratives for mental health was further accelerated in light of:

- The need to support local providers – namely Norfolk and Suffolk Foundation Trust (NSFT) – in delivering optimal patient care and, in so doing, respond to the objectives laid out in their CQC Improvement Programme,
- The desire to align timescales and ambition with neighbouring ICS's – namely Suffolk and North East Essex (SNEE) – to ensure our population does not observe or experience inequity of provision (particularly relevant on the boundaries of our systems),
- To meet national expectations – as referenced above.

Current thinking
Initially at least, we are proposing to establish an adult MH system collaborative and a children and young people's (CYP) system collaborative. This is because the current providers and

models of delivery in each 'space' differ. For example, CYP already has an Alliance (established 2019/20), building on the previous CYP strategic partnership with a signed Alliance agreement in place. It has four priorities of which one is children's mental health with an established system children and young people's mental health executive.

The responsibility for the focus on transition services (18-25 yrs) will need to be agreed for one of the collaboratives to lead, with the ambition to converge over time.

Whilst both collaboratives are prioritising mental health services, they both want to include physical health outcomes and a focus on the wider determinants of health.

Progress to date

A series of half-day meetings were held bringing together the principal providers in each of the collaboratives (on 'day 1') to discuss their ambitions and initial scope. The VCSE sector was also represented as was primary care and members of the ICB.

The areas of focus for year 1 (23/24) have been identified as:

1. For CYP the redesign of community-based support to meet mental health needs and for neurodiverse children and young people, individuals with SEND and their families.
2. For adults/older people - dementia pathways inclusive of delirium and depression.

The reasoning behind this is:

- An initial 'sifting' exercise with NSFT, SNEE, NHSEI regional team and the N&W ICS identified these as areas of opportunity
- Specifically in relation to dementia, a good fit with our ICS local ambition to radically improve outcomes and pathways across our aging population
- (to note, the collaborative/s are part of a much larger programme of community transformation in MH, where delivery of the 2019 MH strategies continue)

Working groups have been established to progress describing the ambitions and scope for each of the collaboratives.

Adult MH system collaborative ('the adult collaborative')

Executive and senior representatives from Norfolk County Council Adult Social Services, Norfolk Community Health and Care, East Coast Community Healthcare (ECCH), NSFT and the ICB met on the 20th January. Also in attendance were VCSE and primary care. The meeting concluded with agreement in the following areas:

Ambition

Crucial to the success of the adult collaborative is being able to take action together, to align resources, have mandated authority to act and be equally accountable. To do so would require strong trusting relationships between colleagues and organisations.

Scope

a. Building the 'case for change' for dementia provision, inclusive of delirium and depression.
b. Identifying national best practice and best definitions.
c. Given the breadth of the pathway, using a. and b. to advise on which element/s of provision are addressed first.

Points of note

- It is acknowledged that dementia can span all-age – albeit in smaller numbers.

- Agreement must be reached with the CYP MH collaborative over the 18-25 cohort, transition, and other areas of inter-dependency.
- The University of East Anglia is a world class leader in Dementia; we must utilise their expertise and learning.

Thereafter

1. From February 23 a working group, consisting of a sub-set of leads from the organisations named has met, the output of their work being to:
    - draft a partnership agreement for the adult collaborative
    - further build the 'case for change' on the dementia portfolio.
2. Submit the recommendation to establish the Adult collaborative – March/April 23.
3. Further meeting of the same partners on the 11th April 23 to receive the outputs – namely the partnership agreement and case for change - from the working group for approval.
4. Adult MH system collaborative established – late April 23.
5. Thereafter identified delivery groups, drawn from the wider ICS membership, to further develop and implement the dementia redesign.
6. Review arrangements after 1 year.

<u>CYP system collaborative</u> ('the CYP collaborative')

Executive and senior representatives from Norfolk County Council Children's Services, Suffolk County Council, Cambridgeshire Community Services, ECCH, NSFT and the ICB met on the 31st January. Also in attendance were VCSE and primary care. The meeting concluded with agreement in the following areas:

Ambition

Implementation of the Thrive model. The intention is to look creatively and holistically at all the resources across the key partners and to re-design the support model to achieve the best outcomes. The ambition includes making structural, operational, and cultural changes required to deliver community based multi-disciplinary team working across organisations, to ensure collective support to meet the physical, emotional and mental health and care needs of the child or young person and their family. This is a clear step beyond 'partnership collaboration' to a fully integrated approach.

Scope

The intention is to ultimately consider all community-based support (teams, resources, and pathways) that meets the mental and physical health, education and social needs as within the scope of the new collaborative. This can only be achieved when all health, care, education, community and voluntary sector providers and system leaders (the ICB and Council) fully collaborate to improve the outcomes for our children and young people.

The only resources defined as 'out of scope' are those covered within the Adult Mental Health System Collaborative and the Regional Specialist Collaborative.

It is envisaged that the children and young people's system collaborative will be established in phases over a number of years and that the scope will therefore expand as the work develops.

Initially the focus will be on the redesign of community-based support to meet mental health needs and for neurodiverse children and young people, individuals with SEND and their families. All resources and pathways in those areas will be 'in scope' for the first phase.

Points of note

The Children Act 2004 (the Act) also provides the legislative spine on which to improve wellbeing and integrate children's services, promote early intervention, provide strong leadership, and bring together different professionals in multi-disciplinary teams to achieve positive outcomes for children and young people and their families. Local authorities are given a lead role (DCS) in securing the co-operation of partners in setting up children's trust arrangements - the Act allows some flexibility in how these are structured and organised.

In Norfolk this is the Children and Young People's Strategic Alliance. Complemented by our Norfolk Children Safeguarding Partnership.

The concept of well-being covers physical and mental health and emotional well-being, protection from harm and neglect, education training and recreation, contribution to society and social and economic well-being.

This is captured through the Norfolk ambition for every child to flourish and the eight outcomes it represents.

Therefore;

- The CYP collaborative is not intended to replace the CYP Alliance; the latter will set the strategic direction and oversee delivery.
- Specialist / tertiary care for core CYP mental health care will remain with a specialist provider - namely NSFT. All other services currently commissioned are in scope for the collaborative to consider alternative delivery models.
- The changes in mental health support/service arrangements, will be in line with the N&W CYP strategy signed off by all partners in 2019.
- Change management capacity and leadership is critical to facilitate cultural change.
- There is a preference for those aged 18-25 yrs with mental health, NDD or SEND care needs transitioning to adult support packages to come under the CYP collaborative.
- For clarity the geographical footprint covered is Norfolk; the agreement in discussion (still subject to internal sign-off) is that Waveney provision for children and young people's mental health is overseen in the Suffolk collaborative.

Thereafter

1. The establishment of a core executive. Initially at least made up of Chief Executives or Executive Directors from NCC, NSFT, CCS, and the ICB. The group will:
    - Be the accountable/authorising/delegated body, leading the structural and cultural change; providing clear delineation on what each brings.
    - Define an agreed purpose for those services identified; including priorities and expected outcomes.
    - Provide oversight and accountability for delivery of expected outcomes.
    - The group will meet, in shadow-form to receive and approve the common paper – mid March 23.
2. From February 23 a working group, consisting of a sub-set of leads from the organisations named has met, the output of their work being to:
    - draft a 'common paper' describing the ambition and scope of the CYP collaborative for sign off by each organisation
    - work up a proposal for the areas initially in scope for the CYP collaborative.
3. Submit the final documentation together with a recommendation to establish the CYP collaborative – March/April 23.
4. CYP MH system collaborative established – April 23.
5. Establish delivery groups drawn from the wider membership of CYP Alliance to develop and implement the redesign agreed by the core executive; considering available data, information, and insights to understand enablers i.e., workforce, and identify and agree resource – developmental stage: 1-18 months / implementation 06-24 months.

6. Review arrangements - 24 months.

Waveney

One area that requires clarity in defining the remit of our collaboratives is the position of Waveney. Whilst this area falls within the county of Suffolk, all NHS funded services are the responsibility of the Norfolk & Waveney ICB.

In developing these proposals, there has been extensive engagement between colleagues from the Norfolk and Waveney and Suffolk and NE Essex systems to determine how best to establish arrangements that are clear and practical, whilst considering the need to achieve consistent delivery arrangements for some integrated services.

The position that has been identified by partners as logical and pragmatic is for all NHS funded mental health support for children and young people in Suffolk (including for Waveney) to be in scope for the Suffolk Collaborative. This model reflects the recognition among partners of the key role county councils play in organising and delivering wider children's services (social care, education, public health etc) and the resulting importance of ensuring there are consistent county-based models.

Decisions about NHS funded mental health services for adults and older people in Waveney that are the responsibility of Norfolk and Waveney ICB are not within the scope of the Suffolk Mental Health Collaborative. Decision making for these services will be within the proposed Norfolk and Waveney Adult and Older People Mental Health Collaborative, which will likely include senior representation from Suffolk County Council.

The two ICBs are working together to develop and agree the best way of implementing these arrangements and any addressing and outstanding issues.

Engagement and co-production

During October 2022, an engagement task and finish group was established to oversee, develop, and implement our engagement on the collaboratives.

The group membership includes 3 patient and public advisors, Healthwatch Norfolk, NSFT, Norfolk County Council, voluntary sector and primary care representation with a reach that extends outside of these groups to cover all of Norfolk and Waveney.

The first output from the group has been to launch an engagement exercise, 'Let's Talk…about Mental Health', to help us understand if the priorities as identified in our adult, and children and young people's mental health strategies, 2019, are still correct. The survey ran from January 2023 to February 2023, and was open to responses from service users, staff, family, carers, and members of the public. This was mainly done via an online portal, and was promoted via existing networks, websites, health care settings and via patient and carer representatives. Overall, the spread of responses reflects a range of individual demographics and a mix of service-user, carer, family member, and staff across the system.

The qualitative data is rich in detail and has specific feedback about service lines, individual organisations and occasionally named staff members. We are currently sharing the initial analysis with stakeholders from across the health and social care system and discussing these findings in more detail. In response to the findings, we will establish:

- what work we are already doing to address some of the concerns raised
- what work we have planned to address some of the concerns raised
- where any gaps might be, or where we can work together and provide additional support to address these concerns

- what the root cause of some of the issues raised might be, and what we can do to resolve these wider determinants of mental health and wellbeing

This will inform the specific work of the collaboratives as they seek to redesign clinical pathways.

Further, each collaborative once established will articulate how they intend to co-produce their programmes of work and where experts by experience will feature in their governance and decision-making processes.

Recommendation to ICB Board:

The ICB Board is asked to:

- Agree to the establishment of the adult mental health system collaborative and a children and young people's system collaborative from April 2023.
- Endorse the direction of travel set out in this paper.

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 9.1

Subject:	Common paper on establishment of the Children and Young People's System Collaborative
Presented by:	Jocelyn Pike, Acting Director of Mental Health Transformation
Prepared by:	Anne Borrows; Associate Director of Special Projects, NHS Norfolk & Waveney Integrated Care Board (N&W ICB) Steve Bush; Director of Children and Young People's Services, Cambridgeshire Community Services NHS Trust (CCS) Rebecca Hulme; Director - Children, Young People and Maternity, N&W ICB Steff Kamara; Interim Director for Children, Families and Young People's Services, Norfolk and Suffolk Foundation NHS Trust (NSFT) James Wilson; Service Director – Children's Service Norfolk County Council (NCC) Peter Witney; Senior Project Manager - Place Development and System Support, N&W ICB
Submitted to:	• NCC Cabinet • N&W ICB Board • CCS Board • NSFT Board
Date:	March/April 2023

Purpose of paper:

To update on the progress in establishing the Children and Young People's System Collaborative.

To secure a mandate from each of the key partners to create streamlined governance arrangements which empower the appropriate leaders to drive forward the new collaborative at pace. This would likely include integrated and co-located teams, new ways of working together, shared leadership and the sharing of caseloads.

Context

Discussions over collaboration across mental health (MH) in Norfolk and Waveney (N&W) have been a focus for several years. In 2019 both the adult, and children and

young people's (CYP) MH strategies respectively placed integration at the heart of their service models moving forward.

The 2022 Health and Care Act established the legislative framework to promote better joined-up services. This includes a duty for all health and care organisations to collaborate to rebalance the system away from competition and towards integration. For local government the 2021 national review of Children's Social Care and recent government response provide a further clear national policy direction towards the creation of integrated services and a role for local authorities to bring the system together around a common cause.

Working in this way should mean that health and care providers, including voluntary sector organisations and primary care, will organise themselves around the needs of the population rather than planning at an individual organisational level, in delivering more integrated, high-quality, and cost-effective care.

During 2022 the formation of system collaboratives for mental health was further accelerated in light of:

- The need to support local providers – namely Norfolk and Suffolk Foundation NHS Trust (NSFT) – in delivering optimal patient care and, in so doing, respond to the objectives laid in in their CQC Improvement Programme,
- The desire to align timescales and ambition with neighbouring ICSs – namely Suffolk and North East Essex (SNEE) – to ensure our population does not observe or experience inequity of provision (particularly relevant on the boundaries of our systems),
- To meet national expectations – as referenced above.

Current Challenges

Across the public sector we continue to see high levels of need within communities and demand for services. In particular this manifests in high and increasing numbers of referrals for acute or more specialist support which leaves those specialists struggling with capacity. In turn this stifles investment in more preventative or early intervention support which all recognise is so badly needed. We see this for example in the extremely high rate of referral per head of population to Children and Young People's Mental Health services in Norfolk, in high and increasing numbers of children referred for Education Health and Care Plans, the long waiting times for support and diagnosis across key pathways and in pressure on the social care system which has high caseloads and more children and young people identified with the most complex needs.

Alongside demand pressure, the other key challenge relates to our ability to connect our interventions together across different services. As needs become more complex within children and families it is more important than ever that health and care professionals from different backgrounds can come together as a single team and that we can make support as easy and simple as possible to access and to understand.

It is recognised that although current partnership relationships are strong and there are good examples emerging of integrated work, we cannot achieve the step-change

we need without deeper integration of the offer and greater ambition around collaboration.

Ambition

The creation of a new collaborative presents an extremely powerful opportunity to realise our ambition that all children FLOURISH and to create a nationally leading model.

Our intention is to look creatively and holistically at all the resources across the key partners and to re-design the support model to achieve the best outcomes. The ambition includes making structural, operational, and cultural changes required to deliver community based multi-disciplinary team working across organisations, to ensure collective support to meet the physical, emotional and mental health and care needs of the child or young person and their family. This is a clear step beyond 'partnership collaboration' to a fully integrated approach.

Some of the key features and opportunities we want to embed within the new approach are;

- A focus on early intervention and prevention – moving the resource and support further upstream over time and reducing the reliance on specialist and acute support

- A focus on 'place', looking to offer support within local communities and provide help where children, young people and families are day to day – with less reliance on specialist settings, clinics or institutions

- To look holistically rather than separately at needs – resulting in strategic integration but also joined up casework for each child, young person and family and aiming for a single personalised assessment and plan in each case. It is clear that physical and mental health, education and social needs all interact and that we have greater chance of success in any area if we look at the whole – so we want to design ways of working for teams that enable that

- A move away from a clinical model which focuses on diagnosis or labelling of needs to one which is rooted in community-led early help and which exploits the capacity within children and families and communities to help themselves

- An opportunity to look at our portfolio of resources across the partnership and make things more efficient and effective, sharing 'back-office resource' leading our staff teams together and putting our collective scale to work in the interests of children, young people and families

Scope

Our intention is to ultimately consider all community-based support (teams, resources, and pathways) that meets the mental and physical health, education and social needs as within the scope of the new collaborative. This can only be achieved

when all health, care, education, community and voluntary sector providers and system leaders (the ICB and Council) fully collaborate to improve the outcomes for our children and young people.

The only resources defined as 'out of scope' are those covered within the Adult Mental Health System Collaborative and the Regional Specialist Collaborative.

It is envisaged that the children and young people's system collaborative will be established in phases over a number of years and that the scope will therefore expand as the work develops.

Initially, and beginning from 1st April 2023, the focus will be on the redesign of community-based support to meet mental health needs and for neurodiverse children and young people, individuals with SEND and their families. All resources and pathways in those areas will be 'in scope' for the first phase.

Flourishing in Norfolk

The Flourishing in Norfolk Strategy (2021- 2025) outlines several guiding principles:

- Child and young person focused
- Positively framed – based on aspirations rather than just needs
- Places importance on how children, young people and families feel about their lives
- Inclusive of all children and young people in Norfolk
- Recognises our shared responsibility for children, young people, and families
- Co-produced with young people
- Represents the interests and focus of all Children and Young People Strategic Alliance members

We will be working with our partners to embed FLOURISH as an ambition that underpins all our work, but FLOURISH isn't just an ambition for social care, education, health, and other professionals working directly with children, young people, and families. Our businesses, communities and every person living or working in our county has a role to play in helping Norfolk's children and young people to Flourish.

Governance and Delegation

In order to achieve our ambitions, it is recognised that we need to create streamlined governance arrangements which empower the appropriate leaders to drive forward the new collaborative at pace. The intention of this paper is to secure such a mandate for each of the key partners to move forward. This would include integrated and co-located teams, new ways of working together, shared leadership and the sharing of caseloads.

At this stage the proposal does not go as far as recommending consideration of pooled budgets, formal financial delegation, formal delegation of existing accountabilities or the TUPE transfer of staff between organisations. However,

potentially as the work develops, these could become recommended options and if so a further paper would be taken through the partnership governance and that of the key partners for approval.

From a partnership perspective the existing Children and Young People Strategic Alliance will provide the strategic endorsement for the creation of the new collaborative and will have oversight of the work as it develops. Achievement of this will support delivery of the objectives within the ICB Joint Forward Plan and the Integrated Care Strategy.

The core partner organisations who will co-design the new collaborative are the NHS Norfolk and Waveney Integrated Care Board (N&W ICB), Norfolk and Suffolk Foundation NHS Trust (NSFT), Cambridgeshire Community Services NHS Trust (CCS) and Norfolk County Council (NCC).

As such each of these organisations will also seek strategic endorsement for the creation of the collaborative from their key governance boards, specifically

- NCC Cabinet
- N&W ICB Board
- CCS Board
- NSFT Board

To complete the design and implementation work we envisage the following new governance being established.

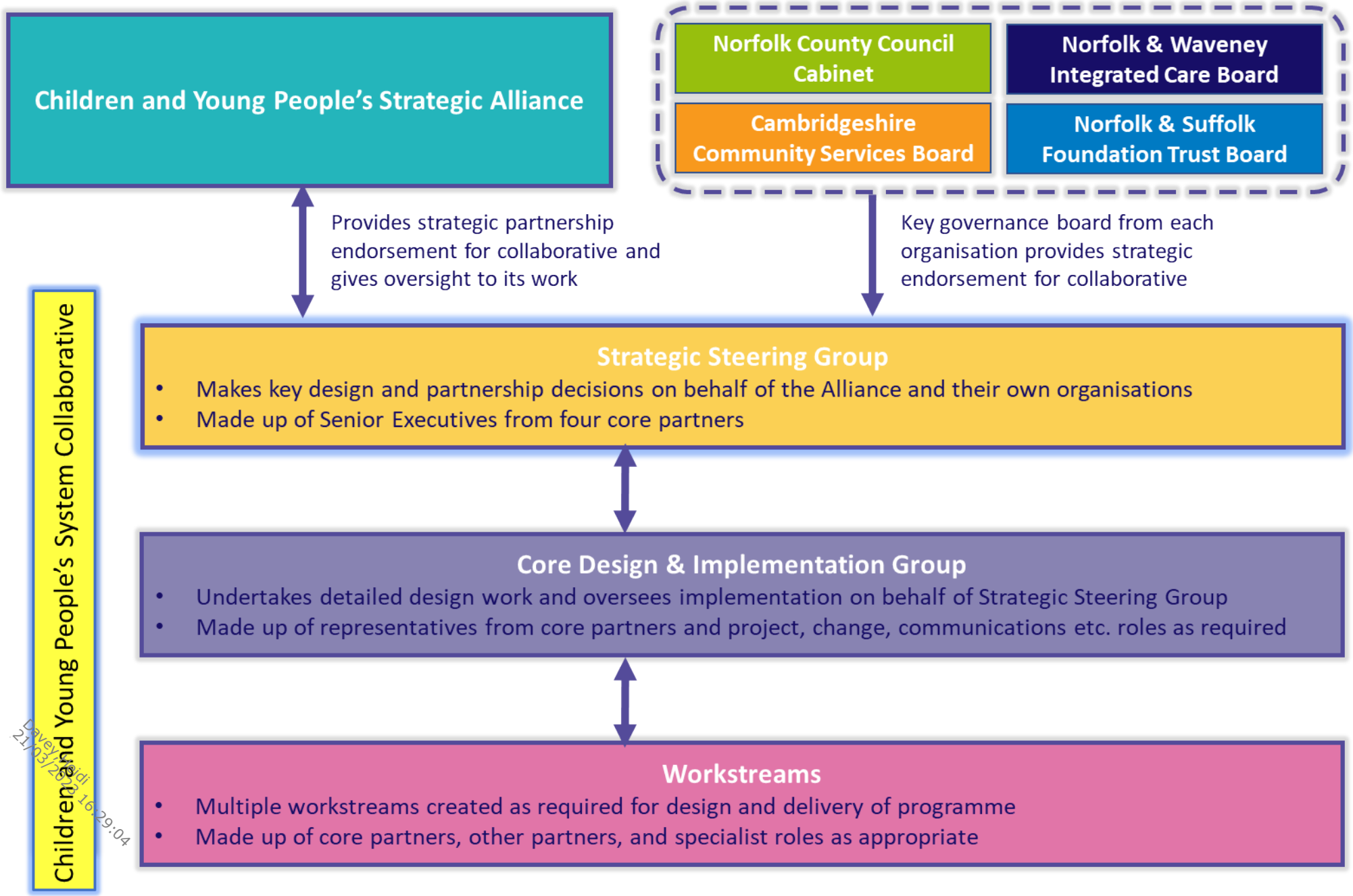
A Strategic Steering Group made up of senior executives from the core partners. This group would be empowered to work on behalf of the Alliance and their own organisations to create the collaborative and would make the key design and partnership decisions. The CYP financial resources currently deployed by the ICB, NHS England and NCC (social care and public health) would be used to transform care under this partnership model. The representatives on this group would be

- Executive Director Children Services, NCC
- Chief Executive, CCS
- Chief Executive Officer, NSFT
- Acting Director of Mental Health Transformation, N&W ICB

A core design and implementation group will work on behalf of the Steering Group to undertake the detailed redesign work and to oversee its delivery on the ground. This group will have representatives from the core partners as well as project, change, communications and other programme roles as required. This group will be the engine room for the programme but will take all key design decisions/options for consideration at the Strategic Steering Group.

The core design group would commit to working in an inclusive way and involving strategic partners as needed. After the initial mandate is established, regular reporting on progress will take place at the Strategic Alliance. Additional opportunities will be provided for members of the wider alliance to engage with relevant detailed design work as it develops.

The diagram below provides an overview of those arrangements.


Children and Young People's Strategic Alliance
Norfolk County Council Cabinet
Norfolk & Waveney Integrated Care Board
Cambridgeshire Community Services Board
Norfolk & Suffolk Foundation Trust Board
Provides strategic partnership endorsement for collaborative and gives oversight to its work
Key governance board from each organisation provides strategic endorsement for collaborative
Children and Young People's System Collaborative
Strategic Steering Group
• Makes key design and partnership decisions on behalf of the Alliance and their own organisations
• Made up of Senior Executives from four core partners
Core Design & Implementation Group
• Undertakes detailed design work and oversees implementation on behalf of Strategic Steering Group
• Made up of representatives from core partners and project, change, communications etc. roles as required
Workstreams
• Multiple workstreams created as required for design and delivery of programme
• Made up of core partners, other partners, and specialist roles as appropriate

Approach and How We Will Work Together

The Collaborative's remit is to build on the Children and Young People's Strategic Alliance and bring together health, care, VCFSE and education partners to support this work and further develop systems to support people using these services.

The CYP system collaborative is not intended to replace the CYP Strategic Alliance; the latter will receive and develop the strategic proposals and oversee delivery.

It is acknowledged there are some co-dependencies with the Adult Mental Health System Collaborative, notably for the 18-25 age group. The responsibility for the focus on transition services (18-25 yrs) will need to be agreed for one of the collaboratives to lead, with the ambition to converge over time. There may need to be an overarching committee in common, or at least a joint meeting to agree on areas of interdependency or commonality either instead of or until such a time as convergence occurs.

The transition in Waveney will also require attention, as for services for children and young people the current decision taken is that this would fall under the remit of the Suffolk Alliance and are therefore not part of this collaborative. This will remain under review by both N&W ICB and SNEE ICB.

However, it should be noted that for adults, the services within Waveney are within scope of the Adult Mental Health System Collaborative.

We will adhere to the following principles:

a) collaborate and co-operate with integrity and respect.
b) be accountable to each other.
c) ensure open and transparent communication, discussing major concerns or issues openly, exhibiting clarity where conflicts of interest arise, and working together to realise opportunities relating to any joint undertakings.
d) deploy appropriate resources to support collaboration and coproduction.
e) act in a timely manner, recognising the time-critical nature of joint activity and respond accordingly to requests for support.
f) make 'best for our population' decisions. Work collaboratively to deliver person centred, sustainable, high-quality care and service outcomes for people using mental health services
g) adhere to statutory requirements and best practice. Comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation.
h) manage stakeholders effectively.
i) develop capacity and opportunity for greater integration, including joint management/leadership.

Working in Year 1

The initial aim is to develop the governance for this group and set out aims and ambitions which support the existing integrated work being done (see Examples section below).

Some of the principles for this are detailed below:

- The implementation of the Thrive model and outcomes associated with Flourishing in Norfolk. This will include ensuring multi-disciplinary teams working across organisations are in place
- The development of a system collaborative to develop a social model of prevention and intervention; with an initial focus on the redesign of community-based support to meet mental health need and for neurodiverse children and young people, individuals with SEND and their families.

Examples of Integrated Work

The examples below are areas of integration which are either in place or planned to be in place. These areas could be expanded across Norfolk and similar services could be implemented as needed:

- Integrated Front Door, involving the ICB, CCS, NSFT and VCSE partners
- Castle Green (a short-stay unit being developed collaboratively with NCC and NSFT)
- An integrated practice model for children with complex emotional needs which has been co-created by NCC and NSFT
- Flourishing in Norfolk strategy

Considerations / Risks

Some of the risks which have been identified are:

1. Currently CYP and Adults Mental Health services are commissioned separately, which potentially misses areas of co-operation and can make aligning the services challenging.

2. 18-25 years provision and transition.
    a. Different services work to different age ranges, making transition between services complicated.

    b. The distinct needs of 18–25-year-olds can be overlooked. NCC Children's services are only responsible for 18–25-year-olds if they are care leavers or have an identified SEND. The criteria for adult services is different to children's services, which may result in some people no longer receiving care.

3. There is a lack of alignment of planning, development, and provision of maternity services.

Recommendation

To comment on and endorse the continued establishment of the Children and Young People's System Collaborative, and to proceed to design. In particular, the creation

of streamlined governance arrangements which empower the appropriate leaders to drive forward the new collaborative at pace. This would likely include integrated and co-located teams, new ways of working together, shared leadership and the sharing of caseloads.

Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**Local Maternity and Neonatal System (LMNS) Programme Report**
Presented by:	**Tricia D'Orsi ICB Executive Director of Nursing** (Senior Responsible Officer for Local Maternity and Neonatal)
Prepared by:	**Toni Jeary – LMNS Programme Manager** **Nicola Lovett – LMNS Lead Midwife**
Submitted to:	**Norfolk and Waveney Integrated Care Board Quality and Safety Committee (QSC)**
Date:	**28 March 2023**

Purpose of paper:

Norfolk and Waveney Integrated Care Board (ICB) are asked to note the statutory responsibility of the LMNS to report to the ICB. As the responsible executive, this report provides the ICB with information to review the progress of the LMNS Programme. It provides detail of the work undertaken on behalf of the ICB to ensure safety and quality oversight of maternity services including details of LMNS Programme risks and mitigating actions

Executive Summary:

The ICB has responsibility for the Local maternity and Neonatal System (LMNS). The LMNS is a system partnership responsible for supporting the implementation of the Maternity Transformation Programme, formed to co-ordinate and undertake the recommendations from the Better Births (2016) report and National Maternity review. The LMNS supports and facilitates the Better Births ambition of ensuring maternity services in England become safer and more personalised. Surveillance of the delivery of care is outlined in the Perinatal Quality Surveillance Model (Dec 2020) which challenges the ICB to 'take a more formal role in perinatal clinical oversight alongside transformation and improvements activity'. (Implementing a revised perinatal quality surveillance model December 2020, P.7)

The LMNS as an integral part of the ICB is responsible for oversight of the implementation of the recommendations from safety reports such as the Ockenden Review into Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (2021;2022), the East Kent report by Kirkup (2022) and a further pending review by Ockenden in Nottingham.

This report updates on

- LMNS Programme Team substantive posts
- Electronic Patient Records
- Maternity Voices Partnership
- Maternity workforce
- Entonox updates
- East Kent Report
- CQC maternity inspection of JPUH.

Recommendation to the Board:

For ICB Board to:

- Note the work undertaken by the LMNS to deliver the Maternity Transformation Programme
- Note the LMNS role in Quality and Safety Oversight and response to Ockenden and East Kent

Key Risks	
Clinical and Quality:	Risk of failure to achieve sufficient progress in delivering the quality improvements identified in Better Births, the NHS Long Term Plan and the Ockenden and east Kent Reports population if services not sufficiently accessible or available to meet their needs.
Finance and Performance:	Funding through NHS Long Term Plan and in response to the Ockenden Report Perinatal Quality Surveillance Model and will increase investment in maternity services with a particular focus on workforce and system development. The LMNS will work with all partners to identify areas of challenge and gaps in provision and seek to mitigate these were possible.
Impact Assessment (environmental and equalities):	The guidance supports the rights of families to have access maternity care that is responsive and safe, and delivered in settings that meet their health and social needs.
Reputation:	Any risks relating to the rights families to have access maternity care that is responsive and safe, and delivered in settings that meet their health and social needs may result in scrutiny.
Legal:	Human rights law gives pregnant women the right to receive maternity care, to make their own choices about their care and to be given standards of care that respect their dignity and autonomy as human beings.
Information Governance:	No impact
Resource Required:	Program to be supported through LMNS Program Team hosted on behalf of the system by Norfolk and Waveney ICB Additional sources of funding required
Reference document(s):	Better Birth Maternity Transformation NHS Long Term Plan Ockenden Reports (one and two) East Kent report Perinatal Quality Surveillance Model,
NHS Constitution:	The guidance and report supports the principles of the NHS Constitution. (values 1-7)
Conflicts of Interest:	No conflicts identified

Reference to relevant risk on the Governing Body Assurance Framework	None

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	

1. LMNS Programme

LMNS as a system, are asked to take responsibility – with accountability to ICBs – for ensuring universal implementation of initiatives. The LMNS Programme Board receive a monthly highlight report to ensure they are fully sited on progress against the programme priorities. The Programme is currently on track to achieve the 22/23 deliverables.
The 23/24 deliverables will be informed by the Single Delivery plan expected March 2023, which will incorporate Ockenden and East Kent recommendations.

1.1. LMNS Programme Team Staffing Update

LMNS funding into the ICB is non recurrent, historically the LMNS Programme Team has been staffed through secondments and fixed term contracts, with high staff turnover. The ICB as the responsible executive has agreed to establish a core LMNS Programme Team supporting substantive posts to ensure delivery of the ongoing systemwide requirements of Maternity Transformation and Quality and Safety Assurance.

1.2. Maternity Voices Partnership (MVP)

The LMNS supervise and oversee the Norfolk & Waveney Maternity Voices Partnerships (MVP) who are also aligned to the three Acute Trusts. MVPs ensure service user voice is incorporated into in the development, review and updating of maternity guidelines, Standard Operating Procedures (SOPs), surveys and patient information, and the Maternity Transformation Programme.

In January 2023 the MVPs presented Annual Reports to the LMNS Board, these are published on the LMNS website https://improvinglivesnw.org.uk/lmns . Each MVP has identified the increase in workload as a result of Ockenden. The Maternity Single Delivery Plan is due in March 2023 and indications are that there will be an increased expectation for MVP engagement in maternity and neonatal services. We know from pilot work in the core competency framework that there is potentially an increased requirement for MVP engagement in training.

Norfolk & Waveney LMNS have benefited from the MVPs extensive work programme. MVP engagement is a key requirement in the Clinical Negligence Scheme for Trusts (CNST). Provision for the maternity incentive scheme has been built into CNST maternity pricing for 2022/23. The scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Safety Action 7 focusses on evidencing MVP engagement. MVPs supported all three Trusts in achieving Safety Action 7.

The Annual reports highlight that the current funding model is not sustainable especially as each MVP needs to transition to a Maternal and Neonatal Maternity Voices Partnership (MNVP). The MVPs are proposing a funding increase supported by the LMNS Board, work is underway to secure funding for 23/24 with an ongoing commitment to this level of funding.

1.3. Digital and Data-Electronic Patient Record (EPR)

The Norfolk and Waveney EPR programme team are working to deliver a 'System' EPR in line with the government guidance. Maternity and neonatal are potentially in scope, however, this will be dependent on the supplier's state of readiness to meet the specialty needs. Nationally concerns have been raised that generic EPRs are not ready to meet the maternity/neonatal digital and data record requirements.

The 2022 N&W LMNS Maternity survey highlighted a 'paper and resource heavy' digital service in urgent need of replacement to converged modern digital record across the LMNS. The service is struggling to meet service needs, support staff and implement national deliverables in a timely manner. Our service users are voicing concerns at the inequitable access to personal digital records across the LMNS.

There is urgent need to level up digital maturity across the LMNS and converge the digital maternity record. The earliest availability of an EPR is 2026, with undetermined inclusion and/or suitability for maternity/neonatal remains unknown. This has been identified as a high-risk area by LMNS Board and the ICB mitigation work is underway, which may include a solution for 23/26. Solutions will require a system wide response.

2. Quality and Safety Oversight

2.1. CQC

The James Paget NHS Foundation Trust had a CQC inspection on 10th January 2023. The Trust is still waiting for the final reports. A regulation Section 29A warning notice has been issued. A Section 29A is a warning notice under section 29A of the Health and Social Care Act 2008 where concerns were identified, and that there is a need for significant improvements in the quality of healthcare.

Since receiving the warning notice, the Trust has been supporting it's maternity colleagues in going through the detail of the warning notice and planning the hospital's response to the issues raised, in anticipation of receiving the full report from the CQC, expected late March / early April 2023. They have also formed an Executive Maternity Improvement Group, to which the ICB and LMNS are invited.

2.2 East Kent report (2022)

This report challenges Boards to remain focused on delivering personalised safe maternity and neonatal care, and ensure that women babies, and families are listened to, understood, and responded to with respect, compassion and kindness. Every Board must examine culture with their organisations and understand how they listen and respond to staff. Leadership and culture across organisations must positively support the care and experience provided. The LMNS report has been submitted to both ICB Public Board, ICB Quality and Performance Board, and LMNS Board as required. Actions from the East Kent report will be embedded into the Single Delivery Plan (launch date likely 22nd March 2023). This will form the basis of the LMNS work programme for 23/24.

2.3 Entonox

Since January 2023 Trusts have reported monthly LMNS Board regarding Entonox and safety issues. The recent release of updated NHSE Guidance. NHS England » Guidance on minimising time weighted exposure to nitrous oxide in healthcare settings in England Requires wider Trust oversight. LMNS Board have requested updates from each Trust for March LMNS Board. Maternity departments will need work closely with other departments and Board expect to see assurance that departments such as Estates and Facilities are support Trust Maternity departments to adhere to the guidance.

2.4 Provider Staffing Review
Workforce / Culture – Ockenden and East Kent and workforce data identifies that the maternity workforce which is multidisciplinary requires an improvement in culture, as well as recruitment and retention. The LMNS as a system will need to work to address poor culture and staffing. The LMNS Board & ICB will have a key role in supporting this work.

The LMNS, in partnership with Trusts hosted a successful recruitment campaign for all student midwives qualifying in 2023. This has resulted in 56 applications across the System, which if all recruited, will reduce the vacancy rate.

In April the LMNS Board will focus on staffing levels to support safe care. A staffing report will be provided by each Trust this will include a breakdown of staff groups, specialist midwifery posts and support staff, leaderships posts and medical staffing, expected levels, vacancies, sickness and staff turnover, with risks and action plans. This will inform the ongoing work required by the system to improve workforce and culture.

3. Conclusion and Next Steps
The LMNS Programme is developing a robust approach to Quality and Safety Surveillance. Risks and challenges within the system are being highlighted and appropriate actions taken. On publication of the Single Delivery Plan the LMNS Programme will be reviewed and updated to ensure the Norfolk & Waveney System delivers the maternity and neonatal requirements.

The LMNS Board will continue to receive detailed reports and take actions as required, with the expectation that it will report to the ICB on delivery of the Transformation Programme, the quality and safety oversight of services

Recommendations
For ICB Board to:

- Note the work undertaken by the LMNS to deliver the Maternity Transformation Programme
- Note the LMNS role in Quality and Safety Oversight and response to Ockenden and East Kent

Improving lives **together**

Norfolk and Waveney Integrated Care System

Integrated Care Board Finance Report

February 2023

(month 11, 2022-23)

Board: 28th March 2023

Contents

1. Executive Highlights

- This report represents the February year-to-date position of the organisation – this comprises the April to June CCG position (pre-audit), plus the July to February Integrated Care Board (ICB) statutory organisation position.

- The consolidated CCG and ICB has reported a **Year to Date break-even position**, which is in line with the plan submission, this is a result of some offsetting variances, the major items being:
  - £(4.0)m increase in acute independent sector activity;
  - £(2.6)m Elective Recovery Fund underachievement;
  - £(6.0)m Continuing Health Care (CHC) expensive high acuity cases and excess inflation above funded levels;
  - £(3.2)m increases in Community Equipment supporting acute discharges and High cost Long Term Packages;
  - £(4.6)m non-achievement of system back office efficiency target; offset by
  - £24.8m benefit relating to the movements against year-end accruals in CHC, Primary Care, Prescribing, Community and BCF;
  - £5.4m benefit relating to the availability of non-recurrent mitigations;
  - £3.7m of combined smaller favourable benefits;
  - £2.7m non-recurrent temporary pay vacancies throughout the organisation.

- The **forecast out-turn (FOT) position is break-even**, inline with plan.

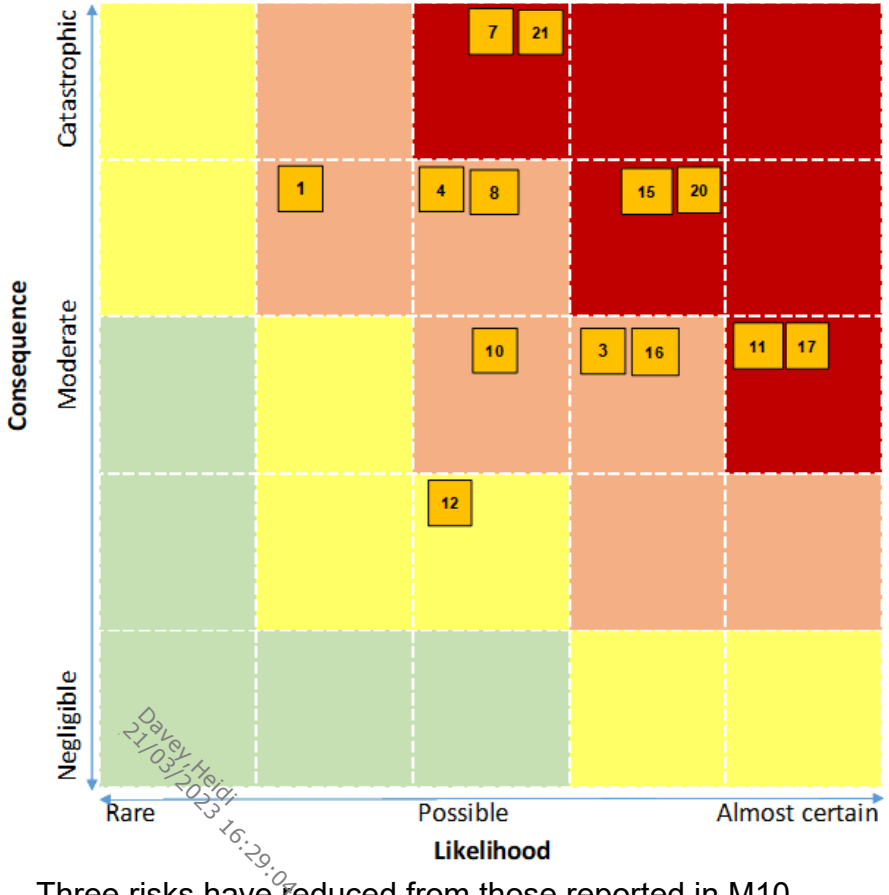
- The plan included £5.4m of unmitigated risks in line with NHSEI guidance – relating to excess CHC inflation and Elective Recovery Fund (ERF) income – £4.95m has crystalised in the year-to-date position, and £5.4m is forecast for the full year.

- The estimated value of potential risks to the full year position amount to £1.3m (M08 = £1.4m) – these are items which have not yet crystalised but have been identified as having the possibility of causing a financial issue. Appendix D shows the new protocol released by NHSE/I for organisations to follow should they wish to change their forecast out-turn.

2. ICB Strategic Financial Risk Register

This risk dashboard categorises the key financial strategic risks by their impact and likelihood to help the strategic focus to be on those that will cause the ICB the greatest issues.

Key: = Worsening Risk = Stable risk = Improving risk



Financial Strategic Risks	Ref.	Details	Risk appetite	Jan-23	Feb-23	Mar-23
Achievement of Financial plan	1	Achieve the 2022/23 financial plan **(BAF 11)**	8	12	12	8
	3	Transition following end of HDP top up allocations	6	12	12	12
	12	Personal Health Budgets (PHB)	4	8	8	6
	15	Underlying deficit position **(BAF 11A)**	12	20	20	20
	16	Capita - Primary Care payments	9	12	12	12
	17	Inflationary pressures	9	15	15	15
	19	ISP patient choice	9			
	20	Impact of new prescribing guidance	8	20	20	20
	21	Impact of Direct Commissioing transfer		15	15	15
Demand and capacity	4	Capacity increases in response to COVID continue	8	12	12	12
	5	System approach to service redesign	9			
	7	Continuing Health Care demand growth	6	15	15	15
	9	Acute demand management	8			
	10	Treatment breaks / cancelled operations	6	9	9	9
	11	RTT backlog and Acute demand management	10	15	15	15
	18	Care Home capacity	12			
Efficiency	8	Efficiency, transformation development/delivery	8	20	20	12

Extreme	7	7	6
High	6	6	7
Moderate	0	0	0
Low	0	0	0
Total Risks	**13**	**13**	**13**

Three risks have reduced from those reported in M10 recognising assurance around delivery of the ICB Financial plan and Efficiency Programme (Risk 1 and 8), and reduced CHC PHB Case referrals (Risk 12).

Only 1 of the 3 reductions have changed from Red to Amber Risk classification (risk 8).

The full risk register is shown in Appendix E.

3. ICB Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 28th February 2023.

Non Current assets:
IFRS16 was implemented in April 2022 to include the right of use assets for the lease of the premises in King's Lynn. The premises at Norfolk County Council were introduced in December 2022 as a right of use asset, transactions have been back dated to August 2022 when access was obtained. Corresponding entries are also included in both current and non-current Lease Liabilities.

Current assets:
Total current assets have decreased since year end, driven principally by aged debtors and cash. The £8.5m balance is made up of aged debtors of £6.9m (including NHSE £4.3m and NCC £2m), net of a provision against this balance of £1.7m and prepayments and accrued income of £3.3m.

Trade debtors are subject to a quarterly review of bad debt for provision or write off, which are presented to the Audit Committee. Further details are presented in Appendix B.

Current liabilities:
Total current liabilities has decreased by £20m since year end driven principally by ICB and system invoice accrual timing. The £177m balance is made up of trade creditors of £7m, Prescription Pricing Authority accruals of £22m, payroll costs including GP pensions of £2m, deferred income of £10m, prior year accruals of £6m and ICB and system invoice accruals of £130m. Provisions include legal, staffing, estates costs, prescribing and elective recovery claw-back for 2021/22. The elective recovery provision has been released in February 2023.

Long Term liabilities:
The non-current payables balance is the deferred income relating to research & development which are funded in advance.

Taxpayers equity:
The ICB is directly funded by NHSE with cash allocated on a monthly basis. Any future commitments to balance the general fund shortfall will be supported by the next months cash request from NHSE. This will however continue to remain negative as the NHSE principle is that cash should only be drawn based upon one months commitment at a time.

NHS NORFOLK & WAVENEY ICB STATEMENT OF FINANCIAL POSITION	Position as at 31/03/22	Position as at 31/01/23	Position as at 28/02/23
ASSETS EMPLOYED			
Non-Current assets			
Right-of-use-Assets	0	849	849
Accumulated Depreciation	0	(122)	(140)
Total non-current assets	0	727	709
Current assets			
Trade and Other Receivables	9,552	8,119	8,475
Cash and Cash Equivalents (less Cash in Hand)	1,481	361	541
Cash in Hand	0	0	0
Total current assets	11,033	8,480	9,016
Current liabilities			
Trade and Other Payables	(195,365)	(174,916)	(177,457)
Lease Liabilities	0	(91)	(12)
Provisions for liabilities and charges (including non-current)	(5,194)	(5,914)	(3,543)
Total current liabilities	(200,559)	(180,921)	(181,012)
Long Term liabilities			
Non-Current Payables	(612)	(612)	(612)
Non-Current Lease Liabilities	0	(548)	(535)
Total non-current liabilities	(612)	(1,160)	(1,147)
Net assets employed	(190,138)	(172,874)	(172,434)
FINANCED BY TAXPAYERS EQUITY			
General fund	(190,138)	(172,874)	(172,434)
Total taxpayers equity	(190,138)	(172,874)	(172,434)

4. ICB Operational Risks and Mitigations

The table opposite identifies the Financial risks the ICB is experiencing, including the impact that has crystalised in the year-to-date position, of £14.8m ❶; together with the risk that is included within the year end forecast position (FOT), £23.1m ❷ (£22.1m M10).

The FOT risk includes £5.2m of original planning risk identified relating to CHC excess inflation (£2.4m included in ❸) and ERF income (£2.8m ❹). In M10 the ICB received £1.2m in relation to Non-NHS ERF income reducing this risk.

Financial Strategic Risks							
BAF Reference	Risk Ref.	Risk Details	Risk Score	Prior Month	YTD Crystalised £m	Crystalised in FOT £m	Not in FOT £m
N/a	1	**If** Prescribing for Mental Health continues to reduce **then** further Investment will be needed to ensure delivery of the Mental Health Investment Standard which will exceed the ICBs budget.	3 x 4 = 12	3 x 4 = 12	0.0	1.0	0.0
FINCOM19	2	**If** the Independent Sector Acute activity for Ophthalmology increases **then** the ICB will exceed the Acute budgets.	Removed	Removed	2.9	7.8	0.0
N/a	3	**If** the Integrated Community Equipment Store Prices and Volume increase **then** the ICB will exceed the Community budgets.	4 x 3 = 12	4 x 3 = 12	1.7	1.8	0.0
FINCOM08	4	**If** the ICB does not deliver the Efficiency plans embedded in its forecast **then** the ICB will exceed the budgeted spend (Schemes identified as High or Medium Risk)	3 x 4 = 12	5 x 4 = 20	0.0	1.6	0.3
FINCOM20	5	**If** the uptake of the Continued Glucose Monitoring Testing and Drugs is undertaken following NICE guidance **then** the ICB will exceed the GP Prescribing budgets.	5 x 4 = 20	5 x 4 = 20	0.0	0.0	1.2
FINCOM07	6	**If** the Continuing Health Care Non-NHS market Price Rises exceed the forecasted 11% rise overall **then** the ICS will exceed the budget.	5 x 3 = 15	5 x 3 = 15	3.0	4.3 ❸	1.5
FINCOM11	7	If additional ERF activity is not achieved then this causes a full year financial adverse variance.	5 x 3 = 15	5 x 3 = 15	2.6	1.7 ❹	0.0
N/a	8	**If** the ICS System partners do not achieve the Efficiency Savings in relation to the Back Office Staff **then** the ICB who hold the gross £(5)m budget will exceed the budget.	5 x 4 = 20	5 x 4 = 20	4.6	5.0	0.0
N/a	9	**If** the ICS do not defer the System Development Fund projects **then** the slippage assumed in the plan will not be achieved and the ICB will exceed the budget.	3 x 4 = 12	3 x 4 = 12	0.0	0.0	0.0
N/a	10	Aggregated other smaller Risks across all portfolios	2 x 3 = 6	2 x 3 = 6	0.0	0.0	1.1
		Total Risks			**14.8** ❶	**23.1** ❷	**4.2**
N/a	1	Aggregated other smaller Mitigations across all portfolios	2 x 3 = 6	2 x 3 = 6	(14.8)	(23.1)	(2.9)
		Total Mitigations			**(14.8)**	**(23.1)**	**(2.9)**
FINCOM01		**Total Financial Impact of assessed risk less identified mitigations**	3 x 4 = 12	2 x 4 = 8	**0.0**	**0.0**	**1.3** ❺

In addition, the ICB has identified a net potential uncrystallised unmitigated risk of £1.3m ❺ (M10 = £1.4m). This remains at a similar level to the M10 reported position.

5. ICS Financial summary

Revenue position: The system financial performance is extracted from the Month 11 (February) WD10 IFR submission.

The position M11 YTD is a £19.6m deficit, £17.8m adverse to plan.

The most significant variances are as follows:

- JPUH: Operational pressures impacting the achievement of the additional Elective Recovery Fund, implementation and recognition of efficiency savings and the staffing of additional capacity
- NNUH: adverse variance resulting from timing of Cost Improvement Plans (CIP).

Forecast outturn for the system is a £20m deficit with JPUH adverse variance partly offset by the £4.8m surplus FOT at NNUH.

Capital position (Capital Delegated Expenditure Limit – CDEL): The year-to-date system CDEL expenditure as at February was £69.9m, £18.8m lower than below plan.

All organisations have a YTD underspend, this is mainly due to slippage/delays in project roll out of £10.5m.

The £8.8m system CDEL FOT overspend includes extra funding not yet reflected in the PFR plans:

- JPUH: RAAC funding of £3.2m.
- QEH: SEDC expansion £2m and Clinical £6.6m.

When these are included the CDEL underspend is £2.9m, largely reflecting the 'overplanning assumptions' included in the plan.

Revenue surplus/(deficit) £m	Month 11 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
JPUH	(1.5)	(20.3)	(18.9)	0.0	(24.8)	(24.8)
NNUH	0.4	(0.4)	(0.8)	0.0	4.8	4.8
QEH	(0.9)	(0.7)	0.2	0.0	0.0	0.0
NSFT	0.0	0.0	0.0	0.0	0.0	0.0
NCH&C	0.2	1.8	1.7	0.0	0.0	0.0
Provider Subtotal	**(1.8)**	**(19.6)**	**(17.8)**	**0.0**	**(20.0)**	**(20.0)**
ICB	0.0	0.0	0.0	0.0	0.0	0.0
N&W System Total	**(1.8)**	**(19.6)**	**(17.8)**	**0.0**	**(20.0)**	**(20.0)**

System CDEL	Month 11 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance (Under)/Over	Plan	Actual	Variance (Under)/Over
	£m	£m	£m	£m	£m	£m
JPH	20.3	17.3	(3.0)	24.6	27.5	2.9
NNUH	16.9	10.3	(6.6)	17.9	15.4	(2.5)
QEH	36.7	31.3	(5.4)	40.5	49.1	8.6
NSFT	9.1	6.8	(2.3)	9.8	9.8	(0.0)
NCH&C	5.6	4.2	(1.4)	6.0	5.8	(0.2)
N&W System Total	**88.7**	**69.9**	**(18.8)**	**98.9**	**107.7**	**8.8**

Glossary of terms (1)

Term	Description
BCF: Better Care Fund	A programme which supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.
BPPC: Better Payment Practice Code	The NHS national payments code for good practice with associated mandated reporting. Sets a target of 95% compliance of paying suppliers within 30 days.
Cat M: Category M drugs	Part of the Drug Tariff which is used to set the reimbursement prices of over 500 medicines. It is the principal price adjustment mechanism to ensure delivery of the retained margin guaranteed as part of the contractual framework, using information gathered from manufacturers on volumes and prices of products sold plus information from the Pricing Authority on dispensing volumes to set prices each quarter.
CIP: Cost Improvement Programme	A provider measure of Efficiency and Productivity.
CHC: Continuing Health Care	A package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive funding individuals have to be assessed according to a legally prescribed decision making process to determine whether the individual has a 'primary health need'.
GIRFT: Get It Right First Time	A national programme designed to improve the treatment and care of patients by reviewing health services. The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.
GMS: General Medical Services	Contract which forms the basis of the relationship between the NHS and its GP contractors. The current contract came into force on 1 April 2004 and has been negotiated and updated annually between NHS Employers and the British Medical Association (BMA) since then. It is based upon a multi facetted formula which identifies spend and applies specific ratios resulting in an overall annual percentage pay award for each practice.
GPFV: General Practice Forward View	National development programme of investment in workforce, technology and estates designed to speed up transformation of General Practice services.
HDP: Hospital Discharge Programme	National funding stream to enable earlier discharge increasing flow in the system and release capacity in the acute hospitals.
LCS / LES: Locally Commissioned Services or Locally Enhanced Services	Services provided by GP practices that are either enhanced or additional to the core services offered. These are generally commissioned to meet a local need based on either deprivation or proximity to existing services. Includes services such as phlebotomy, anti-coagulation, atrial fibrillation and care homes. They can reduce onward referrals to Acute settings and funding is separate to practices core contracts.
Model Hospital	An NHS digital information service designed to help the NHS improve productivity, quality and efficiency. Enables health systems and trusts to compare their productivity and quality, and identify opportunities to improve.

Glossary of terms (2)

Term	Description
MHIS: Mental Health Investment Standard	The nationally set requirement for ICBs to increase investment in Mental Health services in line with their overall increase in allocation each year. This is subject to separate external audit on an annual basis to confirm compliance.
NCSO: No Cheaper Stock Obtainable	Items for which in the opinion of the Secretary of State for Health there is no product available to contractors at the price in Part VIII of the Drug Tariff, generally resulting in a higher priced product having to be used.
PHM: Population Health Management	An approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population by focusing on the wider determinants of health by using data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources.
PLICS: Patient Level Information and Costing Systems	Costing system which brings together healthcare activity information with financial information in one place. PLICS provides detailed information about how resources are used at patient-level, for example, staff, drugs, and diagnostic tests and combined with other data sources, provides trusts with a rich source of information to help understand their patients and their services.
PMS: Personal Medical Services	Voluntary option for GPs and other NHS staff to enter into locally negotiated contracts. PMS contracts offer local flexibility compared to the nationally negotiated GMS contracts by offering variation in the range of services which may be provided by the practice, the financial arrangements for those services and the provider structure (who can hold a contract).
QIPP: Quality, Innovation, Productivity and Prevention	The collective measure of system transformation efficiencies and productivity.
QOF: Quality and Outcomes Framework payments	This is a voluntary annual reward and incentive programme for all GP practices in England, detailing practice achievement results. It is not about performance management but resourcing and rewarding good practice.
Rightcare	Teams who work locally with systems to present a diagnosis of data and evidence across that population, working collaboratively with systems to look at the evidence to identify opportunities and potential threats. They use nationally collected robust data to complete delivery plans on a continuous basis, to evaluate the system and establish a base plan to maximise opportunities and turnaround issues.
Running costs / Programme costs	Running costs represent the costs of administering the ICB and the work it carries out / Programme costs represent the costs of services commissioned by the ICB.
s.117: Section 117 of Mental Health Act 1983	Entitlement to free after-care if a patient has been in hospital under specific sections of the Mental Health Act 1983. It meets the needs that a patient has because of the mental health condition that caused them to be detained and is designed to reduce the chance of the condition getting worse so avoiding a return to hospital.

Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	**Review of the Governance Handbook**
Presented by:	**Karen Barker, Director of Corporate Governance and ICS Development**
Prepared by:	**Amanda Brown, Head of Corporate Governance**
Submitted to:	**ICB Board**
Date:	**28 March 2023**

Purpose of paper:

To present an updated Governance Handbook to the Board for approval.

Executive Summary:

Introduction
Further to Board approval on 1 July 2022, an updated NHS Norfolk and Waveney Integrated Care Board (ICB) Governance Handbook is attached for Board approval. The document sets out the changes proposed in track.

The Governance Handbook is designed to support and supplement the ICB Constitution. It sets out a framework which demonstrates the ICB's governance arrangements for exercising its duties and functions. In this respect, whilst it is not a legal requirement to have a Governance Handbook, it supports the ICB to build a consistent corporate approach and form part of the corporate memory.

The approved version of this document will become version 2.

Changes made to the document are summarized below:

Sections 1 to 4 – No change

Section 5 – Scheme of Reservation and Delegation
Changes to these terms of reference concerning the transition of Pharmacy, Optometry and Dentistry from NHS England to the ICB have already been approved by the Board and have been incorporated into the attached document.

Section 6 – Model Standing Financial Instructions

Deleted the word ‘assurance’ from title of Audit and Risk Committee

Section 7 – Approach to working with people and communities
This is a working draft that describes the ICBs approach to working with people and communities. Please note that due to the way this document has been inserted into the Governance Handbook it will appear as if it has been completely re-written but that is not the case. The following details the changes that have been made:

- Branding changed from In Good Health to Improving Lives Together
- Updated version control
- Added link to control page to NHSE feedback not available at time of previous publication
- Removed an appendix that showed an out of date timeline
- Updated the introduction to remove reference to a mapping exercise that didn’t really work
- Aims and principles - Removed the page numbers that signposted to other parts of the document as it made it very confusing and hard to keep up to date and updated to reflect P&C committee meetings, and named C&E reps for Place.
- Changed tense throughout the document to update as appropriate from we will to we have/are to reflect that work is moving on.
- Updated progress to date but challenges remain the same
- Updated the section on page 20 to reflect progress on co-production and removed the graphic about the people and communities hub
- Also updated the section on patient voice in primary care to reflect progress
- Updated the Quality Management Approach section to focus more on the co-production projects
- Updated the ‘how will we know this works’ and governance sections

Section 8 – Conflicts of Interest Policy
The ICB’s Conflicts of Interest Policy has been completely refreshed following the findings from a recent learning event. This enabled the ICB to test its resilience and processes and provided an opportunity to talk with colleagues to gather their feedback. Further, it provided the chance to look at other ICBs to see what is working well in other geographically similar systems. Accordingly, we brought all this information together to draft this final policy presented to the board today.

Section 9 – Standards of Business Conduct Policy
Minor changes made to correct the name of the Audit and Risk Committee, reference to the secondary employment policy and stipulate that any secondary employment is declared on the individual’s declarations of interest form.

Section 10 – Petitions Policy
No changes.

Section 11 – Eligible nominating PMS (GMS/APMS) Providers
Practice names updated

Section 12 – Working with voluntary, community and social enterprise organisation’s

No change

Changes to Committee's Terms of Reference
Changes have been made to those committees as indicated below.

Appendix A - Integrated Care Partnership
The Norfolk and Waveney Integrated Care Partnership agreed to make two changes to its Terms of Reference at its meeting held on 8 March 2023. The first was to extend the deadline for Member and Public questions to three working days' notice, and the second was to add the chairs of our Place Boards to the membership of the ICP.

Appendix B – Audit and Risk Committee
Membership amended so that in addition to the chair of the committee there is a minimum of 2 but up to 3 non-executive members.

Appendix C – Remuneration, People and Culture Committee
Amendments have been made to section 6 which concerns the responsibilities of the Committee. These changes expand on the requirements for scrutinising the delivery of the strategic people priorities and to make clear that the committee will have oversight and provide assurance to the Board that the ICS is delivering against the ten outcomes-based functions.

Appendix D – Patients and Communities Committee
The Committee will be considering amendments to its terms of reference at its meeting in March. Proposed amendments will therefore be brought to the May Board meeting for approval.

Appendix E – Finance Committee
The membership of the committee has been updated to remove one of the ICB executive board members (either the CEO, Director of Nursing or Medical Director). In addition, a clinical person from a provider active within the Norfolk and Waveney locality has been added to the part 1 attendance.

Appendix F – Primary Care Commissioning Committee
Changes to these terms of reference concerning the transition of Pharmacy, Optometry and Dentistry from NHS England to the ICB have already been approved by the Board and have been incorporated into the attached document.

Appendix G – Quality and Safety Committee
The committee have reviewed their terms of reference and propose several changes to ensure they are fit for purpose. These include expanding the part 1 only members as well as tidying up wording and clarifying responsibilities of the committee. The committee's objectives have also been reviewed and are included as an appendix to the terms of reference.

Appendix H – Performance Committee
Amendments have been made to membership by removing the medical director or nominated deputy and changes to attendees have also been made.

Appendix I – Conflicts of Interest Sub Committee
The purpose of a Conflicts of Interest Committee is to act independently when conflicts of interest occur and provide a space to deliberate matters of interest. Changes have been made to the Terms of Reference to ensure the Committee has an appropriate level of responsibility to discuss and decide upon possible breaches of the ICB's Conflicts of Interest Policy. Therefore, the changes (in addition to standard changes in language and terms) have been made to address this gap and ensure the role is covered by the Committee.

The Board is asked to note and approve the proposed amendments to the ICB Governance Handbook.

Recommendation to the Board:

The Board is asked to approve the amendments to the ICB Governance Handbook.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	Ensuring that the ICB has appropriate governance processes in place is a key part of maintaining it's reputation.
Legal:	Ensuring that the ICB is compliant with statutory requirements.
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	For Board approval.

Norfolk and Waveney
Integrated Care Board

NHS NORFOLK & WAVENEY INTEGRATED CARE BOARD

GOVERNANCE HANDBOOK

Version 1.4

Revision History

Document Control Sheet

Revision Date	Summary of changes	Author(s)	Version Number
December 2022 to March 2023	Amendments made to committee terms of reference: Integrated Care Partnership, Performance Committee, Audit and Risk Committee, Quality and Safety Committee, Remuneration, People and Culture Committee, Finance Committee, Conflicts of Interest Committee – additional attendees included. Finance Committee, clarification of Part 1 attendees roles. Updates to Conflicts of Interest Policy, Standards of Business Conduct Policy.	Corporate Affairs	1.2
February 2023	Amendments made to PCCC Terms of Reference and ICB SoRD to reflect delegation of POD which were approved at February 2023 Board		1.3
March 2023	Included v10 of People Approach		1.4

Approvals

This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	NHS England	Corporate Affairs	1

Document Control Sheet

Policy title	Governance Handbook
Policy area	This Policy has been prepared and reviewed by the Corporate Affairs team.
Who is it aimed at and which settings?	All staff whether temporary, fixed term, or under consultancy, contract for services or agency arrangements, Governing Body and Committee members, ICB clinical advisors and anyone else undertaking work for the ICB.
Approved by	ICB Board
Effective date	1 July 2022
Review date	Annually

Contents

SECTION 1
Introduction

Introduction to the Governance Handbook
The purpose of this document is to bring together a range of corporate statutory documents into one place and is described as the NHS Norfolk and Waveney Integrated Care Board Governance Handbook (the "Governance Handbook").

The Governance Handbook is designed to support and supplement the ICB's Constitution. It sets out a framework which demonstrates the ICB's governance arrangements for exercising its duties and functions. In this respect, whilst it is not a legal requirement to have a Governance Handbook, it supports the ICB to build a consistent corporate approach and form part of the corporate memory.

The Governance Handbook sets out how the general public can inform decision making (see in particular section 7 on people and communities approach) and who makes decisions (see the ICB's functions and decision map at section 3.) The general public can always find out what is happening at the ICB via our website at www.improvinglivesnw.org.uk or by attending one of our meetings held in public.

Accordingly, the Governance Handbook will be published on the ICB website for transparency and ease of access and will be updated regularly as a matter of routine.

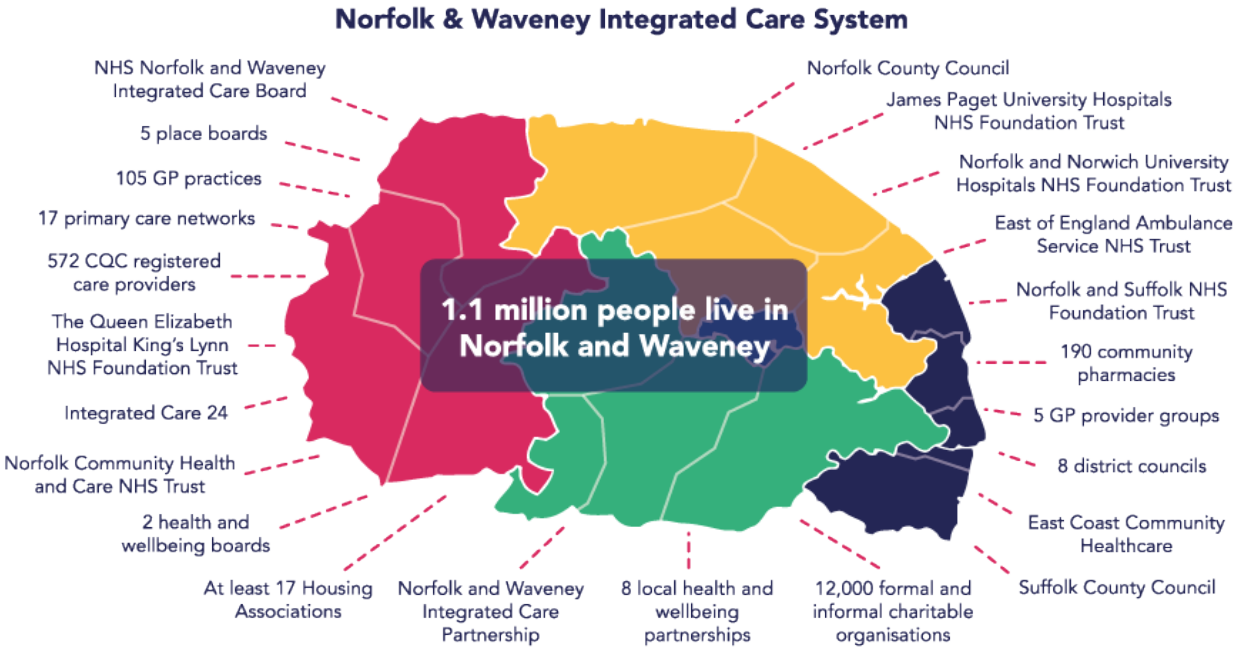
The Governance Handbook includes:

- Introduction
- Governance Structure
- Functions and Decisions Map
- Scheme of Reservation and Delegation (including delegation arrangements)
- Standing Financial Instructions
- People and Communities Approach
- Conflicts of Interest Policy
- Standards of Business Conduct Policy
- Petitions Policy
- Eligible nominating PMS (GMS/APMS) Providers
- Working with Voluntary, Community and Social Enterprise

The Terms of Reference for the ICB's Committees and also the statutory committee of the Integrated Care Partnership are contained in the appendices

SECTION 2
Governance Structure

Integrated Care Systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. This diagram shows the wide range of organisations that form the Norfolk and Waveney Integrated Care System:



The mission of our ICS is: To help the people of Norfolk and Waveney to live longer, healthier and happier lives.

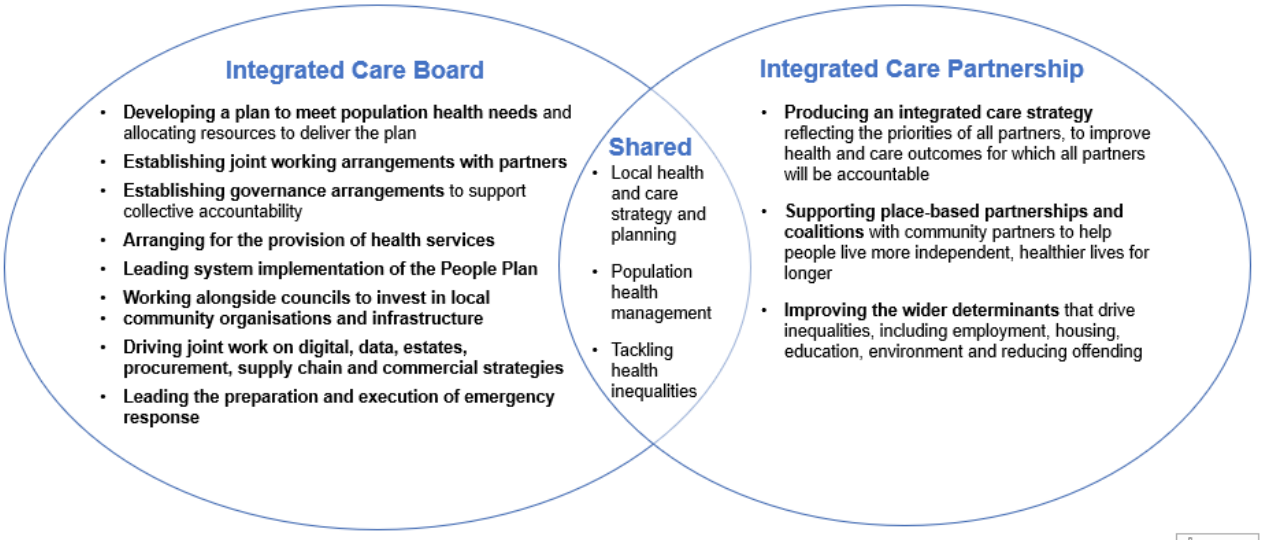
Like all Integrated Care Systems in England, we will work to:

Each ICS must include an Integrated Care Board and an Integrated Care Partnership:

- **NHS Norfolk and Waveney Integrated Care Board (ICB)** is accountable for the overall performance and finances of the NHS in Norfolk and Waveney. The ICB was established on 1 July 2022, following the dissolution of NHS Norfolk and Waveney Clinical Commissioning Group on 30 June 2022. However the ICB has a very different role to the CCG – helping to bring organisations together, working collaboratively, removing traditional barriers and more.

- **Norfolk and Waveney Integrated Care Partnership (ICP)** is responsible for agreeing an integrated care strategy for improving the health care, social care and public health across the whole population. It works to address the wider determinants of health, such as employment and housing. The partnership is established locally and jointly by the Suffolk and Norfolk county councils and the ICB.

The ICP and ICB are of equal importance. Unlike the ICB, the ICP is a statutory committee of the ICS, not a statutory body, and as such its members can come together to take decisions on an integrated care strategy, but it does not take on functions from other parts of the system. The diagram below shows the different roles of the ICB and the ICP:



ICB Constitution

The ICB Constitution is based on the model constitution produced by NHS England (NHSEI). The ICB model constitution is based on the Health and Care Act and NHSE policy as well as legal requirements that must be included in the Constitution. The ICB Constitution has been approved by NHSE and by the ICB Board. Applications for changes to the Constitution are made to NHSE following approval by the Board. The ICB Constitution is published on the ICB website www.improvinglivesnw.org.uk .

The Board of the ICB

The Board of the ICB is a unitary Board that meets in public every other month. Details of meeting dates and times as well as papers can be found on the ICB website. The purpose of the Board is to govern effectively and in doing so, build patient, public and stakeholder confidence that their healthcare is in safe hands. The Board is responsible for:

- Formulating strategy for the organisation (taking into account the ICP's Integrated Care Strategy)
- Holding the organisation to account for delivery of the strategy

- Being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable
- Shaping a healthy culture for the organisation and the wider ICS partnership.

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.

The members of the Board of the ICB Board can be viewed on the website www.improvinglivesnw.org.uk.

ICB Committees
The following committees support the work of the Board:

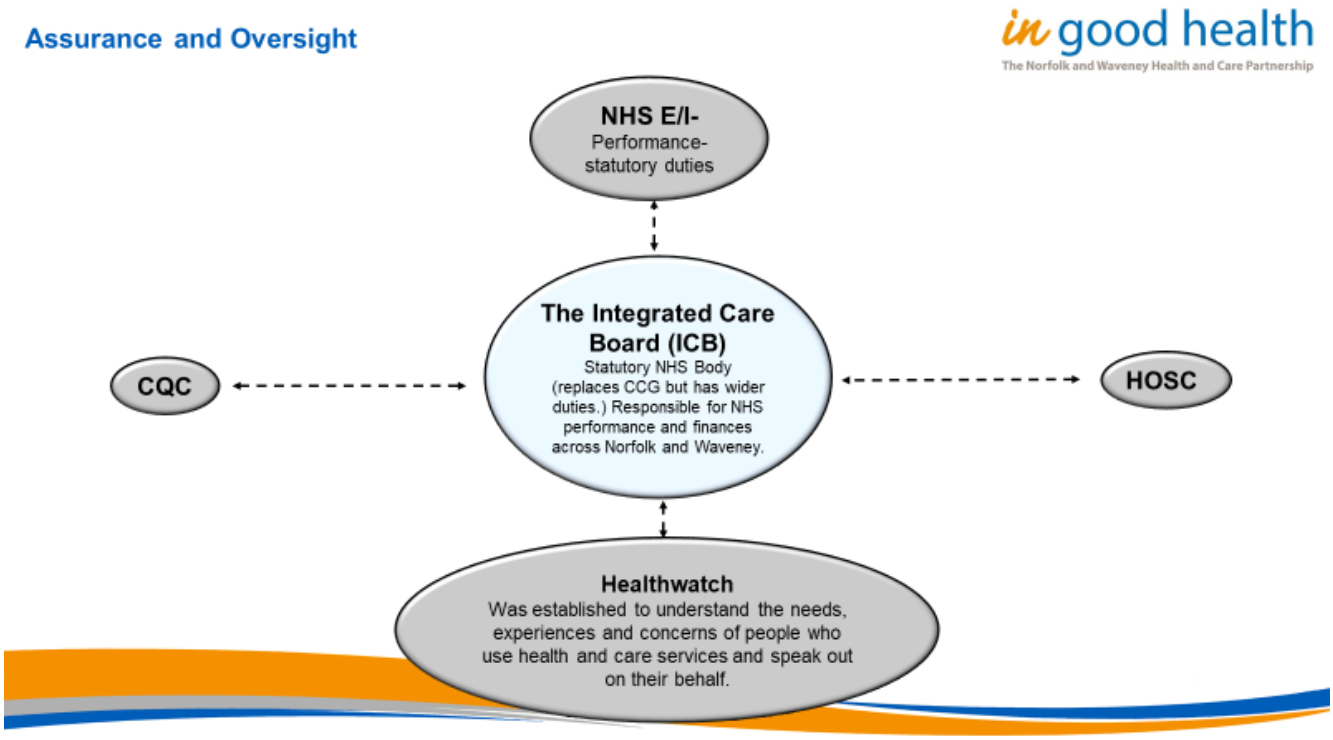
Name of Committee	Remit	Chair
Audit and Risk Committee	The Audit and Risk Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.	Non-Executive Member for Audit and Risk
Remuneration, People and Culture Committee	This Committee's statutory purpose is to confirm the ICB Pay Policy, but the committee will also have a remit with regard to organisational development and ensuring work is developed on culture and for our staff.	Non-Executive Member for Remuneration, People and Culture
Patients, and Communities Committee	The purpose of this committee is to ensure that there is rigour and challenge with regard to the ICB's ambitious transformation objectives.	Non-Executive Member
Finance Committee	This Committee provides oversight of financial matters bringing external and impartial rigour and challenge to the management of the ICB's finances.	Non-Executive Member for Finance
Primary Care Commissioning Committee	The Committee enables collective decisions on the review, planning and procurement of primary care services in Norfolk & Waveney.	Local Authority Partner Member from ICB Board
Quality and Safety Committee	The Committee is responsible for the oversight and development of the ICB's Quality Strategy, which sets out its plan for quality and safety improvement.	Non-Executive Member
Performance Committee	The committee will ensure oversight of the delivery of key performance standards by commissioned providers, performance of the system against the NHS Outcomes Framework and progress with improving wider outcome measures of population health.	ICB Board Partner Member, Primary Medical Services
Conflicts of Interest Committee (sub committee)	The sub-Committee is authorised to make decisions on behalf of the ICB with regard to issues which cannot be decided by the Board due to the Board not being quorate as a result of conflicts of interest.	Non-Executive Member for Audit and Risk

In addition, the Norfolk and Waveney Integrated Care Partnership, as a statutory committee jointly formed between the Norfolk and Waveney Integrated Care Board and Norfolk County Council and Suffolk County Council.

Name of Statutory Committee	Remit	Chair
Integrated Care Partnership	The Integrated Care Partnership will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.	Cabinet member for Adult Social Care, Public Health and Prevention, Norfolk County Council

Assurance and Oversight

The diagram below sets out the system for assurance and oversight of the ICB.



SECTION 3
Functions and Decision Map

As prescribed by the ICB's Constitution and legislative requirements, the ICB must publish within its Governance Handbook a Functions and Decision Map.

The purpose of a Functions and Decision Map is to provide a high-level structural chart that sets out which decisions are delegated and taken by which parts of the system.

Our Functions and Decisions Map is based on a framework made up of tiered model which allows delegation to different levels. The tiered delegated model can be seen below.

A tiered delegated model

in good health
The Norfolk and Waveney Health and Care Partnership

A tiered delegation model is proposed, that will receive c200 functions from the CCG but will preserve the partnership approach to delivery and improvement and form the basis of a model that can more easily evolve as Place and Provider Collaborative arrangements develop.

Committee structure

ICB Board and Committee Structure (formal delegation)

in good health
The Norfolk and Waveney Health and Care Partnership

NHS Norfolk and Waveney Integrated Care Board

Audit and Risk Committee	Remuneration, People and Culture Committee	Primary Care Committee	Patient and Communities committee	Performance Committee	Finance Committee	Quality and Safety Committee
The Committee will contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.	The Committee's statutory purpose is to confirm the ICB Pay Policy but the Committee will also have a remit with regard to organisational development and ensuring work is developed on culture and for our staff.	The Committee will enable collective decisions on the review, planning and procurement of primary care services in Norfolk & Waveney.	The Committee will ensure there is rigour and challenge with regard to the ICB's ambitious transformation objectives.	The Committee will ensure oversight of the delivery of key performance standards by commissioned providers, performance of the system against the NHS Outcomes Framework and progress with improving wider outcome measures of population health. Replaces SIAG.	The Committee will bring oversight of financial matters bringing external and impartial rigour and challenge to the management of the ICB's finances.	The Committee is responsible for the oversight and development of the ICB's Quality Strategy, which sets out its plan for quality and safety improvement.

Conflicts of Interest Sub Committee
The sub-Committee is authorised to make decisions on behalf of the ICB with regard to issues which cannot be decided by the Board due to the Board not being quorate as a result of conflicts of interest.

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SECTION 4
Delegation Agreements

This section sets out the 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.

Delegations under this section are set out in the ICB's Scheme of Reservation and Delegation that can be found in section 5 of this document.

Norfolk and Waveney
Integrated Care Board

SECTION 5

NHS Norfolk and Waveney Integrated Care Board

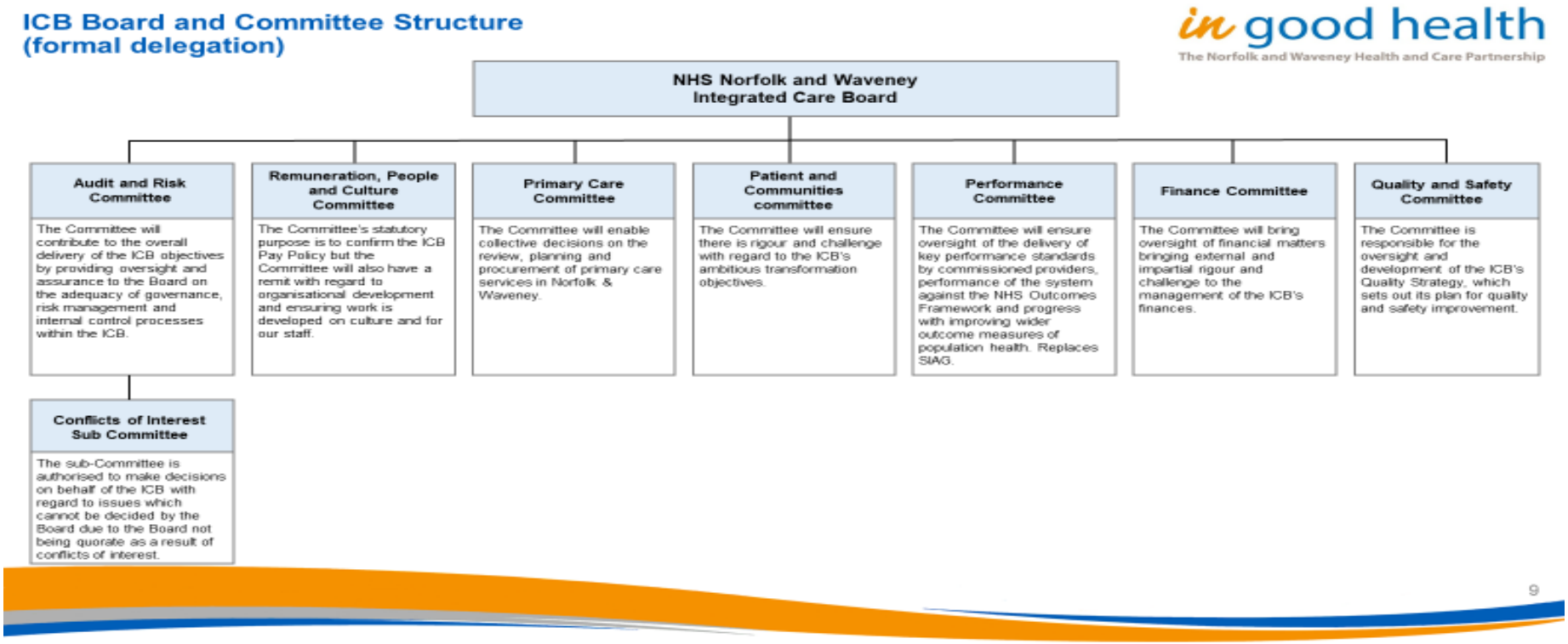
Scheme of Reservation and Delegation (SoRD)

The Scheme of Reservation and Delegation (SoRD) sets out:

- Those functions that are reserved to the Board
- Those functions that have been delegated to an individual or to Committees and Sub-Committees
- Those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act

In line with Section 4.4 of the ICB Constitution, the ICB Board 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

This SoRD will be published in full on our website www.improvinglivesnw.org.uk



Decisions and functions reserved to the board

	Decisions and functions reserved to the board	Reference
Annual Report	Approval of the ICB's Annual Report and Accounts	Section 7.4 of the Constitution
Finance	Approval of arrangements for discharging the ICB's statutory financial duties.	
Finance	Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income	

	and expenditure of the ICB's ability to achieve its agreed strategic aims.	
Finance	Approval for arrangements for risk sharing and or risk pooling with other organisations (for e.g. pooled funds with other ICBs or pooled budget arrangements under section 75 of the NHS act 2006)	
Remuneration	Remuneration for non-executive members. Any discussions about remuneration for the non-executive members will be held without the non-executive members present	S 3.14 of the Constitution
Scheme of Reservation and Delegation	Approval of the Scheme of Reservation and Delegation including: Decisions that individual employees of the ICB participating in joint arrangements on behalf of the ICB can make. Such delegated decisions must be disclosed in this scheme of reservation and delegation. Approve decisions delegated to joint committee established under section 75 of the 2006 Act.	Section 4.4.2 of the Constitution
IFR	Approval of arrangements for managing exceptional funding requests.	
Corporate	Review of the ICB's governance arrangements to ensure that the ICB continues to reflect the principles of good governance.	
Corporate	Approval on changes to the Constitution (subject to subsequent NHS England approval.)	Section 1.6 of the Constitution
Corporate	Approval of amendments to the Terms of Reference of the Committees of the Board of the Integrated Care Board	Section 4.6.3 of the Constitution
Corporate	Approval of the ICB's Governance Handbook	
Corporate	Approval of the ICB's risk management arrangements	
Corporate	Approving arrangements for handling Freedom of Information requests	s. 1.4.5.f of the Constitution
Audit	Providing assurance of strategic risk	
Audit	Appointment external auditor firm	
Audit	Appointment of internal auditor firm	
Planning	Approval of the Vision and objectives of the ICB	
Planning	Approve consultation arrangements for the ICB's plan	s9 of the Constitution

Planning	Review and approval of the ICB's annual ICB plan	
EPRR	Approve the ICB's arrangements for business continuity and emergency planning.	s1.4.5g of the Constitution
Conflicts of Interest	Ensure that the Register of Interests are reviewed regularly and updated as necessary.	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote a comprehensive health service.	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to meet the public sector equality duty.	
Duties	Monitoring of progress of delivery of public sector equality duty.	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to secure public involvement	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote awareness of and have regard of the NHS Constitution.	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to act effectively, efficiently, and economically.	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to obtain appropriate advice.	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote innovation	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote research and the use of research.	
Duties	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote integration.	

Duties	Approve arrangements for co-ordinating the commissioning of services with other ICBs and or with the local authority, where appropriate	

Decisions and functions delegated by the board to ICB committees

Committee	Decisions and functions delegated to the committee	Reference
Audit and Risk Committee	**Standing Orders:** Reporting of non-compliance with the standing Orders of the ICB	Section 3.6 Standing Orders, Constitution
Audit and Risk Committee	**Standing Orders:** Reporting of urgent decisions taken by the Board for review	Section 4.9.6 of the Standing orders, Constitution
Audit and Risk Committee	**Annual report and Accounts:** To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.	ToR
Audit and Risk Committee	**Annual report and Accounts:** To review the annual report and financial statements (including accounting policies) before submission to the Board	ToR
Audit and Risk Committee	**Risk and Internal Control:** To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks.	ToR
Audit and Risk Committee	**Risk and Internal Control:** To have oversight of system risks where they relate to the achievement of the ICB's objectives.	ToR
Audit and Risk Committee	**Risk and Internal Control:** To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.	ToR

Audit and Risk Committee	**Risk and Internal Control:** To identify opportunities to improve governance, risk management and internal control processes across the ICB.	ToR
Audit and Risk Committee	**Internal Audit:** Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework. Considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources. Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and Monitoring the effectiveness of internal audit and carrying out an annual review. Recommend appointment of internal auditors.	ToR
Audit and Risk Committee	**External Audit**: Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses. The Audit panel will be formed to recommend the appointment of External Auditors.	ToR
Audit and Risk Committee	**Counter Fraud:** Approve the ICB's Counter Fraud and security management arrangements.	ToR
Audit and Risk Committee	**Counter Fraud:** To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.	ToR

Audit and Risk Committee	**Freedom to Speak Up:** To review the adequacy and security of the ICB's arrangements for its employees, contractors, and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.	ToR
Audit and Risk Committee	**Conflicts of Interest**: The Committee shall satisfy itself that the ICB's policy, systems, and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.	ToR
Audit and Risk Committee	**Finance:** To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.	ToR
Audit and Risk Committee	**Finance:** To ensure consistency that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.	ToR
Audit and Risk Committee	**Finance:** Review of ICB risk sharing or risk pooling arrangements	ToR
Audit and Risk Committee	**Finance:** Approval the ICB's banking arrangements	ToR
Audit and Risk Committee	**IG:** To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.	ToR

Audit and Risk Committee	**IG:** Approval of the arrangements for ensuring the appropriate safekeeping and confidentiality of records and for the storage management and transfer of information and data	ToR
Remuneration, people and culture committee	For the Chief Executive, Members of the Board 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.	s. 8.1.6 of the Constitution
Remuneration, people and culture committee	For the Chief Executive, Members of the Board and other Very Senior Managers -Determine arrangements for termination of employment and other contractual terms and non-contractual terms.	s. 8.1.6 of the Constitution
Remuneration, people and culture committee	Approval of the nominations and appointments process for Board members.	ToR
Remuneration, people and culture committee	Oversight of executive board member performance	ToR
Remuneration, people and culture committee	For all ICB staff -Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change) including staff on very senior managers grade, including all board members, excluding the Chair and Non-Executive Members.	s. 8.1.6 of the Constitution ToR
Remuneration, people and culture committee	For all ICB Staff- Oversee contractual arrangements.	s. 8.1.6 of the Constitution
Remuneration, people and culture committee	For all ICB Staff -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.	s. 8.1.6 of the Constitution

Remuneration, people and culture committee	For Clinical Advisors- Determine ICB pay policy and oversee contractual arrangements.	s. 8.1.6 of the Constitution
Remuneration, people and culture committee	Oversee the development of an ICB culture and Organisational Development plan, taking into account national People and OD frameworks, and recognising the changing needs of our people to ensure the ICB is best place to work	ToR
Remuneration, people and culture committee	Assurance as to succession planning for the Board.	ToR
Remuneration, people and culture committee	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).	ToR
Remuneration, people and culture committee	Approve human resources policies for employees and for other persons working on behalf of the ICB.	ToR
Remuneration, people and culture committee	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote education and training for persons who are employed or are considering becoming employed in an activity which is connected with the health service.	ToR
Finance committee	To set the strategic financial framework of the ICB and ICS and monitor performance against it.	Terms of Reference
Finance committee	To develop the system financial information systems and processes to be used to make recommendations to the Board on financial planning in line with the strategy and national guidance	Terms of Reference
Finance committee	To work with ICS partners to identify and allocate resources where appropriate to address financial performance, quality and safety	Terms of Reference

	related issues that may arise and to ensure Value for Money in that resource allocation	
Finance committee	To work with ICS partners to consider major investment/disinvestment business cases for material (smaller of 3% of organisational annual expenditure and £5m with a de-minimus level of £1m) service change or efficiency schemes and to agree a process for sign off	Terms of Reference
Finance committee	To articulate the financial position and financial impacts (both short and long-term) to support decision-making	Terms of Reference
Finance committee	To develop a medium- and long-term financial plan, consistent with strategic and operational plans	Terms of Reference
Finance committee	To oversee the management of the system financial target and the ICB's own financial targets	Terms of Reference
Finance committee	To monitor and report to the board overall financial performance against national and local metrics, highlighting areas of concern	Terms of Reference
Finance committee	To monitor and report to the board key service performance which should be taken into account in assessing the financial position	Terms of Reference
Finance committee	To develop the system estates strategy and plan to ensure it properly balances clinical, strategic and affordability drivers (if not covered by separate strategic estates forum)	Terms of Reference
Finance committee	To monitor the system capital programme against the capital envelope and take action to ensure that it is appropriately and completely used	Terms of Reference
Finance committee	To gain assurance that the estates, digital and clinical strategic plans are built into system financial plans and strategy to ensure effective oversight of future prioritisation and capital funding bids	Terms of Reference

Conflicts of Interest Committee	Where decisions are required to be made on behalf of the ICB but cannot due be decided by the Board dues to the Board not being quorate as a result of conflicts of interest decisions are to be taken by the conflicts of interest committee. The committee has authority to act in accordance with this SoRD and its terms of reference.	Terms of Reference
Conflicts of Interest Committee	Responsibility for overseeing the ICB's policies and procedures with regard to conflicts of interest	Terms of Reference
Patients and Communities Committee	Approve the ICB's arrangements for handling complaints.	Terms of Reference
Patients and Communities Committee	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to have regard to the need to reduce inequalities	Terms of Reference
Patients and Communities Committee	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote the involvement of patients, their carers and representatives in decisions about their healthcare.	Terms of Reference
Patients and Communities Committee	Review and approve arrangements as to the delegations to place boards or place Directors.	Terms of Reference
Quality and Safety Committee	Be assured that there are robust processes in place for the effective management of quality • Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern • Agree and put forward the key quality priorities that are included within the ICB strategy/ annual plan, including priorities to address variation/ inequalities in care	Terms of Reference

	• Oversee and monitor delivery of the ICB key statutory requirements	
	• Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner	Terms of Reference
	• Approve arrangements including supporting policies to minimise clinical risk maximise patient safety and to secure continuous improvement in quality and patient outcomes	Terms of Reference
	• Approval of the arrangements for discharging the CCG's statutory duty associated with its commissioning functions to act with a view to securing continuous improvements to the quality of services.	Terms of Reference
	• Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained • Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites • Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes • Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place • Receive assurance that the ICB identifies lessons learned from all relevant sources, including, incidents, never events,	Terms of Reference

	complaints and claims and ensures that learning is disseminated and embedded • Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD report) • To be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety. • Receive assurance that the ICB has effective and transparent mechanisms in place to monitor the quality of Children, Maternity and Neonatal care. • Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality and Safety Committee (e.g., System Quality Group, Infection Prevention and Control, Safeguarding Boards / Hubs etc.).	

Performance Committee	The Committee will ensure oversight of the delivery of key performance standards by commissioned providers, performance of the system against the NHS Outcomes Framework and progress with improving wider outcome measures of population health. The responsibilities and decision making remit will include but not be limited to: a) Evaluation of health services b) Provider resilience and failure c) Performance review and management d) Conduct and lead oversight of both system and commissioned provider performance. e) Hold the system's Groups, Place(s) and Providers to account and provide challenge to the system where this is required to address opportunities to improve performance and outcomes. f) Determine where a Peer Review approach is required to support improvement in the system; overseeing the subsequent review and ensuring the learning is implemented. g) Determine where a 'deep dive' is required on a particular measure and relevant to one or more providers. h) Facilitate targeted national support through the System Improvement Director (SID). i) In line with the SOF and the system's associated SOF segmentation, where relevant, agree with the SID a Service Improvement Plan (SIP). j) Direct improvement resources when required in the system, including defining the parameters of any new improvement plans, peer review of existing plans where expected outcomes are not delivered and coordinating with regulators where formal improvement or intervention support is required.	

	k) Approve the KPIs and outcome metrics for use across the system. l) Agree the scope and approve the development plan for the system's Integrated Performance Report (IPR) for use at System, Place and Provider level. m) Negotiate any metrics or improvement trajectories with NHSE/I, relevant to SOF segmentation as may be required from time to time. n) Support innovation and best practice to be consistently adopted across the system. **o)** Ensure the system is optimally using benchmarking data for performance improvement. p) Work jointly with NHSE/I to lead the oversight of place-based arrangements and individual organisations in line with SOF principles. q) Agree and coordinate any support and intervention carried out by NHSE/I, other than in exceptional circumstances. r) Participate in any place-based system, functional or organisational support and intervention carried out by NHSE/I. s) Create robust cross-organisational arrangements to tackle the systemic challenges that the health and care system is facing. t) Act as a leadership cohort, demonstrating what can be achieved with strong local leadership, operating with increased freedoms and flexibilities	

Primary Care Commissioning Committee	NHS England has delegated to the ICB authority to exercise the primary care commissioning and dental functions in accordance with section 13Z of the NHS Act and as set out in Schedule 2 of the Delegation Agreement as follows: **Schedule 2A: Primary medical services** • decisions in relation to the commissioning and management of Primary Medical Services; • planning Primary Medical Services in the Area, including carrying out needs assessments; • undertaking reviews of Primary Medical Services in respect of the Area; • management of the Delegated Funds in the Area; • co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and • such other ancillary activities that are necessary in order to exercise the Delegated Functions. **Schedule 2B: Primary dental services and prescribed dental services** • decisions in relation to the commissioning and management of Primary Dental, Services; for clarity this includes primary care, community care/special care dental services and secondary care dental services; • planning Primary Dental Services in the Area, including carrying out needs assessments; • undertaking reviews of Primary Dental Services in the Area; • management of the Delegated Funds in the Area;	Terms of Reference

	• co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and • such other ancillary activities that are necessary in order to exercise the Delegated Functions. **Schedule 2C: Primary ophthalmic services** Ophthalmic services are hosted by Hertfordshire and West Essex Integrated Care Board (H&WE ICB) on behalf of the ICB. In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will report general optometry services matters to the Committee including information to support decision making as and when matters arise. The ICB remains responsible and accountable for the provision of this service. • decisions in relation to the management of Primary Ophthalmic Services; • undertaking reviews of Primary Ophthalmic Services in the Area; • management of the Delegated Funds in the Area; • co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and • such other ancillary activities that are necessary in order to exercise the Delegated Functions.	

	Schedule 2D: Pharmaceutical services and local pharmaceutical services Pharmaceutical services are hosted by HWE ICB on behalf of the ICB. NHS England has established mandated local committees to be known as Pharmaceutical Services Regulations Committees (PSRC). The PSRC is an ICB committee with representatives from all East of England ICBs attending. NHS England has delegated decision making to each PSRC in relation to matters under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 as amended. H&WE ICB will coordinate and host the PSRC to agreed Terms of Reference as set out in the NHS England Pharmacy Manual (https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-manual/). In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will provide quarterly reports to the Committee on decisions made at the PSRC. Applications and Notifications will be made by H&WE ICB on behalf of the ICB to the PSRC for determination. The ICB remains responsible and accountable for the provision of this service. To support the delivery of these functions the PCCC has established a Primary Medical Services Delivery Group and a Dental Services Delivery Group. The Primary Care	

	Commissioning Committee Scheme of Delegation (attached at Section 4a) sets out where decisions are made.	
Integrated Partnership Committee (ICP) statutory joint committee of ICB and Norfolk and Suffolk County Councils	Production and approval of an integrated care strategy for Norfolk and Waveney	Statutory

Decisions and functions delegated to be exercised jointly

Committee/entity that will exercise the function/decision	Decisions and functions delegated to the committee	Legal power	Governing arrangements
Norfolk County Council	Children, Adolescent Mental health Services- specifically commissioning for the integrated delivery of Tier 3 plus integrated education and healthcare solution for children aged 5-14 who have severe and challenging behaviour problems. Pooled fund.	Section 75	Section 75 Agreement dated 1 April 2016 made between NCC (1) and the CCGs of Norfolk and Waveney (2)
Norfolk County Council	Commissioning of a provider for mediation and dispute resolution services as required by Sections 52-57 of the Children and Families Act 2014	Section 75	Section 75 Agreement dated 8 June 2021

Decisions and functions delegated by the board to other statutory bodies

Body		Legal power	Governing arrangements
Norfolk County Council	Integrated Speech and Language Service for Children and Young People aged 0-19 Years	Section 75	Section 75 dated 3 March 2021

Decisions and functions delegated by the board to individual board members and employees

Individual board member or employee	Decisions and functions delegated to the individual	Reference
Chief executive	**General:** Exercise or delegation of those functions of the clinical commissioning group which have not been retained as reserved by the group, delegated to the Governing Body or other committee or sub-committee or a specified member or employee	
	HR: Approval of the arrangements of for discharging the ICBs statutory duties as an employer.	
	Finance: Approval of a comprehensive system of internal control, including budgetary control that underpins effective, efficient, and economic operation of the ICB via delegated limits set out in the financial limits.	
	Finance: Approval of the ICB's corporate budgets that meet the financial duties	
	Finance: Lead responsibility for discharge of the ICB's statutory duty associated with its	

	commissioning functions to act effectively, efficiently, and economically.	
	Finance: Approve the ICB's Financial Limits	
	Corporate: Approve proposals for action on litigation against or on behalf of the ICB.	
	Corporate: Prepare and recommend a scheme of reservation and delegation that sets out who has responsibility for operational decisions within the ICB.	
	Corporate: Prepare the ICB's Governance Handbook	
	Corporate: Exercise the powers that the Board has reserved to itself in an emergency or for an urgent decision along with the Chair.	
	Corporate: Determining arrangements for handling Freedom of Information requests	
	Strategic: Leading of the vision and objectives of the ICB	
	CSU: Approval of any contracts for commissioning or decommissioning commissioning or corporate support services to the ICB.	
Director of People	Responsibility to oversee the discharge of public sector equality duty	
Director of Finance	Prepare the ICB's Financial Limits	
	Oversee and Manage each contract on behalf of the ICB.	
	Approval of all budget movement actions between service areas subsequent to formal approval of the financial plan as delegated from the Board (with reporting to the Finance Committee as necessary.)	

Director of Nursing	ICB Executive Lead for Safeguarding for Adults and Children	
	ICB Executive Lead for Children and Young People (including Looked After Children)	
	ICB Executive Lead for Special Educational Needs and Disability ("SEND")	
	ICB Executive Lead for Infection, Prevention and Control (IPC)	
Director of Performance Transformation and Strategy	Production of the ICB's Plan.	
Chair	Exercise the powers that the Board has reserved to itself in an emergency or for an urgent decision along with the Chief Executive.	
Conflict of Interest Guardian	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;	**6.1.6 of the Constitution**

	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.	

Decisions and functions delegated to the board by other organisations

Body making the delegation	Decisions and functions delegated to the individual	Reference
NHS England	Primary Medical Services, Primary Dental Services and Prescribed Dental Services, Primary Ophthalmic Services, Pharmaceutical Services and Local Pharmaceutical Services	Delegation Agreement

SECTION 6

Model Standing Financial Instructions v1.2

Revision History

Document Control Sheet

Revision Date	Summary of changes	Author(s)	Version Number
14/06/2022	Inserted Model Standing SFIs Template v1.2	AB	1

Approvals

This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1

Document Control Sheet

Policy title	Standing Financial Instructions
Policy area	This Policy has been prepared and reviewed by the Corporate Affairs team.
Who is it aimed at and which settings?	
Approved by	
Effective date	
Review date	Annually

Integrated Care Board Model Standing Financial Instructions Template V1.2

Version 1.3, 30 May 2022

NHS England may update or supplement this document. Elements of this guidance are subject to change We also welcome feedback from system and stakeholders to help us continually improve our guidance and learn from implementation. The latest versions of all NHS England guidance relating to the development of ICSs can be found at ICS Guidance.

ICS implementation guidance

Integrated care systems (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.

They exist to achieve four aims:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- enhance **productivity and value for money**
- help the NHS support broader **social and economic development**.

Following several years of locally-led development, and based on the recommendations of NHS England, the government has set out plans to put ICSs on a statutory footing.

To support this transition, NHS England is publishing guidance and resources, drawing on learning from all over the country.

Our aim is to enable local health and care leaders to build strong and effective ICSs in every part of England.

Collaborating as ICSs will help health and care organisations 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.

Contents

Purpose and statutory framework

These Standing Financial Instructions (SFIs) shall have effect as if incorporated into the Integrated Care Board's (ICB) constitution. In accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022, the ICB must publish its constitution.

In accordance with the Act, as amended, NHS England is mandated to publish guidance for ICBs, to which each ICB must have regard, in order to discharge their duties.

The purpose of this governance document is to ensure that the ICB fulfils its statutory duty to carry out its functions effectively, efficiently and economically. The SFIs are part of the ICB's control environment for managing the organisation's financial affairs as they are designed to ensure regularity and propriety of financial transactions.

SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services.

The ICB is established under Chapter A3 of Part 2 of the National Health Service Act 2006, as inserted by the Health and Care Act 2022 and has the general function of arranging for the provision of services for the purposes of the health services in England in accordance with the Act.

Each ICB is to be established by order made by NHS England for an area within England, the order establishing an ICB makes provision for the constitution of the ICB.

All members of the ICB (its board) and all other Officers should be aware of the existence of these documents and be familiar with their detailed provisions. The ICB SFIs will be made available to all Officers on the intranet and internet website for each statutory body.

Should any difficulties arise regarding the interpretation or application of any of these SFIs, the advice of the chief executive or the chief financial officer must be sought before acting.

Failure to comply with the SFIs may result in disciplinary action in accordance with the ICBs applicable disciplinary policy and procedure in operation at that time.

Scope

All officers of the ICB, without exception, are within the scope of the SFIs without limitation. The term officer includes, permanent employees, secondees and contract workers.

Within this document, words imparting any gender include any other gender, words in the singular include the plural and words in the plural include the singular.

Any reference to an enactment is a reference to that enactment as amended.

Unless a contrary intention is evident, or the context requires otherwise, words or expressions contained in this document, will have the same meaning as set out in the applicable Act.

Roles and Responsibilities

Staff

All ICB Officers are severally and collectively, responsible to their respective employer(s) for:

- abiding by all conditions of any delegated authority;
- the security of the statutory organisations property and avoiding all forms of loss;
- ensuring integrity, accuracy, probity and value for money in the use of resources; and
- conforming to the requirements of these SFIs

Accountable Officer

The ICB constitution provides for the appointment of the chief executive by the ICB chair. The chief executive is the accountable officer for the ICB and is personally accountable to NHS England for the stewardship of ICBs allocated resources.

The chief financial officer reports directly to the ICB chief executive officer and is professionally accountable to the NHS England regional finance director

The chief executive will delegate to the chief financial officer the following responsibilities in relation to the ICB:

- preparation and audit of annual accounts;
- adherence to the directions from NHS England in relation to accounts preparation;
- ensuring that the allocated annual revenue and capital resource limits are not exceeded, jointly, with system partners;
- ensuring that there is an effective financial control framework in place to support accurate financial reporting, safeguard assets and minimise risk of financial loss;
- meeting statutory requirements relating to taxation;
- ensuring that there are suitable financial systems in place (see Section 6)
- meeting the financial targets set by NHS England;
- use of incidental powers such as management of ICB assets, entering commercial agreements;
- ensuring the Governance statement and annual accounts & reports are signed;
- ensuring planned budgets are approved by the relevant Board; developing the funding strategy for the ICB to support the board in achieving ICB objectives, including consideration of place-based budgets;
- making use of benchmarking to make sure that funds are deployed as effectively as possible;
- executive members (partner members and non-executive members) and other officers are notified of and understand their responsibilities within the SFIs;

- specific responsibilities and delegation of authority to specific job titles are confirmed;
- financial leadership and financial performance of the ICB;
- identification of key financial risks and issues relating to robust financial performance and leadership and working with relevant providers and partners to enable solutions; and
- the chief financial officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risk.

Audit and risk committee

The board and accountable officer should be supported by an audit and risk assurance committee, which should provide proactive support to the board in advising on:

- the management of key risks
- the strategic processes for risk;
- the operation of internal controls;
- control and governance and the governance statement;
- the accounting policies, the accounts, and the annual report of the ICB;
- the process for reviewing of the accounts prior to submission for audit, management's letter of representation to the external auditors; and the planned activity and results of both internal and external audit.

Management accounting and business management

The chief financial officer is responsible for maintaining policies and processes relating to the control, management and use of resources across the ICB.

The chief financial officer will delegate the budgetary control responsibilities to budget holders through a formal documented process.

The chief financial officer will ensure:

- the promotion of compliance to the SFIs through an assurance certification process;
- the promotion of long term financial heath for the NHS system (including ICS);
- budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for;
- the improvement of financial literacy of budget holders with the appropriate level of expertise and systems training;
- that the budget holders are supported in proportion to the operational risk; and
- the implementation of financial and resources plans that support the NHS Long term plan objectives.

In addition, the chief financial officer should have financial leadership responsibility for the following statutory duties:

- the duty of the ICB to perform its functions as to ensure that its expenditure does not exceed the aggregate of its allotment from NHS England and its other income; and
- the duty of the ICB, in conjunction with its partner trusts, to seek to achieve any joint financial objectives set by NHS England for the ICB and its partner trusts.

The chief financial officer and *any senior officer responsible* for finance within the ICB should also promote a culture where budget holders and decision makers consult their finance business partners in key strategic decisions that carry a financial impact.

Income, banking arrangements and debt recovery

Income

An ICB has power to do anything specified in section 7(2) of the Health and Medicines Act 1988 for the purpose of making additional income available for improving the health service.

The chief financial officer is responsible for:

- ensuring order to cash practices are designed and operated to support, efficient, accurate and timely invoicing and receipting of cash. The processes and procedures should be standardised and harmonised across the NHS System by working cooperatively with the existing Shared Services provider; and

- ensuring the debt management strategy reflects the debt management objectives of the ICB and the prevailing risks;

Banking

The CFO is responsible for ensuring the ICB complies with any directions issued by the Secretary of State with regards to the use of specified banking facilities for any specified purposes.

The chief financial officer will ensure that:

- the ICB holds the minimum number of bank accounts required to run the organisation effectively. These should be raised through the government banking services contract; and

- the ICB has effective cash management policies and procedures in place.

Debt management

The chief financial officer is responsible for the ICB debt management strategy.

This includes:

- a debt management strategy that covers end-to-end debt management from debt creation to collection or write-off in accordance with the losses and special payment procedures;

- ensuring the debt management strategy covers a minimum period of 3 years and must be reviewed and endorsed by the ICB board every 12 months to ensure relevance and provide assurance;
- accountability to the ICB board that debt is being managed effectively;
- accountabilities and responsibilities are defined with regards to debt management to budget holders; and
- responsibility to appoint a senior officer responsible for day to day management of debt.

Financial systems and processes

Provision of finance systems

The chief financial officer is responsible for ensuring systems and processes are designed and maintained for the recording and verification of finance transactions such as payments and receivables for the ICB.

The systems and processes will ensure, inter alia, that payment for goods and services is made in accordance with the provisions of these SFIs, related procurement guidance and prompt payment practice.

As part of the contractual arrangements for ICBs officers will be granted access where appropriate to the Integrated Single Financial Environment ("ISFE"). This is the required accounting system for use by ICBs, Access is based on single access log on to enable users to perform core accounting functions such as to transacting and coding of expenditure/income in fulfilment of their roles.

The Chief Financial officer will, in relation to financial systems:

- promote awareness and understanding of financial systems, value for money and commercial issues;
- ensure that transacting is carried out efficiently in line with current best practice – e.g. e-invoicing
- ensure that the ICB meets the required financial and governance reporting requirements as a statutory body by the effective use of finance systems;
- enable the prevention and the detection of inaccuracies and fraud, and the reconstitution of any lost records;
- ensure that the financial transactions of the authority are recorded as soon as, and as accurately as, reasonably practicable;
- ensure publication and implementation of all ICB business rules and ensure that the internal finance team is appropriately resourced to deliver all statutory functions of the ICB;
- ensure that risk is appropriately managed;
- ensure identification of the duties of officers dealing with financial transactions and division of responsibilities of those officers;
- ensure the ICB has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the ICB;

- ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes; and

- where another health organisation or any other agency provides a computer service for financial applications, the chief finance officer shall periodically seek assurances that adequate controls are in operation.

Procurement and purchasing

Principles

The chief financial officer will take a lead role on behalf of the ICB to ensure that there are appropriate and effective financial, contracting, monitoring and performance arrangements in place to ensure the delivery of effective health services.

The ICB must ensure that procurement activity is in accordance with the Public Contracts Regulations 2015 (PCR) and associated statutory requirements whilst securing value for money and sustainability.

The ICB must consider, as appropriate, any applicable NHS England guidance that does not conflict with the above.

The ICB must have a Procurement Policy which sets out all of the legislative requirements.

All revenue and non-pay expenditure must be approved, in accordance with the ICB business case policy, prior to an agreement being made with a third party that enters a commitment to future expenditure.

All officers must ensure that any conflicts of interest are identified, declared and appropriately mitigated or resolved in accordance with the ICB standards of business conduct policy.

Budget holders are accountable for obtaining the necessary approvals and oversight of all expenditure incurred on the cost centres they are responsible for. This includes obtaining the necessary internal and external approvals which vary based on the type of spend, prior to procuring the goods, services or works.

Undertake any contract variations or extensions in accordance with PCR 2015 and the ICB procurement policy.

Retrospective expenditure approval should not be encouraged. Any such retrospective breaches require approval from any committee responsible for approvals before the liability is settled. Such breaches must be reported to the audit and risk assurance committee.

Staff costs and staff related non pay expenditure

Chief People Officer

The chief people officer [CPO] (or equivalent people role in the ICB) will lead the development and delivery of the long-term people strategy of the ICB ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS.

Operationally the CPO will be responsible for;

- defining and delivering the organisation's overall human resources strategy and objectives; and
- overseeing delivery of human resource services to ICB employees.

The CPO will ensure that the payroll system has adequate internal controls and suitable arrangements for processing deductions and exceptional payments.

Where a third-party payroll provider is engaged, the CPO shall closely manage this supplier through effective contract management.

The CPO is responsible for management and governance frameworks that support the ICB employees' life cycle.

Annual reporting and Accounts

The chief financial officer will ensure, on behalf of the Accountable Officer and ICB board, that:

- the ICB is in a position to produce its required monthly reporting, annual report, and accounts, as part of the setup of the new organisation; and
- the ICB, in each financial year, prepares a report on how it has discharged its functions in the previous financial year;

An annual report must, in particular, explain how the ICB has:

- discharged its duties in relating to improving quality of services, reducing inequalities, the triple aim and public involvement;
- review the extent to which the board has exercised its functions in accordance with its published 5 year forward plan and capital resource use plan; and
- review any steps that the board has taken to implement any joint local health and wellbeing strategy.

NHS England may give directions to the ICB as to the form and content of an annual report.

The ICB must give a copy of its annual report to NHS England by the date specified by NHS England in a direction and publish the report.

Internal audit

The chief executive, as the accountable officer, is responsible for ensuring there is appropriate internal audit provision in the ICB. For operational purposes, this responsibility is delegated to the chief financial officer to ensure that:

- all internal audit services provided under arrangements proposed by the chief financial officer are approved by the Audit and Risk Assurance Committee, on behalf of the ICB board;
- the ICB must have an internal audit charter. The internal audit charter must be prepared in accordance with the Public Sector Internal Audit Standards (PSIAS);
- the ICB internal audit charter and annual audit plan, must be endorsed by the ICB Accountable Officer, audit and risk assurance committee and board;

- the head of internal audit must provide an annual opinion on the overall adequacy and effectiveness of the ICB Board's framework of governance, risk management and internal control as they operated during the year, based on a systematic review and evaluation;

- the head of internal audit should attend audit and risk assurance committee meetings and have a right of access to all audit and risk assurance committee members, the Chair and chief executive of the ICB.

- the appropriate and effective financial control arrangements are in place for the ICB and that accepted internal and external audit recommendations are actioned in a timely manner.

External Audit

The chief financial officer is responsible for:

- liaising with external audit colleagues to ensure timely delivery of financial statements for audit and publication in accordance with statutory, regulatory requirements;

- ensuring that the ICB appoints an auditor in accordance with the Local Audit and Accountability Act 2014; in particular, the ICB must appoint a local auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year; the ICB must appoint a local auditor at least once every 5 years (ICBs will be informed of the transitional arrangements at a later date); and

- ensuring that the appropriate and effective financial control arrangements are in place for the ICB and that accepted external audit recommendations are actioned in a timely manner.

Losses and special payments

HM Treasury approval is required if a transaction exceeds the delegated authority, or if transactions will set a precedent, are novel, contentious or could cause repercussions elsewhere in the public sector.

The chief financial officer will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and process are in place to minimise risks from losses and special payments.

NHS England has the statutory power to require an integrated care board to provide NHS England with information. The information, is not limited to losses and special payments, must be provided in such form, and at such time or within such period, as NHS England may require.

ICBs will work with NHS England teams to ensure there is assurance over all exit packages which may include special severance payments. ICBs have no delegated authority for special severance payments and will refer to the guidance on that to obtain the approval of such payments

All losses and special payments (including special severance payments) must be reported to the ICB Audit and Risk Assurance Committee.

For detailed operational guidance on losses and special payments, please refer to the ICB losses and special payment guide which includes delegated limits.

Fraud, bribery and corruption (Economic crime)

The ICB is committed to identifying, investigating and preventing economic crime.

The ICB chief financial officer is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the board and Audit and Risk Assurance Committee and defined roles and accountabilities for those involved as part of the process of providing assurance to the board.

These arrangements should comply with the NHS Requirements the Government Functional Standard 013 Counter Fraud as issued by NHS Counter Fraud Authority and any guidance issued by NHS England .

Capital Investments & security of assets and Grants

The chief financial officer is responsible for:

- ensuring that at the commencement of each financial year, the ICB and its partner NHS trusts and NHS foundation trusts prepare a plan setting out their planned capital resource use;
- ensuring that the ICB and its partner NHS trusts and NHS foundation trusts exercise their functions with a view to ensuring that, in respect of each financial year local capital resource use does not exceed the limit specified in a direction by NHS England;
- ensuring the ICB has a documented property transfer scheme for the transfer of property, rights or liabilities from ICB's predecessor clinical commissioning group(s);
- ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure that schemes are delivered on time and to cost;
- ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences; and
- for every capital expenditure proposal, the chief financial officer is responsible for ensuring there are processes in place to ensure that a business case is produced.

Capital commitments typically cover land, buildings, equipment, capital grants to third parties and IT, including:

- authority to spend capital or make a capital grant; and
- authority to enter into leasing arrangements.

Advice should be sought from the chief financial officer or nominated officer if there is any doubt as to whether any proposal is a capital commitment requiring formal approval.

For operational purposes, the ICB shall have nominated senior officers accountable for ICB property assets and for managing property.

ICBs shall have a defined and established property governance and management framework, which should:

- ensure the ICB asset portfolio supports its business objectives; and
- complies with NHS England policies and directives and with this guidance

Disposals of surplus assets should be made in accordance with published guidance and should be supported by a business case which should contain an appraisal of the options and benefits of the disposal in the context of the wider public sector and to secure value for money.

Grants

The chief financial officer is responsible for providing robust management, governance and assurance to the ICB with regards to the use of specific powers under which it can make capital or revenue grants available to;

- any of its partner NHS trusts or NHS foundation trusts; and
- to a voluntary organisation, by way of a grant or loan.

All revenue grant applications should be regarded as competed as a default position, unless, there are justifiable reasons why the classification should be amended to non-competed.

Legal and insurance

This section applies to any legal cases threatened or instituted by or against the ICB. The ICB should have policies and procedures detailing:

- engagement of solicitors / legal advisors;
- approval and signing of documents which will be necessary in legal proceedings; and
- Officers who can commit ICB revenue resources in relation to settling legal matters.

ICBs are advised not to buy commercial insurance to protect against risk unless it is part of a risk management strategy that is approved by the accountable officer.

Section 7

Improving lives **together**
Norfolk and Waveney Integrated Care System

Our Approach to Working with People and Communities in Norfolk & Waveney

Working DRAFT v10 January 2023

Version control	Date	Author	Status	Comments
V1	March 2022	Rebecca Champion	Draft	Initial draft shared with evidence pack to NHSEI
V5	April 2022	Rebecca Champion	Draft	Draft shared with system partners for comment
V7	19 May 2022	Rebecca Champion	Draft	Submitted to system oversight group for comment
V8	27 May	Rebecca Champion	Working Draft	Submitted to NHSEI
V8	8 June – 18 July 2022	Rebecca Champion	Working Draft	Draft shared with public and stakeholders for comment including easy read summary version
V9	23 June 2022	Rebecca Champion	Working Draft	Draft updated to reflect new map & changes to names and structures for inclusion in the governance handbook
V10	23 January 2023	Rebecca Champion	Working Draft	Updated to reflect feedback from public engagement & system developments. Submitted to Patients & Communities Committee

This is a working draft which describes an approach to working with people and communities in Norfolk and Waveney. This document and the design of the approach are still under development as local discussions continue, as it is recognised that this approach will take time to fully develop and embed. A version of this document was shared with NHS England as a working draft on 27 May 2022 as part of the strategic assurance around working with people and communities.

It received **very positive feedback** as well as some suggestions for improvement that have been reflected in version 10.

Key Definitions:

Integrated Care System (ICS) - new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

Integrated Care Board (ICB) - an organisation with responsibility for NHS functions and budgets. Membership of the board includes 'partner' members drawn from local authorities, NHS trusts/foundation trusts and primary care

Clinical Commissioning Group (CCG) – NHS bodies that will be replaced by ICBs on 1st July 2022.

Integrated Care Partnership (ICP) - a statutory committee bringing together all system partners to produce a health and care strategy. Representatives include voluntary, community and social enterprise (VCSE) organisations and health and care organisations, and representatives from the ICB board.

Health and Wellbeing Partnerships (HWP) - are local place-based partnerships work on addressing the wider determinants of health, reducing health inequalities and aligning NHS and local government services and commissioning.

Lived experience - knowledge gained by people as they live their lives, through direct involvement with everyday events. It is also the impact that social issues can have on people, such as experiences of being ill, accessing care, living with debt etc.

More definitions are included in the glossary.

Norfolk and Waveney Integrated Care System

Summary – What is this document saying?

People with lived experience tell their story once and it is heard across the ICS

New partnerships are being created to help everyone involved in supporting health and care work together better. Listening to the lived experience of the people and communities in Norfolk and Waveney is vital in helping people live longer, healthier and happier lives. It also helps us make sure that the care and support offered in Norfolk and Waveney is designed around our population.

All the partners in our ICS are talking and listening to people & communities every day. Our vision is that people would tell their story of lived experience once and it's heard by everyone in the ICS. We want to develop on-going relationships with communities to learn what matters to them, and work together to address waiting times, improve access to services and support people to live the healthiest life possible.

We want to build on the existing engagement and insight that happens across all our system partners and find ways of working together to share and learn from this insight. Working together will also mean we can pool our resources and work more efficiently across the ICS.

We learnt during the COVID-19 pandemic that we need to get better at listening to what really matters to our people and communities, especially if we are going to address health inequalities. A really effective way to do that is to use trusted communicators, people who are part of the local community – 'people like me'. A good way to do that is by working with Voluntary, Community & Social Enterprise (VCSE) organisations who already have long standing relationships and networks throughout Norfolk and Waveney.

We recognise that to do all this we will need to use good quality, innovative communications, that are accessible for everyone and available in a range of formats. Whilst we see the value of offering lots of digital opportunities in a large rural area like Norfolk and Waveney, we are also aware that not everyone has a good mobile signal or access to broadband connections and that some people just are not able to access information online. We will all use a range of methods of going out to our people and communities so we can move forward as an ICS together.

As of 1 July 2022, NHS Norfolk & Waveney ICB will oversee and work with ICS partners to make sure that we constantly listen to and engage with people and communities – as one whole system. That is why this document sometimes refers to structures and processes in the ICB. Our glossary at the end of this document is designed to help with the new terms and language used.

We hope you enjoy reading about our approach to working with people and communities in Norfolk and Waveney!

Introduction

Integrated Care Systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area. These partnerships will help to coordinate services and to plan in a way that improves the health of people and communities and reduces inequalities between different groups.

The purpose of this document is to outline the strategic approach being undertaken in Norfolk and Waveney ICS to working with people and communities, so that we can achieve the ambition laid out in the guidance that partners in an integrated care system (ICS) should work together to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

This strategic approach will follow the recommendations of the NHS Confederation in 'Building Common Purpose'. It will give us a way of working with all our partners to ensure that how we work with people and communities, how we respond to their views and experiences, and how we identify and share the impact of what we learn, are aligned.

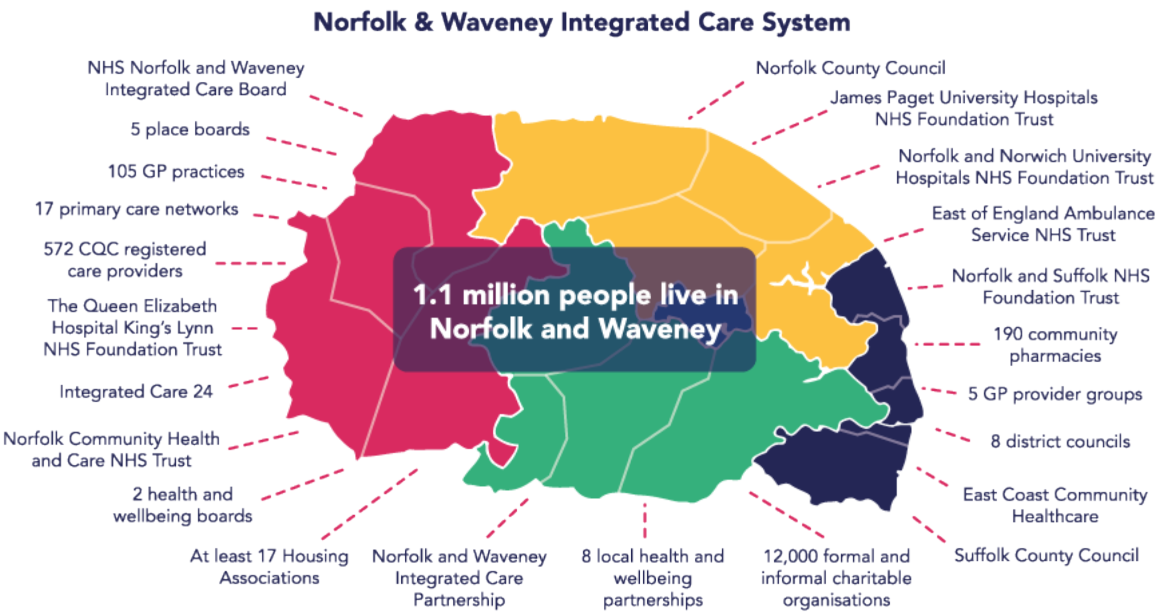
Building on learning during the COVID-19 pandemic, our vision is to improve our collective ability to listen to what people are saying across Norfolk and Waveney about what matters to them. We can do this by going out to the communities we serve, and by building on existing community engagement assets among our ICS partners including the VCSE sector. Feedback and insight can be joined up across ICS partners and channelled into decision making structures, so that insight shared in one part of the ICS is gathered and heard by other partners across the system.

Some aspects of the approach described in this document already exist, some are under development and others are still at an early, visionary stage. It will be made clear how far each area is developed. We are taking an evolving approach which is being designed together, with ICS partners and with the people and communities we serve.

It will take time to fully achieve our vision - it's a huge task – but we are starting from a good place as there's lots of good work and enthusiasm in Norfolk and Waveney already. The COVID-19 pandemic has strengthened existing relationships and helped us forge new ones, so we work together to consistently give our people and communities a voice across the ICS.

Our ICS

The Norfolk and Waveney Integrated Care System is made-up of a wide range of partner organisations, working together to help people lead longer, healthier and happier lives. From 1 July 2022, our Integrated Care System will include the following organisations:



Appendix 1 has a more detailed overview of our population.

Over and above everything else we want to achieve; we've set ourselves three goals:

1. To make sure that people can live as healthy a life as possible.
This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something we must change.

2. To make sure that you only have to tell your story once.
Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.

3. To make Norfolk & Waveney the best place to work in health & care.
Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

Like all Integrated Care Systems in England, we will work to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Aims and principles

The overarching vision for working with people and communities in Norfolk and Waveney is that all ICS partners will consistently collaborate to share insight and learning. This will maximise resources and ensure that the voice of local people, especially from inclusion groups, is shared as widely as possible.

We will work towards the following 10 principles from national ICS guidance when working with people and communities at neighbourhood, place and system level. These will be tested with local people as this approach develops and adapted to reflect local aspirations as needed.

1. **Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.**
   - **We have** appointed a Director of Patients and Communities to oversee the all the work with our people and communities. A Patient and Communities Committee meets every other month and includes two lived experience members. Named representatives from the ICB communications & engagement team are aligned to each of the Place Boards
   - **We will** continue work to align communications & engagement resources at place level with local system partners to co-produce shared plans, and continue to develop the ICB structures to ensure voice of people and communities reflected at all tiers
2. **Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.**
   - **We have** created a systemwide communications & engagement group to work together as a system wherever possible in planning and feeding back. We have a 'You Said, We Did' section on our people and communities hub
   - **We will** co-produce a joint set of principles for use by all partners across the ICS to underline the importance of working with people and communities as early as possible in developing plans and feeding back the difference this has made.
3. **Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.**
   - **We have** developed population health management and data review processes in partnership across the system for example Protect NoW
   - **We will** develop the insight bank to systematically record qualitative data collected by system partners to build a 3-dimensional picture of lived experience and improve our ability to listen to informal feedback for example by using social media monitoring tools.
4. **Build relationships with excluded groups, especially those affected by inequalities.**
   - **We have** made strong links with the Health Inclusion Group about how they can support this approach to working with people and communities
   - **We will** look for specific opportunities to develop better relationships with specific communities with quieter voices, for example working with a prison healthcare provider to look at how the voices of people in/leaving prison can be embedded across the ICS
5. **Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.**
   - **We have** already developed good working relationships with Healthwatch Norfolk and Healthwatch Suffolk, and with VCSE partners in the Norfolk & Waveney Community Voices Project
   - **We will** continue to build relationships with the VCSE Assembly and with VCSE partners at Place Board in working with people and communities
6. **Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.**
   - **We have** developed a website for the ICS which includes accessible information available in a range of formats. It also hosts the people and communities' engagement hub and contains information about the ICS plans and visions using a range of innovative and accessible formats.
   - We will continue to work with our partners to use every available network to reach people who do not or cannot access information online. Much of this will build on partnership work during the COVID-19 pandemic, such as the Great Yarmouth Community Champions and working with our local library service.
7. **Use community development approaches that empower people and communities, making connections to social action.**

- **We have** learnt a great deal from the COVID-19 pandemic which has led to the Norfolk & Waveney Community Voices Project
- **We will** build on the relationships with our district councils and system partners to empower our people and communities using community development approaches

8. **Use co-production, insight, and engagement to achieve accountable health and care services.**
   - **We have** many examples of good practice in working with experts by experience within Norfolk wand Waveney
   - **We will** work towards an ICS model of co-production using a set of co-produced principles and standards, building on & learning from examples of best practice currently operating within the system
9. **Co-produce and redesign services and tackle system priorities in partnership with people and communities.**
   - **We have** worked with system partners on a carers co-production project to tackle issues for informal unpaid carers around discharge from hospital settings and to promote personalisation and carer awareness training
   - **We will** use this approach to tackle other system priorities including urgent and emergency care, and quality improvement
10. **Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.**
    - **We have** based our entire approach to working with people and communities on this principle as we are aware that all our system partners listen to and gather insight from the people they support everyday
    - **We will** continue to look for different digital and non-digital ways to develop this idea

Progress and challenges to date working with people and communities

The Norfolk and Waveney system has made considerable **progress** to date in working with people and communities:

Establishment of a Norfolk and Waveney ICS Communications and Engagement (ICS C&E) group in September 2021, made up of representatives from Norfolk and Suffolk - 8 NHS provider trusts, 2 county councils, 2 Healthwatch's, 8 district councils, Norfolk Police, 2 Chambers of Commerce, Out of Hours/111 provider, Active Norfolk, Norfolk Older People's Strategic Partnership, 4 VCSE organisations, representatives from housing associations.
Alignment of named communications and engagement representatives to Place Boards from the ICB team to support Place Boards and health and wellbeing partnerships in developing locally specific comms and engagement activity and 'teams' using existing resources from system partners.
Starting the development of an 'Insight Bank' through the Norfolk and Waveney Community Voices Project pilot which includes recording qualitative feedback gathered by community connectors. Hundreds of interactions have been recorded and work is underway to turn large amounts of qualitative data into useful insight, alongside the development of an online platform. The ultimate vision is to offer the 'bank' as a system wide resource
Joint projects underway with NHS trusts designed to improve working with people and communities in health services e.g. carers co-production project to promote personalisation, and to embed carers awareness training and a carers passport for use initially in hospital settings. This partnership of NHS patient experience and engagement leads are also planning a programme of training and support to promote Patient Leadership
Collaborative working with the children and young people's system - Children and Young People Strategic Alliance (CYPSA). CYPSA are working together to deliver the shared ambition that 'Norfolk is a county where all children and young people can Flourish', and the associated Flourish outcomes framework, which places emphasis on health and wellbeing and the voice of children, young people and their families. This is particularly being progressed through the Stakeholder Engagement & Insight CYPSA subgroup, which seeks to improve quality and collaboration around engagement and insight activity across the children and young people system. Similar opportunities are being investigated for the Waveney area of Suffolk
Embedding Equality Impact Assessments (EIAs) within the work of the CCG to ensure a range of protected characteristics are given due consideration in service transformation across the ICS and to underpin working with people and communities
Aligning people and communities work with Norfolk and Suffolk County Councils. Progress has already been made e.g. aligning similar work in Norfolk Children's Services, building on excellent working relationships with Public Health Norfolk and Norfolk and Waveney Health Overview and Scrutiny Committee (HOSC). Also developing links with the Norfolk and Waveney Integrated Care Partnership (ICP) and planning joint work on shared principles for working with people & communities
Improving joint working with District Councils and Housing Associations to make systemwide links with community and tenant engagement

Ensuring that people and communities work is represented on Norfolk and Waveney Health Inclusion Working Groups
Supporting the Local Maternity and Neonatal System (LMNS) to work in a joined up way with the **Maternity Voices Partnerships (MVPs)** to hear insight from pregnant people and young families in Norfolk and Waveney.

Despite all the progress made so far **challenges** do still exist in the system for working with people and communities:

The size and complexity of the system offers many opportunities to hear the voice of people and communities but is also a huge challenge to map and understand effectively
Implementing new ways of working during times of great pressure on the system means staff are struggling to cope with existing demand as well as develop new partnerships
Demand is driving change so fast making it much harder to work with people and communities effectively
Making the necessary connections with all the different ICS partners particularly finding members of staff with an insight role
Lack of skills and contacts in working effectively and consistently with specific communities of interest despite progress during the COVID-19 pandemic e.g. very vulnerable groups, areas of deprivation, young people
Having all the right skills and resources to effectively join up all the insight from people and communities
Developing the people and communities approach during a time of **diminishing volunteers**

Despite these challenges, the ICS will continue to work together in a coordinated way to identify options and solutions to constantly improve our work with people and communities across Norfolk and Waveney to help people live longer, healthier and happier lives.

Case Study – how working as a system helped Norfolk & Waveney roll-out a nationally recognised COVID-19 vaccination programme

Norfolk and Waveney has received regional and national recognition for its performance during the COVID-19 vaccination programme roll out, and regularly featured in the top five performing health and care systems in England. Despite the challenges of rurality, an older population age profile (often less able to travel) and the constraints of transporting the vaccine safely between widespread sites, Norfolk and Waveney has some of the highest vaccine uptake figures in the country.

The success of the ongoing vaccination programme is underpinned by continued support from colleagues across the system - in general practice, district and borough council neighbourhood teams, Norfolk Constabulary (site security) and Norfolk County Council (Public Health, social care, commissioner of care providers and highway authority) and our NHS provider partners, as well as crucial support from the VCSE sector and a staggering number of volunteers from communities across Norfolk and Waveney.

Partnership working gave everyone involved clear oversight of the latest Public Health uptake data related to age, ethnicity and geographical location, which gave crucial insight for planning of site locations, pop up clinics and roving models.

Identifying gaps in provision early meant we could adapt and tailor our delivery model and hesitancy campaigns to address demand, improve access and address inequality. We have also partnered with community and voluntary sector organisations on a range of inclusion initiatives including the provision of respite care and transport to enable carers to access a vaccine, and proactive in-reach into specific communities most adversely impacted by health inequality or least likely to access services.

Work is now underway to apply this flexible model of working in partnership beyond covid vaccinations to include screening, health services and targeted public health initiatives as key enablers to reducing health inequalities.

Listening to 'Quieter Voices' in Norfolk & Waveney - How we think working with people and communities can tackle health inequalities

Norfolk and Waveney ICS is working to draw together the various sources of data available within the system. This will drive much of the ICS activity and will go a long way towards identifying need. Through working with people and communities we want to use the people's voice to test and assure the data is reflecting what matters to local people. This will enable us to move beyond information about 'treatment' & 'services' to hear people's whole lived experience. The following are examples of how the ICS has already developed new ways of addressing health inequalities that are built around insight from local people:

Norfolk and Waveney Community Voices (NWCV) Project – Norfolk and Waveney has many different communities of interest often living alongside and merging with each other. This can make talking and listening to the different people very challenging. We are aware that although they still provide useful insight, the more traditional methods of engaging tend to have a 'response bias'

where it is more likely you will hear from people if they are better educated, older, wealthier and white British.

During the COVID-19 pandemic we learnt that to reach people who are less likely to engage with us we had to use trusted communicators at very local levels, often street by street or village by village. We learnt we have to focus on the hardest to hear, underserved and more vulnerable groups and actively go to them to find out what their priorities are.

Building on the success of the Great Yarmouth Community Champions, Norfolk and Waveney is developing the Community Voices Project to work at district council level, using data and local insight to target conversations with local people. A network of community champions and connectors will take conversations out into the community to promote health messages and learn about what matters to people in relation to their wellbeing. We expect to hear about the challenges faced by local people in accessing services, and about the issues that prevent wellbeing across a range of factors, including those outside the direct health sphere such as housing, employment and finances.

Norfolk and Waveney Insight Bank – We are carrying out a trial of an 'insight bank' where all the qualitative data we collect as part of the NWCV project can be stored. It will provide anonymised information useful for all ICS partners giving insight on a street, neighbourhood, place and system level which will be useful for health and care planning and other services too.

An early version has been developed and community champions will be trained to use it. We are also going to source more robust and sustainable software to develop it further and make it a hub for many local resources.

Working with people and communities at 'place'- level - how all the different voices of our people & communities can be part of local decision-making - The vision is to create a thriving environment for conversations with our people & communities using a spectrum of opportunities. Conversations about 'the place where I live' are often much richer.

By joining up and sharing insight gathered across the system we can hear the voice of people from all over the ICS alongside data on Place Boards, and to support the work of the Health and Wellbeing Partnerships. We have the opportunity to use new sources of insight from different ICS partners, with the ambition to develop a platform(s) to enable the insight to be searchable by themes, postcode etc.

The pandemic helped all partners across Norfolk and Waveney better reach out to and hear from our more vulnerable, marginalized, underserved communities, who are better reached at place and neighbourhood level. This is especially the case if the conversations are facilitated by trusted intermediaries as referenced in the NWCV project above.

Communications and engagement resources from across the ICS could be brought together at place level to ensure the right people and communities are working in partnership to improve local health and wellbeing.

Protect NoW - The Protect NoW programme of work uses data-led, population health management approaches and comprises a growing number of distinct projects, each focused on a common cause of mental and/or physical ill health. It uses behavioural and Public Health insight to establish specific population needs and develop effective interventions through co-production with clinicians, system partners, wider stakeholders, patients and service-users.

Norfolk and Waveney Health Inclusion Group – is a multi-agency group that builds on partnership working during the COVID-19 pandemic and includes many ICS partners outside the NHS. Professionals from statutory and VCSE organisations come together to hear the voice of and

understand the needs of vulnerable and health inclusion groups and align services accordingly. This group offers grassroots support to work with health inclusion groups to understand what matters to them as part of the people and communities work in Norfolk and Waveney.

Equality Impact Assessments (EIAs) – we will continue to support the production of EIAs for projects and transformation within the engagement function of NHS Norfolk & Waveney Integrated Care Board (ICB). These have been recognised as key to reference that due thought has been given to protected characteristics and communities of interest, and also to highlight areas where the voice of people and communities is missing.

Listening to the voice of people in or leaving prison - it's important that we recognise that the population of Norfolk and Waveney includes a significant number of prisoners. These are vulnerable people who have very little control over how their health appointments are managed outside of the prison. They experience inequality related to prison transfers which can disrupt planned care, they cannot control when or where their appointments take place, their appointment always depends on the prison being able to provide escort staff and so are regularly cancelled causing delays, and appointments are often not confidential due to escort staff having to be present.

Accessing care and support outside the prison is a really different and difficult experience for them, so it is important that we find a way for their voice to be heard in a meaningful way. Patient engagement and experience leads are working with healthcare provider representatives from the prisons in Norfolk and Waveney to improve communications channels between local health services and the prison population.

Experts by experience - Norfolk and Waveney already has a wealth of good practice to build on in working with our communities of interest and people with quieter voices. The Norfolk Strategic Housing Partnership has a co-production alliance which works with people with lived experience of homelessness to influence change. The Domestic Abuse Partnership Board are working on a co-production 'framework' for the commissioning of domestic abuse services to encourage nurturing conversations, without expectation or judgement, and as a tool to empower those using it. Listening to the voice of lived experience is key to delivering the Support in Safe Accommodation strategy. Norfolk and Suffolk NHS Foundation Trust has an embedded approach to participation making sure everyone can have a say in how their care is delivered and how that could be improved.

Rethink Mental Illness – Norfolk and Waveney has a substantial and unique approach to ensuring that mental health transformation is informed as a system by lived experience. Rethink Mental Illness is the charity for people severely affected by mental illness.

The Norfolk and Waveney Health and Care Partnership commissioned Rethink's co-production team to bring the views, skills and experience of people living with mental health needs and carers together with those of people whose jobs are to plan and deliver services - so they can work together. Experts by experience have been recruited to various steering and reference groups to work alongside the programme. Paid Experts by Experience are now also sitting on the Norfolk and Waveney Mental Health Partnership Board, working closely with the Mental Health Trust CEO and the Executive Director of Adult Social Services in the delivery of the programme.

Learning from the COVID-19 pandemic - The recent COVID-19 pandemic drove the need for the system to work together in unprecedented ways, and we have gained a lot of very useful insight which we can build on for working with people and communities going forward.

We found our assumptions about people's views are not always correct, and we need to test our ideas and the language we use. For example, we gathered insight around vaccine hesitancy from the following groups to help inform our messaging and campaigns:

- under-18s
- adults under 30
- migrant workers
- adults with autism/LD and their carers
- pregnant people

We also learned a lot about how messages and information travels around different communities, and how important it is that people can identify and trust the person who delivers those messages. We worked more closely with our system partners who work at grassroots level, such as Healthwatch and our VCSE colleagues to establish new ways of listening to the people and communities they work with through trusted communicators.

Working with the Great Yarmouth Community Champions really helped us understand the needs of underserved communities and those who traditionally have not come forward to share their thoughts and experiences about accessing services. We also learnt that we needed to go to them rather than asking them to come to us. Our very successful roving health model for delivering vaccines also gave us the opportunity to hear from different communities and gave us a blueprint for continuing to deliver services and messages in this way in the future.

Case Studies - Making A Difference - Great Yarmouth Community Champions

Great Yarmouth Community Champion **Ana** shared her 'I've Had Mine' poster in Portuguese in an online Portuguese community chat site. Local residents from that community fed back that they had decided to take up the vaccination offer after seeing her advocating for it.

Brigitta, a Lithuanian Community Champion reached out to local Ukrainian residents to help any refugees or guests link to local services and feel at ease in the community. Following a post on Facebook four local Ukrainian families came forward to offer help and support to refugees accessing local shops and churches and helping families with forming new friendships.

Learning through doing – Another opportunity to learn about working with vulnerable and underserved people and communities came in early 2021 when NHS Charities Together (NHSCT) made funding available to the Norfolk and Waveney system to create mutually beneficial partnerships between the NHS and the VCSE sector, to support those communities most impacted by COVID-19. This provided a unique opportunity to develop new ways of working between health and social care and the voluntary sector, and ultimately to move away from the transactional relationships between 'commissioner and provider' to a much more collaborative and integrated approach.

The programme has provided an opportunity to test new approaches to the way we deliver health and care, and to embed the prevention agenda into the heart of the system. There was significant emphasis on new and enhanced partnerships between NHS and the VCSE to reach vulnerable communities, and priority was given to projects that support those people most adversely affected by the pandemic.

Our successful submission for funding was co-developed and included a portfolio of projects. VCSE organisations were supported to develop their proposals by statutory partners, identifying opportunities to align resources, integrate and further collaborate to bolster and strengthen the development of project ideas. Furthermore, a peer review approach was established to ensure a direct link to system priorities and future advocates within the system that can support successful implementation.

Over the next two years, the ICS will support the implementation and evaluation of the ten projects taken forward as part of Norfolk and Waveney's NHSCT programme, with the learning captured and utilised to further develop our strategic response to VCSE integration.

By systematically aligning insight and learning gathered from all this work across the system we will be able to build a picture of on-going dialogue with local people and communities.

The importance of more local conversations should not be forgotten, and 'Place-based' priorities will be co-designed with local people and communities through development of shared plans. This work will be led by the Place Boards and reviewed annually and gives the ICS an opportunity to work with people and communities in a more locally focused way, using a spectrum of opportunities as laid out on page 19.

The importance of accessible and good quality communications

The local health system recognises that good communications is at the heart of everything we do. It helps build confidence with local services and care professionals. It is essential for effective partnership working and will help build trust. It provides patients with the information that they need to be empowered and so make positive choices and take control of their health.

Good communications involves:

- fostering a culture of good two-way communication, engagement and involvement;
- informing and empowering key stakeholders;
- being honest and realistic;
- recognising and meeting the different information needs of groups and individuals;
- working with other agencies to co-ordinate communication.

We live our lives and communicate online as well as through more traditional media. In Norfolk and Waveney, it is recognised that not everyone is able to, or wishes to, use digital platforms and we will continue to use traditional routes of communication such as newsletters, partner newsletters, leaflets and posters.

However, the digital space offers enormous reach and value for money. The ICS will therefore champion digital platforms to help patients interact with services or obtain the information they require. A new ICS website has been developed and this will be kept well designed, easy to navigate and a trusted source for information or links to information. This website now hosts the people and communities hub for Norfolk and Waveney, which aims to develop and maintain a shared vision in listening to and working with local people across the ICS. The ICB communications & engagement team includes a post focusing on digital transformation which will help staff, people and communities understand how advancements in digital technology can help improve health and care experiences.

NHS Norfolk and Waveney ICB, as well as the wider ICS, will use social media such as Twitter, Facebook and other online platforms, to help communicate with local people, and where appropriate, as an engagement tool to stimulate discussion and feedback. A social media policy has been developed which makes clear how social media can be used effectively to contribute to the work of the local health system and to help staff participate online in a respectful, professional and meaningful way that protects the image and reputation of the health system when they are using social media on a personal basis. This has been done in line with similar policies for ICS partner organisations.

Good external communications will be vital in informing and empowering people about Norfolk and Waveney ICS, how public money is spent and how we are working with people and communities in the development of local healthcare services.

It is essential in an ever-changing NHS that patients and the public are able to navigate their way through the services available to them. The ICB will be the custodian of the NHS brand locally, and our communications will support this. When producing any material for publication, the ICB will take account of the NHS Branding and Accessibility Guidelines to make sure that all our information is accessible to a wide variety of audiences. This includes use of our websites and any social media we may develop, and the need to produce our literature in a range of formats as required.

NHS Norfolk and Waveney ICB is striving to meet the Accessible Information Standard in all its communications and engagement. We are working with Healthwatch Norfolk and Healthwatch Suffolk to support the national accessible information campaign. Norfolk and Waveney ICS has appointed a Head of Systems Workforce Equality, Diversity and Inclusion. The aim of this role is to embed the necessary values and behaviours to develop a holistic approach to equality, diversity and inclusion, that puts people and culture at the heart of the ICS.
As a health and care system, it is also important to develop a local brand for the NHS in Norfolk and Waveney. This will help local people understand the role of the ICS and our work with our partners. It is important that the health and care system creates and maintains a reputation for delivering high-quality, safe and responsive care and support to our people and communities. This will be built by the experiences of its stakeholders through direct and indirect contact with the ICS, and how we are portrayed in the media.

A good reputation can be earned by having a clear, locally agreed vision and set of values that is communicated in a clear and positive way. How an organisation behaves also contributes to this and clear communications can help explain why decisions are made. Having a good reputation can help staff morale, and generate local support for change, especially over difficult and contentious issues. It is also an important metric for how NHS bodies and healthcare staff are measured in terms of performance.

The media can influence people's opinions of public services. Many are seen as

independent and credible and are influencers nationally and locally. For this reason, good strong relationships with, in particular, the local and regional media, are important. Our local media can be helpful in promoting the work of the ICS and the transformational service changes and improved health and wellbeing outcomes we are seeking to deliver for local people. And helps hold us to account to our local people and communities, increasing our openness and transparency.

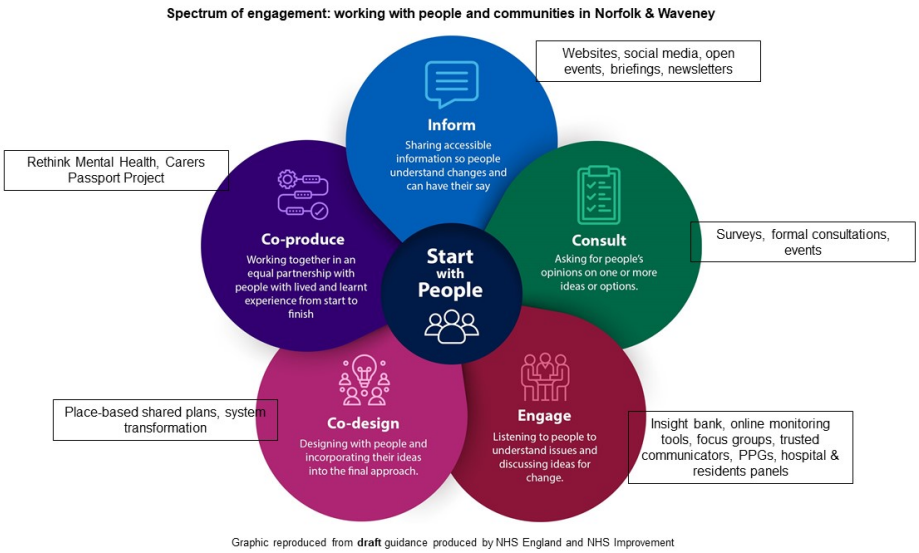
How this ICS approach to working with people and communities will support the NHS ICB legal duties on public involvement

The existing guidance around the NHS legal duties to consult and involve were produced in 2008 and 2017. The new Health and Care Bill will come into effect on 1st July 2022 and will create a very different health and care landscape with a particular emphasis on integration and collaboration. It will continue the legal duties on public involvement, and new statutory guidance is expected to provide the detail of how NHS organisations should work effectively with people and how ICBs will be assessed on this.

The new guidance will change ambitions for how systems work with people – at system, place and neighbourhood levels. The approach being developed in Norfolk and Waveney will:

- ✓ Maximise existing conversations taking place every day with people across the system, starting with the current mapping exercise
- ✓ Involve groups and people we have not been good at listening to before
- ✓ Ensure this information is fed into decision-making structures as they develop
- ✓ Promote the ICB Communications and engagement team as system leaders encouraging trust with ICS partners and local people through the People and Communities Engagement Hub
- ✓ Develop the wider 'system team' of staff in public sector and VCSE organisations who are already working with people and communities and gathering insight
- ✓ Promote methodologies such as Making Every Contact Count (MECC), What Matters to You and Always Events
- ✓ Promote Co-production & Co-design models as part of a wider spectrum of engagement
- ✓ Promote a support programme to encourage thriving patient engagement around primary care

A spectrum of opportunities will be recognised and encouraged by the ICB when working with people and communities within the ICS. All feedback has value and adds to our understanding of the people and communities in Norfolk and Waveney.



The CCG Communications and Engagement Team has worked with its Project Management Office (PMO) to develop a communications and engagement template.
This is one of a suite of documents that will need completing for all the project and transformational work undertaken by the ICB going forward. The template ensures that due consideration is given to working with people and communities at the earliest possible stages of planning to feeding back at the end. A toolkit has been developed to help CCG staff with planning communications and engagement activity in line with our people and communities approach.

Co-production

Co-production refers to a process of shared power to effect change. The term co-production is generally used to mean an end-to-end process where people with lived experience work with those who design services and projects in an equal partnership, sharing power and often involving a significant commitment and where involvement fees or other forms of reciprocity are offered alongside expenses. Think Personal Act Local (TLAP) is held as an exemplar in promoting co-production and they include a comparison of the various definitions on their website.

Examples of co-production do exist in Norfolk and Waveney and work is underway within the system to align existing work and develop a shared approach:

- Development of a co-production hub as part of our people and communities hub to share examples from the system, to promote co-production principles and to signpost to support materials
- The ICB is now represented, alongside Norfolk County Council, on the Norfolk Making It Real (MiR) steering group which promotes co-production particularly for people with lived experience of physical and learning disabilities
- Named Communications and Engagement representatives are working with system partners at Place and Partnership level to promote and support co-production
- Supporting various NHS England funded initiatives in Norfolk and Waveney such as the co-production projects around Quality Improvement as described below.
- Co-production as an integral part of designing research projects
- Exploring ideas around the development of some system-wide shared principles around co-production for Norfolk and Waveney

Thriving Patient Engagement Around Primary Care

General Practice - There are 105 GP practices in Norfolk and Waveney. Most of them have patient groups, often referred to as Patient Participation Groups (PPGs). They offer members of the public the opportunity to become more involved in how the practice runs. This could be about the physical building, waiting times, services offered or wider healthcare issues.

We have 17 primary care networks (PCNs) – this is where GP practices work together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as PCNs.

We are working with patient representatives, practices and our local Healthwatch's to develop a programme of strategic support to local PPGs and practices so that the voice of people and communities can be reflected more locally. The ICB commissioned Healthwatch Norfolk to engage with local practices and PPGs to find out what support would be most useful.

The ICB is now working to deliver the key recommendations from the report. A webpage is now in place which features case studies including examples that promote different models of patient engagement. There is also other information and links to resources including a toolkit produced by Healthwatch Norfolk following the period of engagement which aims to give practices and PPGs a step by step guide.

A systemwide annual conference, and smaller more local learn and share events are also planned. The ICB communications and engagement team also offer talks to PPGs about working with people and communities and the development of the ICS.

Care Quality Commission (CQC) – CQC is the independent regulator of health and adult social care in England. They make sure health and social care services provide people with safe, effective, compassionate, high-quality care and they encourage care services to improve, including General Practice. The ICB talked to CQC about practices being able to try new approaches to involving patients as well as the traditional PPG model so they updated their mythbuster to encourage and reassure practices.

Other primary care providers – ICBs are set to take on more responsibility around other primary care services from April 2023 onwards. Other providers include pharmacies, dentists and opticians. This can provide an opportunity to explore supporting other primary care providers to work with people & communities in a similar way to that already well developed within general practice.

Patient Participation Groups (PPGs)

There are 105 GP practices across Norfolk and Waveney. Most of them have patient groups, often referred to as Patient Participation Groups (PPGs).

PPGs work in partnership with their GP practice and are vital in ensuring that the patient voice is heard. We are keen to hear about different models for hearing the patient voice in primary care and will be developing this alongside our current patient groups.

PPGs work in different ways, some meet in person, others communicate with their practice online – all are keen to welcome and involve new members.

PPGs provide an opportunity for local people to get involved with their practice and influence the provision of local health services. Members contribute their views, make suggestions and provide feedback on services they may have used. Groups can also get involved with supporting local health initiatives and can engage with a wide range of health and care professionals.

Norfolk and Waveney ICB is working to develop a programme of support to local PPGs and practices.

We have worked with Healthwatch Norfolk to conduct an evaluation of Patient Participation Groups across Norfolk and Waveney and gather feedback to develop an understanding of what additional support the ICB can provide to help PPGs and practices be the most successful and develop further.

This has led to the development of a new PPG Toolkit that aims to help groups establish and run a successful PPG. You can read the report and download the toolkit below.

Resources

- PPG Toolkit
- Norfolk and Waveney PPG Evaluation report

New resources will be added soon.

Social Media Managed Service

The ICB Digital team has commissioned a paid for social media service managed by Redmoor Health, initially for one year, to help interested practices develop active and positive social media channels. This includes establishing channels where needed and posting positive health improvement messages on behalf of the practices involved. There are currently over forty practices signed up in Norfolk and Waveney.

Having an active account also encourages communications with the practices around a wide variety of topics including promoting their PPGs and hearing feedback on services. The ICB Communications and Engagement team are supporting this initiative by working together with Digital to provide additional social media content over and above the commissioned service. The team are supporting the promotion of this service as a recognition of the future benefits to practices of using social media to work in partnership with their populations.

You can find out more about different PPG activities and projects below.

If you are interested in finding out more about your own PPG, talk to your practice reception team or contact us at nwicb.haveyoursay@nhs.net

PPG Case Studies

Patient Voice in Aldborough

Aldborough Surgery is situated in a large rural area 7 miles from the coast of North Norfolk. It serves a population of approximately 3,700 spread out across numerous parishes between Cromer to Aylsham and Edgefield to North Walsham. Aldbor...

Learn more

Sheringham PPG

Sheringham Patient Participation Group (PPG) was formed in 2008 with membership consisting of patients and some practice staff. The group met monthly in the GP surgery and over the years managed to raise funds for the practice and waiting room equip...

Learn more

Norfolk and Waveney's Quality Management Approach (QMA) – how working with people and communities will impact quality, safety and patient experience

Norfolk & Waveney ICS is adopting a system wide Quality Management Approach (QMA). The overall is ambition to improve our local population services, health outcomes, and patient and staff experience; as well as providing safe, effective, accessible, sustainable and responsive care.

Norfolk and Waveney ICS has chosen to place quality at the heart of how it plans, transforms, sustains and supports transformation of services.

Our core partners have collaboratively explored how quality can be woven into all that we do. The aspiration is that the ICS will be 'quality led' and that a day-to-day culture of quality improvement will be embedded across all local health and care.

A cornerstone of QMA is patient experience - bringing patient voices into systemwide quality improvement, and in designing of services. Co-design and co-production foster the processes and culture that support our staff, individuals, people and communities to become equal partners in all aspects of quality planning, improvement and control.

The service user voice has been included in the development of the system with patient leaders joining us as we plan. The aim is to extend this involvement into a full co-production model, fully embedded in the quality system. The aim is to improve outcomes for people with lived experience through quality feedback loops, and by bringing patient reported quality feedback to place boards and into transformation projects.

Norfolk and Waveney has been awarded funding by NHS England to promote co-production in quality improvement. Projects that aim to improve care pathways have been identified by local NHS provider trusts to involve patients in partnership with staff. Learning from these projects during 2023 will inform a toolkit to help staff across the system use co-production principles when making changes to pathways in future.

Norfolk and Waveney Patient Experience and Engagement Leads meetings –have been taking place weekly for several years and give an opportunity for people working in NHS provider trusts to meet and share practice across the system. They have also involved representatives from the ICB and have been a vital opportunity to begin to test and develop the idea of the 'wider team' working with people and communities across the ICS to listen to and involve patient experience feedback in quality and wider commissioning.

How will we know this work is helping people and communities?

If this work is effective, our people, communities and ICS partners will be able to see that:

- People feel listened to, and empowered
- People can see the difference their views and insight have made
- The voices of our people and communities are looked for early when planning services
- People have shared their story and it has made a difference and been listened to be partners all over the ICS.

Most of the governance structures within the ICB and ICS are now in place, and the need to monitor and evaluate the impact of the people and communities work is acknowledged.

The Patients and Communities Committee is now in place as of January 2023. It provides NHS Norfolk and Waveney with assurance that it is delivering its functions in a way that meets the needs of our patients and communities across Norfolk and Waveney. That is based on engagement and feedback from local people and groups.

The Committee also specifically focusses on how NHS Norfolk and Waveney and the wider Integrated Care System is actively addressing and reducing health inequalities experienced by individuals and communities. Key to the Patients and Communities Committee will be two Committee members with lived experience, providing vital input, feedback and challenge to support our work as an organisation and the wider ICS. Recruitment for these members is taking place January – April 2023.

The Committee will also receive insight, make sure it is gathered appropriately, and monitor progress to ensure that change is happening. It will also constantly refer back to the 'so what' question – what this means for our people and communities.

The People and Communities Engagement Hub described above also gives a measurable focal point to engagement activity undertaken by the ICB as part of its legal duties. Specific projects and opportunities for working with people and communities are being advertised, and **'You said, We did/We can't'** reports detailing the results of the feedback and any improvements that resulted are being uploaded.

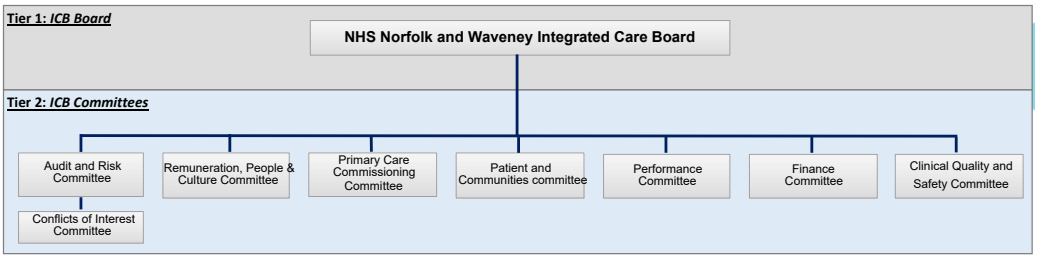
All ICB people and communities activity is being included in a regular systemwide quarterly briefing that is widely shared within the ICB and across the ICS. All system partners are also being encouraged to input into the briefing so that it can become a Norfolk and Waveney resource for the promotion of work with people and communities.

We will use all the existing networks of people and stakeholders to regularly monitor our success in working with people and communities.

People and communities in ICB Governance and workstreams

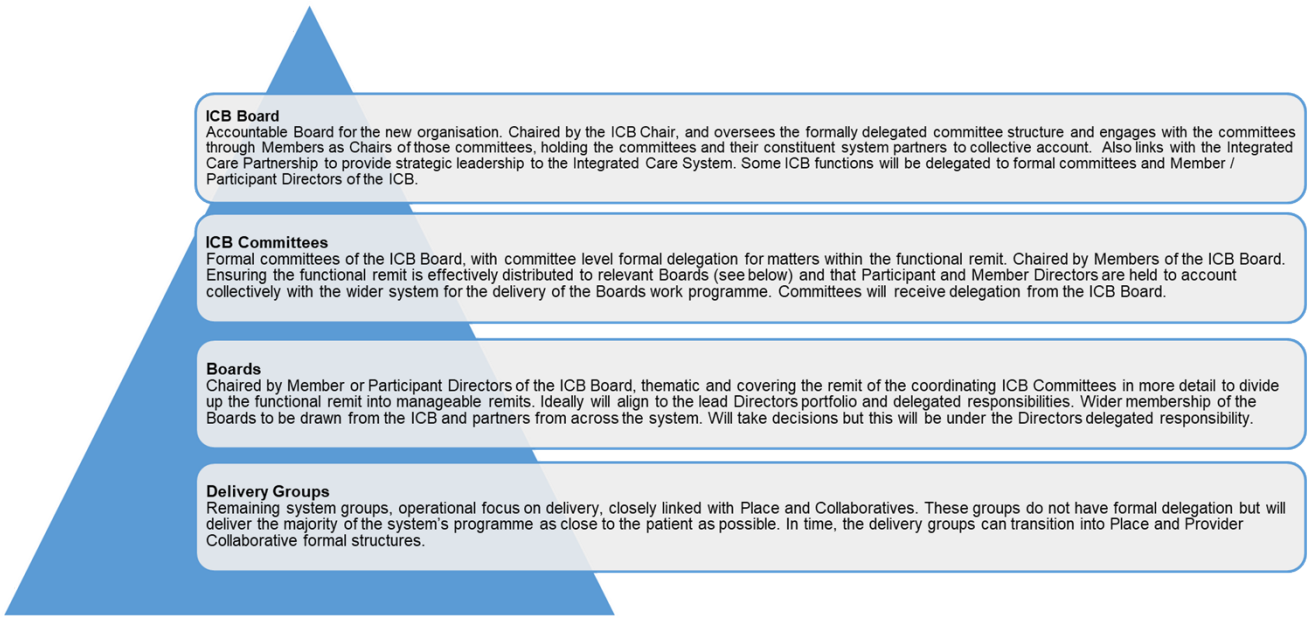
NHS Norfolk and Waveney ICB is committed to embedding the voice of people and communities so that the ICB can listen to and act on the concerns and aspirations of residents. The Patients and Communities Committee will act as a focal point for overseeing how this will happen, led by our Director of Patients and Communities. The committee is chaired by the chief officer of a local VCSE organisation. Meeting papers are made available a week in advance and meetings are held in public.

The ICB Board also includes a programme of learning from our staff, people and communities at all meetings in public to underline that people are at the centre of strategic decision-making. The programme of stories is being developed as much as possible in partnership with local NHS trusts, local authorities and wider system partners to complement stories they also use at board level and to highlight the stories across the ICS.



The ICB Board receives its assurance via the Committees and Executive Management Team (EMT). Scope of assurance for each Committee is set out in the ICB Governance Handbook

As described above, discussions are currently underway around Place Boards and Health and Wellbeing Partnerships, to include communications and engagement structures that would focus on working with people and communities at a much more local level, and drawing on insight from across all ICS partners including trusted communicators in VCSE organisations.



We will continue to build on our good working relationship with Healthwatch Norfolk and Suffolk. The ICB Communications and Engagement Team meets with both Healthwatch organisations every month at operational level, and they are valued members of the Norfolk and Waveney ICS Communications and Engagement Group. Healthwatch also play a key role in the overall assurance and oversight both for the ICB and for the work with people and communities in the wider ICS. They are members of the Patients and Communities Committee.

Norfolk and Waveney ICB will also continue the positive and proactive relationship it enjoys with the Norfolk and Waveney Health Overview and Scrutiny Committee (HOSC), through:

- ✓ regular informal meetings with the Chair and Vice-Chair
- ✓ including proactive information about changes to services and working with people and communities in the members briefings
- ✓ supporting and attending meetings held in public

Equality Impact Assessments (EIAs) have been embedded within the ICB to ensure the voice of underserved communities is given due regard in planning services and in any transformational work. It also highlights areas where more work with particular people and communities would be beneficial to understanding their needs, and links can then made with the communications and engagement team.

The future - The aspirations and ambitions in this document clearly demonstrate a journey to improve communications and engagement with people and communities across Norfolk and Waveney. Whilst a lot of work has taken place over the last 12 months to work together much more closely, it is vital this work continues, at pace, to ensure that all partners across the system work together to share resource, intelligence, insight and feedback.

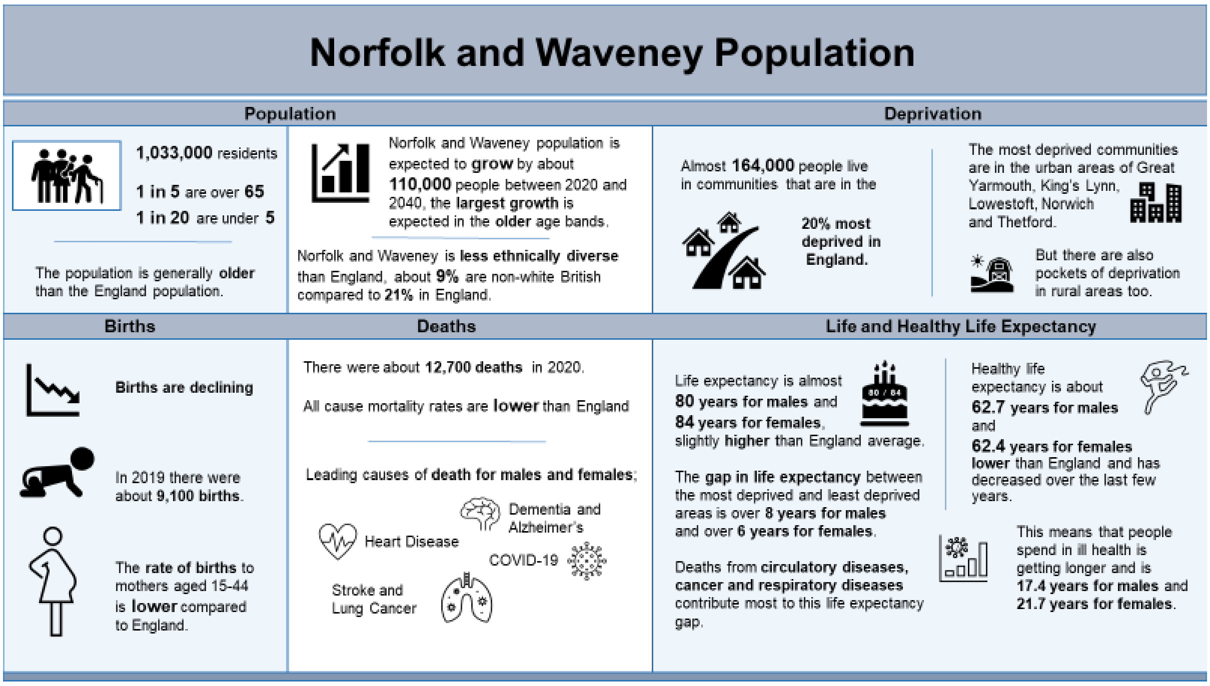
Our collective focus will be to always ensure that the voice, views and feedback of people and communities across Norfolk and Waveney is heard at every opportunity.

The transformation journey ahead will be evaluated at every possible point.

Appendix 1

An overview of the people and communities in Norfolk & Waveney ICS

The Joint Strategic Needs Assessments (JSNAs) available for Norfolk and Waveney have a wealth of information about the local area. Norfolk and Waveney is a large rural area made up of many villages and rural hamlets, market towns and urban areas in Norwich, Kings Lynn, Great Yarmouth, Lowestoft and Thetford. Numerous people move to the area to retire and there are many second and holiday homes. Norfolk and Waveney has many affluent areas that often sit alongside pockets of deprivation, especially in the rural areas.



Age - Norfolk and Waveney has one of the oldest populations in England. About 1 in 4 of the population (25%) is aged 65 and over and about 1 in 30 is aged 85 and over. This makes it the 4th oldest ICS area in the country. The proportion is likely to rise to 28% by 2029. Norwich is the youngest population and North Norfolk the oldest. This has remained the case over the last 10 years.

In 2020 the estimated population was as follows:

- **0–4 years** - 49,700 = **4.8%** of the total population.
- **5-11 years** - 80,200 = **7.8%** of the total population.
- **12-15 years** - 44,300 = **4.3%** of the total population.
- **16-64 years** - 600,600 = **58.2%** of the total population.
- **65+ years** - 257,900 = **25%** of the total population.

More than half of people under 50 live in the areas of Norfolk and Waveney classified as urban city and town, whereas people aged over 50 are more likely to live in more rural areas.

Between 2020 and 2040 there will be a projected increase of almost 110,000 people living in Norfolk and Waveney. The population is projected to increase by approximately 6.7% between 2019 and 2029, which equates to approximately 68,880 spread over the next ten years. 48,100 of this increase is in the population over 65.

Total live births in Norfolk and Waveney have been just below 70,000 between 2013 and 2019, decreasing from just over 10,000 to just over 9,000 births per year over that period. The most live births have been in Norwich, and the fewest in North Norfolk.

The general fertility rate is the number of live births per 1,000 women aged 15-44 years old. In Norfolk and Waveney this has declined from just over 61 births per 1,000 to just over 54 births per 1,000 from 2013-2019. Rates in Norfolk and Waveney have been lower than the England rates since 2013

Ethnicity - The Norfolk and Waveney population are less ethnically diverse than average in England. Norfolk & Waveney's ethnic make-up was characterised by a predominantly White, 940,607 people (96.7%). The proportion of people with an ethnic group other than White was 3.3%. The most diverse areas across Norfolk and Waveney are Norwich, Great Yarmouth and Breckland. There are around 160 languages spoken in Norfolk & Waveney. English is not the first language of around 12,400 school children in the county.

INTRAN is the non-profit-making partnership that commissions and manages interpreting and translation services on behalf of public-facing organisations throughout the East of England. According to INTRAN the top 10 languages requested are:

- Swahili (Kiswahili)
- Slovakian (Slovensky)
- Romanian (Română)
- Lithuanian (Lietuvis)
- Portuguese (Português)
- Latvian (Latvietis)
- Kurdish Sorani (Kurdî)
- Farsi Persian (فارسی)
- Chinese 普通话 ; 國語
- Russian (русский)

During the COVID-19 pandemic the following languages were also frequently requested:

- Turkish (Türkçe)
- Spanish (Español)
- Polish (Jezyk Polski)
- Arabic (Al Arabiya) العربية
- Bulgarian (български)
- Czech (čeština / český jazyk)

Information in Ukrainian (український) was also included to support those relocated during the conflict between Ukraine and Russia.

Disability - Based on the NHS population and person insight dashboard about 1.2% of the registered population has a disability. This is about 13,200 people and includes people with a physical disability, a learning disability and autism. The information might be an underestimate as it is based mainly on national NHS data returns.

Informal Unpaid Carers – are described by NHS England as 'anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.' They are also known as Family Carers, Companion Carers, Primary Unpaid Carers or Support Companions.

The 2011 UK census reported there are 5712 carers aged between 0 and 24, providing unpaid care in Norfolk. Of these 1,752 were aged 15 or under. The total number of carers reported in Norfolk was over 94,000 and more than 13,000 in Waveney. Both these figures had risen by more than 10% since the 2001 census.

As of February 2022, Carers Matter Norfolk (CMN) have approximately 7,000 adult carers registered with the service, showing there are many unpaid informal carers who do not come forward for help or do not recognise themselves as carers.

Appendix 2

Glossary of acronyms and phrases

Acronym	Full Title	Meaning / Definition
ICS	**Integrated Care Systems**	New partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.
ICB	**Integrated Care Board**	Each Integrated Care System (ICS) will have an Integrated Care Board (ICB), a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS.
ICP	**Integrated care partnerships**	(ICPs) are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs.
VCSE	**Voluntary Community and Social Enterprise**	Any organisation working with social purpose that is independent of government and are constitutionally self-governing. They exist for the good of the community, to promote social, economic, environmental or cultural objectives to benefit society as a whole, or particular groups within it. Ranging from small community-based groups/schemes to larger registered Charities.
	Primary care	Primary care is the first point of contact for healthcare for most people. It is mainly provided by GPs (general practitioners), but community pharmacists, opticians, dentists and other community services are also primary healthcare providers.
PCN	**Primary care networks**	GP practices are working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as primary care networks (PCNs) to meet the needs of the local populations.
	Population health	The collection of patient data across multiple health information technology systems. This data is then analysed into a single, actionable patient record. Care providers can improve both clinical and financial outcomes using this data.
PHM	**Population Health Management**	Our health and care needs are changing: our lifestyles are increasing our risk of preventable disease and are affecting our wellbeing, we are living longer with more multiple long-term conditions like asthma, diabetes and heart disease – and the health inequality gap is increasing.
CEO	**Chief Executive Officer**	The chief executive officer (CEO) is the highest-ranking person in an organisation.
HWP	**Health & Wellbeing Partnerships**	HWPs are Local health and wellbeing partnerships work on addressing the wider determinants of health, reducing health inequalities and aligning NHS and local government services and commissioning.
LTP	**NHS Long Term Plan**	The NHS LTP was published in 2019 setting out key ambitions for the service over the next 10 years.
	Local Authority	Generally, this is just another word for a local council, but it can refer to any administrative organisation in local government.
LGA	**Local Government Association**	The Local Government Association is the national membership body for local authorities. Its core membership is made up of 339 English councils and the 22 Welsh councils through the Welsh Local Government Association. The LGA is politically-led and cross-party.
	Provider collaboratives	Provider collaboratives bring NHS providers together across one or more ICSs, working with clinical networks, alliances and other partners, to benefit from working at scale.

	Place-based partnerships	Place-based partnerships will bring together the NHS, local councils and voluntary organisations, residents, people who access services, carers and families. These partnerships will lead design and delivery of integrated services in their local area.
	Health and wellbeing partnerships	Health and wellbeing partnerships will bring together colleagues from county and district councils, health services, wider voluntary, community and social enterprise sector organisations and other partners. They will focus on the local population's health and wellbeing by addressing the wider determinants of health to avoid health crises.
DHSC	**Department of Health and Social Care**	Support ministers in leading the nation's health and social care to help people live more independent, healthier lives for longer.
	Acute care	Acute care providers are emergency services and general medical and surgical treatment for acute disorders rather than long-term residential are for chronic illness
	Commissioning	Identifying health needs of local people, planning and purchasing health services which respond to their needs. CCGs are responsible for deciding what services their local residents need from the NHS and buy these services with public money from the most appropriate providers.
	Care Pathway	The care and treatment a patient receives from start to finish for a particular illness or condition. This usually includes several parts of the health service and social care. For example, a care pathway can involve support from a GP, a specialist doctor, home care and a district nurse.
	CQC	Independent regulator of health and social care in England – including hospitals, care homes and other provider organisations.
	FOI	The Freedom of Information Act 2000 provides public access to information held by public authorities.
	Place	The geographical level below an Integrated Care System (ICS) at which most of the work to join up budgets, planning and service delivery for routine health and care services (particularly community-based services) will happen. The Norfolk and Waveney ICS will comprise five places.
	Place-based Working	This is the new way of working set out as part of integrated care systems. It involves bringing together all the health and care organisations that sit within that place area, such as the hospitals, councils, care providers and voluntary groups, to work together as local partners. Their knowledge of the local people's needs means all of these organisations can work together to make sure health and care services meet the needs of the people who live there.
	Neighbourhood	Within each 'place' there are several neighbourhoods, which cover a smaller population size of roughly 30,000 to 50,000 people. They often focus on integrating primary, community and social care through multidisciplinary teams and joint working arrangements. Neighbourhoods are therefore key to the NHS's commitment to deliver more care as close to home as possible.
	System	In relation to integrated care systems (ICS), this refers to the level of the ICS. Key functions at the system level include setting and leading overall strategy, managing collective resources and performance, identifying and sharing best practice to reduce unwarranted variations in care, and leading changes that benefit from working at a larger scale such as digital, estates and workforce transformation.
	Place Boards	A forum that brings together colleagues from health and care to integrate services and focus on effective operational delivery and improving people's care.

Appendix 3

Norfolk and Waveney ICS – People and Communities

Easy Read version can be found on our website:

https://improvinglivesnw.org.uk/~documents/documents/edi-resource-hub/easy-read/norfolk-and-waveney-ics-people-and-communities-easy-read-summary-060622

SECTION 8
Conflicts of Interest Policy

Revision History

Document Control Sheet

Revision Date	Summary of changes	Author(s)	Version Number

Approvals

Approval Date	Approval Body	Author(s)	Version Number

Document Control Sheet

Name of document	Conflicts of Interest Policy
Version	1
Date of this version	25 January 2023
Produced by	Corporate Affairs Manager
What is it for?	To ensure the ICB complies with its statutory duty to effectively manage conflicts of interest
Evidence base	NHS England guidance
Who is it aimed at and which settings?	Integrated care board, System partners, the public and patients
Consultation	Non undertaken
Impact Assessment:	Completed and attached to policy
Other relevant approved documents	• Standards of business conduct policy • Secondary employment policy • Disciplinary policy • Recruitment and selection policy • Counter fraud bribery and corruption policy
References:	N/A

Monitoring and Evaluation	This policy will be monitored and reviewed for effectiveness by the Corporate Affairs team on a regular basis
Training and competences	N/A
Reviewed by:	Conflicts of Interest Committee
Approved by:	ICB Board
Date approved:	
Signed:	
Dissemination:	
Date disseminated:	
Review Date:	
Contact for Review:	

Version Control

Revision History	Summary of changes	Author(s)	Version Number

1. Introduction

This policy describes the arrangements that NHS Norfolk and Waveney Integrated Care Board (ICB) has in place to manage conflicts of interest. This policy reflects and supports the ICB's constitution and the Statutory Guidance on Managing Conflicts of Interest in the NHS which was issued by NHS England in February 2017 as well as the interim guidance on the functions and governance of the Integrated Care Board issued by NHS England in March 2022.

The ICB can be described both as a statutory body, as established in legislation to replace Clinical Commissioning Groups from 1 July 2022, and separately as a unitary board.

ICBs manage conflicts of interest as part of their day-to-day activities. Effective handling of conflicts of interest is crucial to give confidence to patients, taxpayers, stakeholders/partners and Parliament that ICB commissioning decisions are robust, fair and transparent and offer value for money. It is essential to manage conflicts of interest to protect and maintain public trust in the NHS. Failure to manage conflicts of interest could lead to legal challenge and even criminal action in the event of fraud, bribery and corruption.

Conflicts of interest are common and sometimes an unavoidable part of the delivery of healthcare and as such it may not be possible or desirable to completely eliminate them; rather, it is how they are managed that matters. Section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) ("the Act") sets out the minimum requirements of what both NHS England and ICBs must do in terms of managing conflicts of interest.

This policy reflects the legal requirements and the statutory guidance issued by NHS England under sections 14O and 14Z8 of the Act. This policy also describes the systems the ICB has in place to identify and manage conflicts of interest, and to create an environment in which staff, ICB Board and committee members, feel able, encouraged and obliged to be open, honest and upfront about actual or potential conflicts.

The principles of collaboration, transparency and subsidiarity should be at the centre of any decision making. It is expected that all those who serve as members of the ICB Board, its Committees or those who take decisions where they are acting on behalf of the public or spending public money will observe the principles of good governance in the way they do business.

2. Purpose

The aim of this policy is to protect both the organisation and individuals involved, from impropriety or any appearance of impropriety by setting out how the ICB will manage conflicts of interest to ensure there is confidence in the commissioning decisions made and

to ensure the integrity of all members, officers, office holders, staff, stakeholders and suppliers involved with the work of the ICB.

Conflicts of interest may arise where an individual's personal interests, loyalties or those of a connected person (for example a relative or close friend) conflict with those of the ICB or might be perceived to conflict with those of the ICB.

Such conflicts may create problems such as inhibiting free discussion which could result in decisions or actions being made that are not in the interests of the ICB, and risk giving the impression that the ICB has acted improperly.

The ICB's responsibility includes the stewardship of significant public resources and the commissioning of health and social care services to the population of Norfolk and Waveney.

This policy aims to

- Enable the ICB partner organisations, clinicians and others who are involved in the work of the ICB, to demonstrate fairness and transparency, and that actions are in the best interest of patients and the ICB's local population.
- Ensure that the ICB operates within the relevant legal framework and in accordance with good practice, but without being bound by over-prescriptive rules that stifle efficiency or innovation.
- Safeguard clinically led commissioning, whilst ensuring objective investment decisions.
- Provide the public, providers, parliament, and regulators with confidence in the probity, integrity and fairness of our decisions.
- Uphold the confidence and trust between patients, the public and the NHS, in their recognition that parties want to behave ethically but may need support and training to understand when conflicts (actual or potential) may arise and how to manage them if they do.

3. Legal context

Section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) ("the Act") sets out the minimum requirements of what both NHS England and ICBs must do in terms of managing conflicts of interest

This policy reflects the legal requirements and the statutory guidance issued by NHS England under sections 14O and 14Z8 of the Act.

In addition to complying with the guidance issued by NHS England, ICBs are also required to adhere to relevant guidance issued by professional bodies on conflicts of interest, including the British Medical Association (BMA), the Royal College of General Practitioners, and the General Medical Council (GMC), and to procurement rules including The Public Contract Regulations 2015 and The National Health Service (procurement, patient choice and competition) (no.2) regulations 2013, as well as the Bribery Act 2010

4. Governance Framework – Standing orders, Scheme of Reservation and Delegation and Standard Financial Instructions

All individuals must carry out their duties in accordance with the ICB's Constitution, Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions (SFIs). These set out the statutory governance framework in which the ICB operates and there is considerable overlap between the contents of this policy and provision made within these. Individuals must always refer to, and act in accordance with them at all times to ensure processes are followed.

In the event of doubt, individuals should seek advice from their line manager or Corporate Affairs. Should a conflict arise between the details of this policy and the Constitution, Standing Orders, Scheme of Reservation and Delegation and SFIs then the provision of the Constitution, Standing Orders, Scheme of Reservation and Delegation and SFIs shall prevail

5. What are Conflicts of Interest

For the purposes of this policy 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'

With this in mind, and in accordance with the national guidance, a conflict of interest may be either:

Actual	Potential
There is a material conflict between one or more interests	There is the possibility of a material conflict between one or more interests in the future

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

A conflict of interest can fall into the following categories:

Financial Interests	Indirect Interests
Individual may get direct financial benefits from the consequences of a commissioning decision	Individual has a close association with an individual who has any type of interest in a commissioning decision

Examples include: • Directorship or employment in a private or public company or other organisation which is doing, or may do, business with health or social care organisations • A shareholder (more than 5% of the issued shares), partner or owner of a private or not for profit company, business or consultancy which is doing, or may do, business with health or social care organisations • A management consultant for a provider • Secondary employment • Receipt of secondary income from a provider • Receipt of a grant from a provider • Receipt of any payments (e.g. honoraria, one off payments, day allowances, travel or subsistence) from a provider • Receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role • Having a pension that is funded by a provider (where the value of this might be affected by their success or failure).	**Examples include:** • Spouse / Partner • Close relative e.g., parent, grandparent, child, grandchild or sibling • Close friend - any confusion relating to the declaration of friendship should be discussed with Corporate Affairs to ensure that all declarations are appropriate (e.g. a friend who works as a checkout operator in a shop that supplies the NHS need not be declared but a contracts manager with an NHS supplier should be • Business partner • Any other relationship which may influence or may be perceived to influence the judgement of the individual (e.g. a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house) • Where the individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.
Non-financial Professional Interests	**Non-financial Personal Interests**
Individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career	Individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit
Examples include: • An advocate for a particular group of patients • A GP with special interest e.g. in dermatology, acupuncture etc. • A member of a particular specialist professional body (routine GP membership of the RCGP, BMA or a medical defence organisation would not usually in itself amount to an interest which needs to be declared) • An advisor to for the CQC or NICE • A medical researcher	**Examples include:** • A voluntary sector champion for a provider • A volunteer for a provider • A member of a voluntary sector board or any position of authority in or connection with a voluntary organisation • Suffering from a particular condition requiring individually funded treatment • A member of a lobby or pressure groups with an interest in health • A financial advisor.
General Interest This could be any position held in another public body organisation, NHS, Local Authority or a community group which may have potential to give rise to influence decisions made by the ICB. Similarly, if you have made a declaration that you are a member of the ICB or attend any of its committees/working groups to another organisation, this information MUST be reciprocated back to the ICB to ensure consistency across organisations and vice versa	

Whether an interest held by another person gives rise to a conflict of interest will depend upon the nature of the relationship between that person and the individual, and the role of the individual within the ICB. It should be noted that:

- The above categories and examples are not exhaustive and the ICB will exercise discretion on a case-by-case basis.
- The possibility of the perception of wrongdoing, impaired judgement or undue influence shall also be considered a conflict of interest for the purposes of this Policy and should be declared and managed accordingly; and
- Where there is doubt as to whether a conflict of interest exists, it should be assumed that there is a conflict of interest and declared and managed accordingly.

Where an individual has any queries with respect to conflicts of interest they should seek advice from the ICB Corporate Affairs team.

6. Roles and responsibilities

The following roles and responsibilities apply in the context of this policy:

ICB Board and Committees
The ICB Board and its committees are responsible for upholding the principles of good governance and ensuring that ICB is always acting in the best interests the NHS and its communities. In particular, the chairs of these are responsible for ensuring that any declared interests in relation to agenda items at meetings are managed in accordance with this policy.

Audit and Risk Committee
The Audit and Risk Committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance and internal control. In particular, the Committee is responsible for monitoring compliance with this policy and the organisation's established probity arrangements

Chief Executive
The Chief Executive has overall accountability for the ICB's management of conflicts of interest, which includes the requirements for the management of gifts, hospitality and sponsorship.

Director of Finance
The Director of Finance is responsible for ensuring the adequacy of the ICB's counter fraud arrangements.

Governance Lead
The ICB Governance Lead is responsible for:

- The day-to-day management of matters and queries relating to the application of this policy.
- Maintaining the ICB's Register of Declared Interests
- Providing advice, support, and guidance on how conflicts of interest should be managed
- Ensuring that appropriate administrative processes are put in place;
- Supporting the Conflicts of Interest Guardian and Freedom to Speak Up Guardian in carrying out their roles effectively.

Conflicts of Interest Guardian
The Conflicts of Interest Guardian is in place to further strengthen the scrutiny and transparency of the ICB's decision-making processes. This role will also:

- Act as a conduit for anyone with concerns relating to conflicts of interest.
- Be a safe point of contact for employees or workers of the ICB to raise concerns in relation to conflicts of interest.
- Support the rigorous application of the principles and policies for managing conflicts of interest.
- Provide independent advice and judgment where there is any doubt about how to apply conflicts of interest policies and principles in individual situations.
- Provide advice on minimising the risks of conflicts of interest.

Freedom to Speak up Guardian
The Freedom to Speak Up Guardian is in place to provide an independent and impartial source of advice to staff at any stage of raising a concern.

Executive Management Team
Members of the Executive Management Team and Senior Leadership Team have an ongoing responsibility for ensuring the application of this policy.

All individuals
All individuals are responsible for complying with this policy and for seeking advice if unsure how it applies to them.

7. Decision making staff

Some staff are more likely than others to have a decision-making role or influence on the use of public money. This is because of the requirements of their role. This policy refers to these people as decision making colleagues.

Decision making colleagues in the ICB are:

- executive, non-executive and partner members of the board
- members of ICB committees, and delivery groups which contribute to decision making on the commissioning or provision of services
- those at Agenda for Change band 8d and above, or operating at that level on an interim basis

- administrative and clinical colleagues who:
    - have the power to enter into contracts on behalf of the ICB
    - are involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions

8. Declaring Interests

It is a statutory requirement that individuals must declare any interest that they have (see Appendix A) in relation to ICB business or a decision to be made, in writing, to be reviewed by their line manager and sent on to the ICB's Corporate Affairs team as soon as they are aware of it and in any event no later than 28 days after becoming aware.

Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent during a meeting, they will make an oral declaration before witnesses

which will be formally written in the meeting record. A written declaration will need to be submitted following the meeting to ensure inclusion on the register.

Individuals contracted to work on behalf of the group, or otherwise providing services or facilities to the group, will be made aware of their obligations under this policy to declare conflicts or potential conflicts of interests. This requirement will be written into their contracts for services

The ICB will ensure as a matter of course that declarations of interest are made and regularly confirmed or updated. This includes the following circumstances:

- **On appointment** – all appointments will be asked to make a formal declaration of interest and in the case of Board members, prior to appointment. The ICB will need to assess the materiality of the interest, in particular whether the individual (or family member/business partner) could benefit from any decision the Board might make). If the interest is significant to the extent that the individual would be unable to make a full and proper contribution to the Board because they are required to exclude themselves from decision-making on so regular a basis, then that individual should not become a member of the Board.

- **Annually -** to ensure the register of interest is accurate and up to date. If there are no interests or changes to declare a 'nil return' should be submitted.

- **At meetings –** a standing agenda item will be on the ICB Board, sub-committee and any working group agendas. Even if an interest has been recorded in the register of interests, it should still be declared in meetings before matters relating to that interest are discussed and any declarations will be recorded in the minutes of the meeting.

- **When prompted by the ICB** – because of the ICB's role in spending taxpayers' money, on at least an annual basis the ICB will ensure that individuals are prompted to update their declarations of interest or make a nil return where there are no interests or changes to declare.

- **On changing role or responsibility** – a further declaration should be made to reflect the change in circumstances; this could involve a conflict of interest ceasing to exist or a new one materialising (for example, where an individual takes on a new role outside the ICB, sets up a new business or relationship, starts a new project / piece of work or may be affected by a procurement decision e.g. if their role may transfer to a proposed new provider). A further declaration should be made to reflect the change in circumstances as soon as possible, and in any event within 28 days of the change.

- **During the procurement process** - anyone participating in the procurement, or otherwise engaging with the ICB, in relation to the provision of services or facilities, will be required to make a declaration of interest which will include nil returns. This includes those who will take part in any tender evaluation or decision making with regards to the award of a contract.

Registers of Interest are maintained by the Corporate Affairs team and these registers are available on the ICB website.

All interests declared will be promptly transferred to the relevant registers by Corporate Affairs. Where interests have expired, these will remain on the relevant register for a minimum of 6 months although a private record of the historic interests will be retained by the ICB for a minimum of 6 years after the date on which it expired

9. Registers of Interest

The ICB shall keep and maintain a Register of Interests (Appendix B) of all interests declared. The ICB Corporate Affairs team ensures that the Register includes sufficient information about the nature of the interest and the details of those holding the interest.

The ICB keeps a Register of Interests for the following:

- All ICB employees – including:
    - All full and part time staff
    - Any staff on sessional or short term contracts
    - Any students and trainees (including apprentices)
    - Agency staff
    - Seconded staff

- Members of the ICB Board and its committees – Including (but not limited to)
    - Executive Directors
    - Non-Executive Members
    - Partner Members

- Any third parties contracted to provide services, any person involved in procurement or commissioning decisions and any individual directly involved with business or decision making.

The register(s) will be publicly available and will be refreshed on an annual basis. Individuals should identify changes to their record on their register as soon as they are aware of it and in any event no later than 28 days of the change. The register will be published on the ICB's website.

In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual's name and/or other information may be redacted from the publicly available register(s). If an individual believes that substantial damage or distress may be caused to themselves or somebody else by the publication of information about them, they are entitled to request that the information is not published. Such requests must be made in writing. Decisions not to publish information must be made by the Conflicts of Interest Guardian for the ICB, who will seek legal advice where required, and the ICB will retain a confidential un-redacted version of the register(s).

The Register of Interest will include:

- Name of the person declaring the interest
- Position within or relationship with the ICB
- Type of interest, including for indirect interest details of the relationship with the person who has an interest
- The dates from which the interest relates
- The actions taken to mitigate the risk – these should be agreed with the individual's line manager or a senior manager within the ICB.

10. Management of interests in general

In a situation where a person declares an interest but there is no risk of a conflict arising, it required no action. However, should they declare a material interest the following general management action(s) which could be applied by the ICB include:

- restricting the person's involvement in associated discussions and excluding them from decision making
- removing the person from the whole decision-making process
- removing persons' responsibility for an entire area of work
- removing the person from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context specific. The ICB will always clarify the circumstances and issues with the individuals involved. Colleagues should maintain a written audit trail of information considered and actions taken.

Colleagues who declare material interests should tell their manager or the people they are working about those interests.

The Corporate Affairs team can advise on appropriate management action if this cannot be agreed locally.

11. Management in common situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared. A condensed 'at a glance' version is available at Appendix C.

The ICB should not accept gifts that may affect, or be seen to affect, their professional judgement.

Any personal gift of cash or cash equivalents (for example: vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICB) must always be declared, whatever their value and whatever their source, and the offer which has been declined must be declared to the Corporate Affairs team who has designated responsibility for maintaining the register of gifts and hospitality (Appendix D).

All staff need to consider the risks associated with accepting offers of gifts, hospitality and entertainment when undertaking activities for or on behalf of the ICB or their GP practice.

This is especially important during procurement exercises, as the acceptance of gifts could give rise to real or perceived conflicts of interests, or accusations of unfair influence, collusion, or canvassing.
The information captured below provides a description of what the issues, principles and rules are in respect of the main themes listed above.

<u>Gifts</u>

What are the issues?	Staff in the NHS offer support during significant events in people's lives. For this work they may sometimes receive gifts as a legitimate expression of gratitude. We should be proud that our services are so valued. But situations where the acceptance of gifts could give rise to conflicts of interest should be avoided. Staff and organisations should be mindful

	that even gifts of a small value may give rise to perceptions of impropriety and might influence behaviours if not handled in an appropriate way. A gift means any item of cash or goods, or any service, which is provided for personal benefit, free of charge, or at less than its commercial value
Principles and rules	Overarching principle applying in all circumstances: • Staff should not accept gifts that may affect, or be seen to affect, their professional judgement. Gifts from suppliers or contractors: • Gifts from suppliers or contractors doing business (or likely to do business) with an organisation should be declined, whatever their value. • Subject to this, low cost branded promotional aids may be accepted where they are under the value of a common industry standard of £6* in total and need not be declared. *the £6 value has been selected with reference to existing industry guidance issues by the ABPI. Gifts from other sources (e.g., patients, families, service users): • Gifts of cash and vouchers to individuals should always be declined. • Staff should not ask for any gifts. • Gifts valued at over £50 should be treated with caution and only be accepted on behalf of an organisation (i.e., to an organisation's charitable funds), not in a personal capacity. These should be declared by staff. • Modest gifts accepted under a value of £50 do not need to be declared. • A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value). • Multiple gifts from the same source over a 12-month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.
What should be declared	• Staff name and their role with the ICB Board • A description of the nature and value of the gift, including its source. • Date of receipt. • Any other relevant information (for example, circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Hospitality

What are the issues?	Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of "traditional" working hours. As a result, staff will sometimes appropriately receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted and be mindful

	that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviours. Hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events, etc.
Principles and rules	Overarching principles applying in all circumstances: • Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement. • Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event. • Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors, these can be accepted if modest and reasonable, but individuals should always obtain senior approval and declare these. **Meals and Refreshments** • Under a value of £25 may be accepted and need not be declared. • Of a value between £25 and £75* may be accepted and must be declared. • Over a value of £75* should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept. • A common-sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value). **Travel and accommodation** • Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared. • Offers which go beyond modest or are of a type that the ICB itself might not usually offer, need approval by senior staff (e.g. the ICB governance lead or equivalent), should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. • A non-exhaustive list of examples includes: - Offers of business class or first-class travel and accommodation - (including domestic travel); and - Offers of foreign travel and accommodation.

What should be declared	• Staff name and their role with the ICB Board • A description of the nature and value of the gift, including its source. • Date of receipt. • Any other relevant information (for example, circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Sponsored Events

What are the issues	Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures their ability to take place, benefiting NHS staff and patients. Without this funding there may be fewer opportunities for learning, development and partnership working. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services. As a result, there should be proper safeguards in place to prevent conflicts occurring.
Principles and rules	• Sponsorship of events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefit for the ICB and the NHS. • During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation. • No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied. • At the ICB's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event. • The involvement of a sponsor in an event should always be clearly identified in the interest of transparency. • ICBs should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be • made visibly clear on any promotional or other materials relating to the event. • Staff should declare involvement with arranging sponsored events to the organisation. • All declarations made under this section must be made promptly - A declaration form is at Appendix E.
What should be declared	Organisations should maintain records regarding sponsored events in line with the above principles and rules.

Other forms of sponsorship

What are the issues?	Research is vital in helping the NHS to transform services and improve outcomes. Without sponsorship of research some beneficial projects might not happen. More broadly, partnerships between the NHS and external bodies on research are important for driving innovation and sharing best practice. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage. There needs to be transparency and any conflicts of interest should be well managed.
Principles and rules	• Funding sources for research purposes must be transparent. • Any proposed research must go through the relevant health research authority or other approvals process. • There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services. • The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service. • Staff should declare involvement with sponsored research to their organisation. • The organisation will retain written records of sponsorship of research, in line with the above principles and rules.
What should be declared	Staff should declare: • Their name and their role with the ICB Board. • A description of the nature of the nature of their involvement in the sponsored research. • Relevant dates. • Any other relevant information (e.g., what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Sponsored Posts

What are the issues	Sponsored posts are positions with an organisation that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

Principles and rules	• Staff who are establishing the external sponsorship of a post should seek formal prior approval from their organisation. • Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of arrangements continuing. • Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. For the duration of the sponsorship, auditing arrangements should be established to ensure this is the case. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise. • Sponsored post holders must not promote or favour the sponsor's specific products, and information about alternative products and suppliers should be provided. • Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.
What should be declared	• The organisation will retain written records of sponsorship of posts, in line with the above principles and rules. • Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

Shareholdings and other Ownership Issues

What are the issues	Holding shares or other ownership interests can be a common way for staff to invest their personal time money to seek a return on investment. However, conflicts of interest can arise when staff personally benefit from this investment because of their role within an organisation. For instance, if they are involved in their organisation's procurement of products or services which are offered by a company they have shares in then this could give risk to a conflict of interest. In these cases, the existence of such interest should be well known so that they can be effectively managed.
Principles and rules	• Staff should declare, as a minimum, any shareholdings and other ownership interests in a publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation. • There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts. • Where shareholdings or other ownership interests are declared and give rise to the risk of conflicts of interest

	then the general management actions outlined in this policy should be considered and applied to mitigate risks.
What should be declared	• Staff name and their role within the ICB Board. • Nature of the shareholdings/other ownership interest. • Relevant dates. • Other relevant information (e.g. action taken to mitigate against a conflict, detail of any approvals given to depart from the terms of this policy).

Patents

What are the issues?	The development and holding of patents and other intellectual property rights allows staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas. Staff are encouraged to be innovative in their practice and therefore this activity is welcomed. However, conflicts of interest can arise when staff who hold patents and other intellectual property rights are involved in decision making and procurement. In addition, where produce development involves use of time, equipment or resources from their organisation, then this too could create risks of conflicts of interest, and it is important that the organisation is aware of this and it can be managed appropriately.
Principles and rules	• Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are on-going, which are, or might be reasonably expected to be, related to items to be procured or used by their organisation. • Staff should seek prior permission from their organisation before entering into any agreement with bodies regarding product development, research, work on pathways, etc, where this impacts on the organisation's own time, or uses its equipment, resources of intellectual property. • Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
What should be declared	• Staff name and their role within the ICB Board. • A description of the patent or other intellectual property right and its ownership. • Relevant dates. • Other relevant information (e.g., action taken to mitigate against a conflict, detail of any approvals given to depart from the terms of this policy).

Loyalty Interests

What are the issues?	As part of their jobs staff members need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define as they may often fall in the category of indirect interests. They are unlikely to be directed by a formal process or managed via any contractual means – it can be as simple as having informal access to people in senior positions. However, loyalty interest can influence decision making. Conflicts of interest can arise when decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship, they have rather than through an objective process. The scope of loyalty interests is potentially huge, so judgement is required for making declarations.
Principles and rules	Loyalty interests should be declared by staff involved in decision making where they: • Hold a position of authority in another NHS organisation, or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role. • Sit on advisory groups or other paid or unpaid decision making forums that can influence how their organisation spends taxpayers' money. • Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners. • Are aware that their organisation does business with an organisation with whom close family members and relatives, close friends and associates, and business partners have decision making responsibilities. Where holding loyalty interest gives rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
What should be declared	• Staff name and their role within the ICB Board. • Nature of the loyalty interest • Relevant dates. • Other relevant information (e.g., action taken to mitigate against a conflict, detail of any approvals given to depart from the terms of this policy.

Donations

What are the issues?	A donation is a charitable financial payment, which can be in the form of direct cash payment or through the application of a will or similar directive. Charitable giving and other donations are often used to support the provision of health and care services. As a major public sector employer, the NHS holds formal and informal partnerships with national and local charities. A supportive environment across the NHS and charitable sector should be promoted. However. Conflicts of interest can arise.

Principled and rules	• Acceptance of donations made by suppliers or bodies seeking to do business with an organisation should be treated with caution and not routinely accepted. In exceptional circumstances a donation from a supplier may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value. • Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for an organisation or is being pursued on behalf of that organisation's registered charity (if it has one) or other charitable body and is not for their own personal gain. • Staff must obtain permission from their organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign. • Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued. • Staff wishing to make a donation to a charitable fund in lieu of a professional fee they receive may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.
What should be declared	• Organisations should maintain records in line with their wider obligations under charity law, in line with the above principles and rules.

Secondary employment

What are the issues?	The NHS relies on staff with good skills, broad knowledge and diverse experience. Many staff bring expertise from sectors outside the NHS, such as industry, business, education, government and beyond. The involvement of staff in these outside roles alongside their NHS role can therefore be of benefit, but the existence of these should be well known so that conflicts can be either managed or avoided. Outside employment means employment and other engagements, outside of formal employment arrangements. This can include directorships, non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles and roles within not-for-profit organisations, paid advisory positions and paid honorariums which relate to bodies likely to do business with an organisation.
Principled and rules	• Staff should declare any existing outside employment on appointment, and any new outside employment when it arises to their Line Manager. Please read the Secondary Employment Policy for further detail. • Where a risk of conflict of interest is identified, the general management actions outlined in this policy should be considered and applied to mitigate risks.

	• Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from an organisation to engage in outside employment. • Organisations may also have legitimate reasons within employment law for knowing about outside employment of staff, even if this does not give rise to risk of a conflict. Nothing in this policy prevents such enquiries being made.
What should be declared	• Staff name and their role within the ICB Board. • The nature of the outside employment (e.g., who it is with, a description of duties, time commitment). • Relevant dates. • Other relevant information (e.g., action taken to mitigate against a conflict, details of an approvals given to depart from the terms of this policy).

12. Managing Conflicts of Interest at meetings

To support Chairs in their role, the meeting Secretariat will regularly provide the Chair with access to a copy of the Register of Interests prior to meetings. This should include details of any declarations of conflicts, which have already been made by the members
The Meeting Secretariat should invite members and those in attendance, to declare any interests in relation to agenda items to the Chair in advance of the meeting
Meeting Secretariats are required to use the following templates to administer the meetings. Use of these will help to ensure conflicts of interest are discussed and recorded in line with statutory guidelines.

- Meeting Agenda
- Template for recording minutes

When a member of the meeting (including the chair or deputy chair) has a conflict of interest in relation to one or more items of business to be transacted at the meeting, the chair (or deputy chair or remaining non-conflicted members where relevant) must decide how to manage the conflict. The appropriate course of action will depend on the particular circumstances, but could include one or more of the following:

- Request that the individual does not receive the papers which are relevant or minutes of the meeting which relate to the matter(s) which give rise to the conflict or receive redacted versions.
- Request that the individual leaves the meeting when the relevant matter(s) are about to be discussed or does not attend the meeting.
- Allow the individual to participate in some or all of the discussion when the relevant matter(s) are being discussed but request them to leave the meeting when any decisions are being taken in relation to those matter(s). This may be appropriate where the conflicted individual has important relevant knowledge and experience of the matter(s) which would benefit other members to hear, but this will depend on the nature and extent of the interest which has been declared.
- Noting the interest and ensuring that all in attendance are aware of the nature and extent of the interest but allowing the individual to remain and participate in both the discussion and in any decisions. This is only likely to be the appropriate course of action where it is

decided that the interest which has been declared is either immaterial or not relevant to the matter(s) under discussion.

In the event that the Chair of a meeting has a conflict of interest, the Deputy Chair is responsible for deciding the appropriate course of action to manage the conflict of interest. If the Deputy Chair is also conflicted or not in attendance, then the remaining non-conflicted voting members of the meeting should agree between themselves how to manage the conflict(s).

As a minimum requirement, the following should be recorded in the minutes of all meetings where a conflict of interest has been declared:

- Individual declaring the interest.
- At what point the interest was declared.
- The nature of the interest.
- The Chair's decision and resulting action taken.
- The point during the meeting at which the individual left and returned to the meeting.

Appendix F can be used by meeting Secretariats to record information in these circumstances. Completed forms should be sent to Corporate Affairs.

In addition, the ICB encourages meeting Secretariats and chairs to use the Conflicts Management Plan (Appendix G) to assist with planning appropriate steps which can be taken in certain situations.

13. Managing Conflicts of Interest during the recruitment process

Everyone in the ICB has responsibility to appropriately manage conflicts of interest during the recruitment process because these roles will be involved (in some form) in the decision making processes of the ICB.

Appointing ICB Board Members, Committee Members, and any member of staff
When advertising for a ICB Board Member, Committee member or a member of staff, a request will be made via the recruitment team by the recruiting manager for a Conflict of Interest form to be completed by the successfully shortlisted candidates, and this will need to be brought with them to their interview.
On appointing to any of these roles the ICB will need to consider whether conflicts of interest should exclude individuals from being appointed to the role. This will need to be considered on a case-by-case basis and in conjunction with the principles within the ICB's Constitution. In such cases the Corporate Affairs team must always be consulted for advice prior to any decision being made.
The materiality of the interest will need to be considered, and in particular, whether the individual (or any person with whom they have a close association as listed in the scope of this policy) could benefit (whether financially or otherwise) from any decision the ICB might make. The ICB will also determine the extent of the interest and the nature of the appointee's proposed role within the ICB. If the interest is related to an area of business significant enough that the individual would be unable to operate effectively and make a full and proper contribution in the proposed role, then that individual should not be appointed to the role.
All recruiting managers will need to ensure that they support obtaining the declaration of interest forms for new staff and make the necessary arrangements to manage any declared conflicts of interest.

ICB Board and Committee members from other Organisations

ICBs have been created to give statutory NHS providers, local authorities and primary medical services (general practice) nominees a role in decision-making. It should not be assumed that the ICB Board will always be conflicted because at least three members of the ICB Board must be jointly nominated (the "partner members") It is crucial that the ICB ensures that the Boards and Committees are appropriately composed and take into account different perspectives individuals will bring from their respective sectors to help inform decision making.

14. Managing Conflicts of Interest through the Commissioning Cycle

The NHS England guidance for Managing Conflicts of Interest in the NHS (February 2017) is clear that conflicts of interest need to be managed appropriately throughout the whole commissioning cycle including within the ongoing management of existing contracts and ICBs must have in place processes to ensure this happens.

At the outset of a commissioning process, all individuals involved, including those from external bodies, must complete a Conflict of Interest form, even if there is nothing to declare (Appendix A). Completed forms must be held by the lead Procurement Manager and either the forms or a collated register must be available at every meeting.

Where Conflicts of Interest are declared, the chair of the meeting, in conjunction with the Corporate Affairs team, must put in place clear arrangements to robustly manage these. This includes consideration as to which stages of the process a conflicted individual should not participate in, and, in some circumstances, whether that individual should be involved in the process at all. The steps taken must be clearly documented in the minutes.

Where a conflict is identified which may impact on the management of an existing contract, a discussion must take place with the Corporate Affairs team, and if necessary the Conflicts of Interest Guardian, so that steps can be put in place to manage this. Any mitigation must also be recorded in minutes that are taken.

ICBs will also need to identify as soon as possible where staff might transfer to a provider (or their role may materially change) following the award of a contract. This should be treated as a relevant interest which will be managed in line with this policy and following advice from the Corporate Affairs team and if necessary the ICB Conflicts of Interest Guardian.

Designing service requirements

The NHS England guidance upon which this policy is based states that ICBs have legal duties under the Act to properly involve patients and the public in their respective commissioning processes and decisions. Public involvement supports transparent and credible commissioning decisions and should happen at every stage of the commissioning cycle from needs assessment, planning and prioritisation to service design, procurement and monitoring.

Conflicts of Interest can arise from the inclusion of members of the public or particular groups who are involved in the decision-making process of the ICB. As such, any member of the public or representative of a particular group involved in the influencing or decision making of the ICB will be required to complete a Declaration of Interest form regardless of a conflict being identified. This will be held by the Procurement Manager alongside any other conflict of interest forms completed as part of the procurement process.

Provider engagement

It is good practice to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient needs. Such engagement, done transparently and fairly, is entirely legal but it is important not to gear the requirement in favour of any particular provider(s). If appropriate, the advice of an independent clinical adviser on the design of the service should be secured.

Conflicts of interest, as well as challenges to the fairness of the procurement process, can arise if a commissioner engages selectively with only certain providers (existing or potential) in developing a service specification for a contract for which they may later bid. The ICB is particularly mindful of these issues when engaging with existing / potential providers in relation to the development of new care models.

Procuring new care models

Where new care models or other arrangements of a similar scale or scope, are being procured it is imperative that conflicts of interest are managed in line with this policy. Where further advice is needed, please seek advice from the Corporate Affairs team.

Managing conflicts of interest relating to procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour which is against the interest of patients and the public Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process
In relation to the provider selection regime, 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 recuse themselves from the process
The procedure for managing conflicts of interest during procurements is set out in the ICB's Procurement and Contracting policies.

Register of procurement decisions

To promote transparency in decision-making, and in line with the NHS England Managing Conflicts of Interest in the NHS (February 2017), the ICB will maintain a register of procurement decisions taken, either for the procurement of a new service or any extension or material variation of a current contract. This will include:

- The details of the decision;
- Who was involved in making the decision (including the name of the ICB clinical lead, the ICB contract manager, the name of the decision making committee and the name of any other individuals with decision-making responsibility);
- Summary of any conflicts of interest in relation to the decision and how these were managed; and
- The award decision taken.

It is the responsibility of Managers involved in Procurements to ensure that details of any procurement decisions taken, including single tender actions are provided to the Corporate Affairs team so that the register of procurement decisions can be maintained. Upon receipt of new information, the register of procurement decisions will be updated and published on the ICB website by the Corporate Affairs team.

15. Joint working

Individuals must ensure that joint working arrangements are clear and transparent. Joint working is where, for the benefit of patients, organisations pool skills / resources and experience to enable successful delivery of a project or work area, this may also include

joint committees. Appropriate governance arrangements must be put in place that ensure that conflicts of interest are identified and managed appropriately, in accordance with statutory guidance, without compromising the ICB's ability to make robust commissioning decisions. The ICB currently works in collaboration with Local Authorities and other system partners.

16. Raising concerns and breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of individuals or organisations. For the purposes of this policy, these situations are referred to as 'breaches'.

This policy has been prepared to help individuals approach their decision making properly where there is a conflict of interest. Individuals are expected to use this policy to fulfil their duty to act only in the best interests of the ICB and to be able to provide a convincing justification for their decisions in the event of challenge. The ICB takes seriously the failure to disclose such information as required by this policy.

It is the duty of every ICB employee, Board member, committee member and GP practice member to speak up about genuine concerns in relation to the administration of the ICB's policy on conflicts of interest management, and to report these concerns. Individuals should not ignore suspicions or investigate themselves, but rather speak to the designated ICB point of contact for these matters.

Concerns around suspected or known breaches of this policy should be raised in the first instance with either the Corporate Affairs team or Director or Finance (unless implicated). If individuals prefer to speak to someone else in strict confidence, they can also contact the Conflicts of Interest Guardian. All such notifications will be held in the strictest confidence and in accordance with the ICB's other policies (including the Freedom to Speak Up Policy).

The Counter Fraud, Bribery and Corruption Policy may be consulted and an appropriate referral made to the Local Counter Fraud Specialist where applicable. The Fraud and Security Management Service may also be consulted directly. The person notifying the Conflicts of Interest Guardian can expect a full explanation of any decisions taken as a result of any investigation.

Please see Appendix H for the procedure on reporting Conflicts of Interest Breaches.

If conflicts of interest are not effectively managed there is the potential for corporate offences to be applied contrary to the Bribery Act 2010 which could lead to unlimited fines and criminal prosecution against directors. The ICB could further face civil challenges to decisions they make. For instance, if breaches occur during a procurement exercise, the ICB risks a legal challenge from providers that could potentially overturn the award of a contract, lead to damages claims against the ICB, and necessitate a repeat of the procurement process. Breaches also damage public trust and confidence in the NHS generally.

In extreme cases, staff and other individuals could face personal civil liability, a claim for misfeasance in public office or fitness to practice proceedings by their professional regulator. Failure to manage conflicts of interest could also lead to criminal proceedings including for offences such as fraud, bribery and corruption.

It is an offence under the Fraud Act 2006 for individuals to 1) abuse their position; and/or 2) fail to disclose information to the ICB and/or 3) make a false representation in order to make a gain for themselves or another, or to cause a loss or expose the organisation to a loss. Therefore, if an individual becomes aware that someone has failed to disclose relevant and material information, or made a false representation, they should raise the concern in the first instance with the Local Counter Fraud Service who will then liaise with the Corporate Affairs team, Director of Finance, and the Conflicts of Interest Guardian – all such notifications will be dealt with in the strictest confidence in accordance with the other ICB's policies (including the Freedom to Speak Up Policy).

Individuals who fail to disclose any relevant interests or who otherwise breach the ICB's rules and policies relating to the management of conflicts of interest will be subject to investigation and, where appropriate, to disciplinary action. ICB staff, Board and committee members in particular should be aware that the outcomes of such action may, if appropriate, result in the termination of their employment or position with the ICB.

All breaches will be anonymised, recorded and published on the ICBs website along with any outcomes/actions for the purpose of learning and development once investigations have been completed. NHS England will be notified of any breaches, as appropriate, as soon as possible, including as part of the quarterly returns for the Improvement and Assessment Framework.

Appendix A – Declaration of Interest Template

Template Declaration of Interests for ICB Board Members, employees and any person working for, or on behalf of, the ICB

Name:	
Position within, or relationship with, NHS Norfolk and Waveney ICB	

Detail of interests held (complete all that are applicable):

Type of Interest* *See reverse of form for details	Description of Interest (including for indirect Interests, details of the relationship with the person who has the interest)	Date interest relates From & To		Actions to be taken to mitigate risk (to be agreed with line manager or a senior ICB manager)

***If you have more interests to list please insert extra lines**

If you have no interests to declare and wish to submit a nil return, please tick this box ☐

Data Protection and Freedom of Information

In accordance with the Data Protection Act 2018, the information provided in completing this form will be held by the ICB in both paper and electronic forms. For further details on how the ICB processes personal information please see our Fair Processing Notice. It should also be noted that information provided to the ICB may be subject to release under the Freedom of Information Act 2000.

Statutory duties and publication

Consistent with Section 140 of the NHS Act 2006 and guidance produced by NHS England on the management of conflicts of interest, the ICB is required to hold and publish the interests of members and employees to comply with our statutory duties.

As a minimum, ICBs are expected to publish the interests of its members who fall into the following categories:

- Board, committees and management groups of the ICB
- Any person involved in procurement decisions and/or service re-design
- Any person at AfC 8d and above
- Any person with delegated functions or authority (as set out within the ICB Governance Handbook)

Staff who fall into the above categories should expect their interests to be published online unless in exceptional circumstances where the public disclosure of information could lead to a real risk of harm or is prohibited by law. Similarly, if a person believes that substantial damage or distress may be caused to them or somebody else by the public disclosure of information, they are entitled to request that the information is not published. Requests should be set out in the free text box below.

[Reasons for non-disclosure of information….here]

In this case, if the request to withhold the information is approved, the person's name will be removed from the record and the interest will be published anonymously.

**please see page 2 and 3 for more information

Please confirm below which NWICB Committees you belong to or attend:	
☐ ICB Board	☐ Integrated Care Partnership
☐ Conflicts of Interest Committee	☐ Audit and Risk Committee
☐ Patient and Communities Committee	☐ Quality and Safety Committee
☐ Remuneration, People and Culture Committ	☐ Primary Care Commissioning Committe
☐ Finance Committee	☐ Performance Committee
☐ Executive Management Team	☐ Senior Management Team
☐ Place Board	☐ Other (please state)

If you are a member of the Primary Care Committee; or a person responsible for matters (contractual or finance) relating to primary care and are registered with a Norfolk and Waveney GP Practice, please record this below	
GP Practice:	

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

Signed		**Date**	

Type of Interest	Description
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being: • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations; • A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A management consultant for a provider; • In secondary employment (see paragraph 56 to 57); • In receipt of secondary income from a provider; • In receipt of a grant from a provider; • In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and • Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is: • An advocate for a particular group of patients; • A GP with special interests e.g., in dermatology, acupuncture etc. • A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE); • A medical researcher.
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A voluntary sector champion for a provider; • A volunteer for a provider; • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation; • Suffering from a particular condition requiring individually funded treatment; • A member of a lobby or pressure groups with an interest in health.

Type of Interest	Description
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). For example, this should include: • Spouse / partner; • Close relative e.g., parent, grandparent, child, grandchild or sibling; • Close friend; • Business partner.

Appendix B – Register of Interests Template

NHS Norfolk and Waveney Integrated Care Board (ICB) Register of Interests Declared Interests of the XXXXXXXXXXXX									
Name	Current position	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	

Appendix C – Gifts and Hospitality Guide

<table>
<tr><th>What is a gift of hospitality?</th><th>What can't I accept?</th></tr>
<tr><td>Gift:
Any item of cash or goods, or any service which is provided for personal benefit, free of charge or at less than its commercial value.

Hospitality:
Meals/drinks/visits/entertainment/lecture courses organised by potential suppliers. It must only be accepted when there is legitimate reason, must be proportionate to the nature and purpose of the event and must be recorded.</td><td rowspan="4">• Gifts from suppliers or contractors doing business with the ICB (or likely to) whatever the value
• Cash and vouchers

Meals and refreshments:
• Over £75 must be refused (unless exceptional and senior approval is given – reason for approval must be recorded on the register)

Travel and accommodation:
• If its beyond modest and not normal for the ICB, it should only be accepted in exceptional circumstances and must be declared with a clear reason recorded on the register – for example business or first-class travel, foreign travel and accommodation</td></tr>
<tr><th>What can I accept?</th></tr>
<tr><td>Meals and refreshments:
• Under £25 may be accepted and need not be declared.
• £25 - £75 may be accepted, but must be declared.

Travel and accommodation:
• Modest offers to pay for some travel and accommodation costs related to attendance may be accepted and must be declared.</td></tr>
<tr><td>Low cost branded promotional aids e.g. pens and keyrings under £6</td></tr>
<tr><td>Modest gifts under £25 from non-suppliers, and non-contractors</td></tr>
<tr><th>What to do if I accept a gift or hospitality</th><th>How do I refuse a gift?</th></tr>
<tr><td>Within no later than 14 days you must complete the form (at appendix C) and return it to the Corporate Affairs team for inclusion on the register.</td><td>Politely refuse, explaining the policy and advise the donor that, if they wish, they are welcome to make a contribution to a charitable cause instead</td></tr>
<tr><th>What happens to my form and the register?</th><th>What must you not do</th></tr>
<tr><td>• The information from your form is included in the master register
• The master register has to be published on the ICB's website and in the Annual Report and Accounts
• You can ask that your information is not published.
• The ICB has to report quarterly on its management of interests, gifts and hospitality and this information will be shared with regulators as part of this process.</td><td>You must not ask for any gifts or hospitality

You should not accept gifts that may affect or be seen to affect your professional judgement.</td></tr>
<tr><td rowspan="2"></td><th>When to be caution</th></tr>
<tr><td>When hospitality if offered by actual or potential suppliers or contractors. If it's modest and reasonable it can be accepted (subject to senior approval)

Gifts over £25 can only be accepted on behalf of the ICB (i.e. to a charitable fund) bit not in a personal capacity. They must be declared

Multiple gifts from the same source, over a 12 month period, must be treated the same as single gifts over £25 where the cumulative value exceeds £75</td></tr>
</table>

Appendix D – Register of Gifts and Hospitality Template

Recipient Name	Position	Date of Offer	Date of Receipt (if applicable)	Declined or Accepted?	Supplier/Offer or: Name and Nature of Business	Details of Gift/Hospitality	Estimated Value	Details of previous offers or Acceptance by the Offer or/Suppier	Reason for Accepting or Declining	Details of the officer reviewing and approving the declaration made and date	Other Comments

The information submitted will be held by the ICB for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 2018. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and in the case of 'decision making staff' (as defined in the statutory guidance on managing conflicts of interest for ICBs), may be published in registers that the ICB holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the ICB as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result. Decision making staff should be aware that the information provided in this form will be added to the ICB's registers which are held in hardcopy for inspection by the public and published on the ICB's website.

Decision making staff must make any third party whose personal data they are providing in this form aware that the personal data will held in hardcopy for inspection by the public and published on the ICB's website and must inform the third party that the ICB's privacy policy is available on the ICB's website. If you are not sure whether you are a 'decision making' member of staff, please speak to your line manager before completing this form.

Signed: Date:

Signed: Position: Date:
(Line Manager or a Senior ICB Manager)

Appendix E – Register of Sponsorship Template

Recipient Name	Position	Date of Offer	Date of Receipt (if applicable)	Details of sponsorship	Estimated value	Supplier name and nature of business	Details of any previous offers	Details of Officer reviewing / approving	Declined / accepted	Reason of declining or accepting	Other Comments

The information submitted will be held by the ICB for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 2018. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and in the case of 'decision making staff' (as defined in the statutory guidance on managing conflicts of interest for ICBs), may be published in registers that the ICB holds.

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Signed: Position: Date:
(Line Manager or a Senior ICB Manager)

Appendix D – Register of Gifts and Hospitality Template

Recipient Name	Position	Date of Offer	Date of Receipt (if applicable)	Declined or Accepted?	Supplier/Offer or: Name and Nature of Business	Details of Gift/Hospitality	Estimated Value	Details of previous offers or Acceptance by the Offer or/Suppier	Reason for Accepting or Declining	Details of the officer reviewing and approving the declaration made and date	Other Comments

The information submitted will be held by the ICB for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 2018. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and in the case of 'decision making staff' (as defined in the statutory guidance on managing conflicts of interest for ICBs), may be published in registers that the ICB holds.

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Signed: Date:

Signed: Position: Date:
(Line Manager or a Senior ICB Manager)

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The information submitted will be held by the ICB for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 2018. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and in the case of 'decision making staff' (as defined in the statutory guidance on managing conflicts of interest for ICBs), may be published in registers that the ICB holds.

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Decision making staff must make any third party whose personal data they are providing in this form aware that the personal data will held in hardcopy for inspection by the public and published on the ICB's website and must inform the third party that the ICB's privacy policy is available on the ICB's website. If you are not sure whether you are a 'decision making' member of staff, please speak to your line manager before completing this form.

Signed: Date:

Signed: Position: Date:
(Line Manager or a Senior ICB Manager)

Appendix F- Template for recording interests at meetings

Report from <insert details of committee/ work group>	
Title of paper	<insert full title of the paper>
Meeting details	<insert date, time and location of the meeting>
Report author and job title	<insert full name and job title/ position of the person who has written this report>
Executive summary	<include summary of discussions held, options developed, commissioning rationale, etc.>
Recommendations	<include details of any recommendations made including full rationale> <include details of finance and resource implications>
Outcome of Impact Assessments completed (e.g. Quality IA or	<Provide details of the QIA/EIA. If this section is not relevant to the paper state 'not applicable'>
Outline engagement – clinical, stakeholder and public/patient:	<Insert details of any patient, public or stakeholder engagement activity. If this section is not relevant to the paper state 'not applicable'>
Management of Conflicts of Interest	<Include details of any conflicts of interest declared> <Where declarations are made, include details of conflicted individual(s) name, position; the conflict(s) details, and how these have been managed in the meeting> <Confirm whether the interest is recorded on the register of interests- if not agreed course of action>
Assurance departments/ organisations who will be affected have been consulted:	<Insert details of the people you have worked with or consulted during the process : Finance (insert job title) Commissioning (insert job title) Contracting (insert job title) Medicines Optimisation (insert job title) Clinical leads (insert job title) Quality (insert job title)
Report previously presented at:	<Insert details (including the date) of any other meeting where this paper has been presented; or state 'not applicable'>
Risk Assessments	<insert details of how this paper mitigates risks- including conflicts of interest>

Appendix G – COI Management Plan

Conflicts of Interest – Management Plan
Norfolk and Waveney Integrated Care Board

Definition
A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role, is or could be impaired or otherwise influenced by his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur e.g.

- **Financial interest** – direct financial benefit e.g. shareholder of organisation in receipt of funding, in receipt of secondary income, sponsored research etc.
- **Non-financial professional interest** – e.g. increasing professional reputation or status or promoting career
- **Non-financial personal interest** – e.g. member of voluntary sector organisation or lobbying/pressure group
- **Indirect interest** – close association with another individual who has an interest e.g. close family, friends

A perception of wrong-doing, impaired judgement or undue influence can be as detrimental as any of them occurring. If in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it.

Some disclosed conflicts will require a Management Plan to be put in place. This should be developed between the Line Manager and the Discloser. Once it has been agreed, the Conflict Management Plan will need to be passed to the Governance Team.

Background

Use this space to tell us about the circumstances that have given risk to the conflict:

Who is potentially conflicted?

Please provide the details of potentially conflicted parties in this section:

Why?

Please use this space to explain why and how the conflict will, or may, occur:

What further mitigation could be taken?

Use this section to consider possible mitigations of the declared conflict, - remember, transparency of decision making is key. Possible mitigations include:

- add to publicly available Register of Interests
- exclude conflicted parties from a specific decision making situation
- ensure decisions are in line with operational/commissioning strategies
- decisions are based on local health needs
- be proactive – early engagement with patients, public, clinicians and other stakeholders, including local Healthwatch and Health and Wellbeing Boards
- early engagement with both incumbent and potential new providers over potential changes to the services commissioned for a local population
- seek advice e.g. clinical senates, networks, commissioning support
- invite Health and Wellbeing Board or another ICB to review the proposal The general safeguards will vary to some extent depending on at what stage in the commissioning cycle the decisions are being made.

Consider the 'Six Rs':

- **Register** – Where details of the existence of a possible or potential conflict of interest are formally registered.
- **Restrict** – Where restrictions are placed on the public official/Board member's involvement in the matter.
- **Recruit** – Where a disinterested third party is used to oversee part or all of the process that deals with the matter.
- **Remove** – Where a public official/Board member chooses to be removed from the matter.
- **Relinquish** – Where the public official/Board member relinquishes the private interest that is creating the conflict.
- **Resign** – Where the public official/Board member resigns from their position with the organisation.

Steps taken to date:

Risk Score before and after mitigation

Consequence (impact)		Likelihood				
		Rare 1	**Unlikely 2**	**Possible 3**	**Likely 4**	**Almost certain 5**
Negligible 1		1	2	3	4	5
Minor 2		2	4	6	8	10
Moderate 3		3	6	9	12	15
Major 4		4	8	12	16	20
Catastrophic 5		5	10	15	20	25

Further mitigation proposed:

Low risk	Normal risks which can be managed by routine procedures	The ICB accepts low risks that are likely to result in identified impact
Moderate risk	Responsibility for assessment and action planning allocated to a named individual	The ICB is willing to accept moderate risks that may result in identified impact
Significant risk	Urgent senior management attention with action plan	The ICB is willing to accept some significant risks in certain circumstances
High risk	Immediate action required by a Director	The ICB is not willing to accept any high risk under any circumstances

Risk Score

	Likelihood	Consequence	Risk Rating
Risk before mitigation			
Risk after mitigation			

Conflict Management Plan Review date: _____
(*The review should take place no later than 12 months from the date of this plan, and sooner should circumstances change)*

Agreement

	Signed	Date
Discloser		
Reviewer		
Corporate team		

Appropriate Actions

This section provides an indication of the actions that should be taken where a conflict is identified.
However, each situation is different, and where there is any uncertainty, guidance should be sought from the Corporate Affairs team.

	Financial	Non-financial professional	Non-financial personal	Indirect
Needs Assessment	Fully participate	Fully participate	Fully participate	Fully participate
Review health outcomes	Fully participate	Fully participate	Fully participate	Fully participate
Design services	Discuss and vote	Discuss and vote	Discuss and vote	Discuss and vote
Decide priorities	Discuss but cannot vote	Discuss and vote	Discuss and vote	Discuss and vote
Review commissioning proposals	Remain but cannot speak or vote	Remain but cannot speak or vote	Remain but cannot speak or vote	Discuss and vote
Performance management	Remain but cannot speak or vote (unless interest is deemed not prejudicial)	Remain but cannot speak or vote (unless interest is deemed not prejudicial)	Remain but cannot speak or vote (unless interest is deemed not prejudicial)	Discuss and vote
Review prioritised business cases	Leave the room	Remain but cannot speak or vote	Remain but cannot speak or vote (unless interest is deemed not prejudicial)	Discuss and vote
Procurement/contracting	Leave the room	Remain but cannot speak or vote (unless interest is deemed not prejudicial)	Remain but cannot speak or vote (unless interest is deemed not prejudicial)	Discuss and vote

Appendix H – COI Breach Form

PRIVATE AND CONFIDENTIAL

CONFLICTS OF INTEREST BREACH FORM

PART 1

Breach Details		
Description of event *(give a brief description of the breach. Only state facts about the breach).*		
Details of those involved:		
Name	**Title**	**Contact details**

Please give this form to the ICB's Corporate Affairs Manager as soon as you have completed Part 1. The Corporate Affairs Manager / COI Guardian will then complete Part 2.

PART 2 *to be completed by Corporate Affairs / COI Guardian*

Outcome of Incident / Next steps	
Date of discussion:	

Please detail the outcome of the discussion between the COI Guardian / Corporate Affairs including next steps, actions and lessons learnt		
Please circle:		
Confidential spreadsheet updated and unique identifier been provided (if appropriate)	Yes	Yes
Does an appropriate person need to investigate?	Yes	No
Please provide details on reasons why Yes/No		
Does it need to be scored under the SIRI criteria?	Yes (and if so the outcome)	No
Does it link to any Whistleblowing / HR Policies?	Yes	No
Please provide details on reasons why Yes/No		
Date that the breach report will be taken to Audit and Risk Committee		
Do Communications need to be notified?	Yes	No
Comments		
Please provide date that NHS England were / will be notified		
Please provide date the anonymised details have been / will be published on the ICBs website		

Please provide the date the original whistleblower has / will be informed of the outcome	

SECTION 9
Standards of Business Conduct Policy

Revision History

Document Control Sheet

Revision Date	Summary of changes	Author(s)	Version Number
March 2023	Minor changes made to correct name of audit and risk committee and to refer to secondary employment policy in section 24		1.1

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1

Document Control Sheet

Policy title	Standards of Business Conduct Policy
Policy area	This Policy has been prepared and reviewed by the Corporate Affairs team.
Who is it aimed at and which settings?	.
Approved by	
Effective date	
Review date	Every two years or sooner if required by changes in legislation or guidance.

1. Statement of Intent

1.1. Compliance with the national Code of Conduct and Code of Accountability in the NHS (revised 2004) and other codes as set out at section 1.3 below is integral to the work of NHS Norfolk and Waveney Integrated Care Board (the "ICB"). These Codes form the core framework for the conduct of business in our organisation and apply to members of the Board, its committees, employees of the ICB.

1.2. In response to audit recommendations, the adoption of these Codes by Practice by the members of the Board, its committees and employees will be affirmed formally on an annual basis on behalf of the ICB by the Board.

1.3 That there are 4 main codes of conduct and good governance that apply to NHS organisations. These documents are:

- Code of conduct and accountability (revised 2004)
- Standards for members of NHS boards and CCG Governing Bodies in England (2013)
- Code of conduct for NHS managers (2002)
- Standards of business conduct for NHS staff (1993) (Amended, in part, by the Bribery Act 2010)

And any future iterations of the above codes.

2. Code of *Conduct*

2.1. **Public service values must be at the heart of the National Health Service** and high standards of corporate and personal conduct, based upon the recognition that patients come first, have been a requirement throughout the NHS since its inception.

2.2. There are three crucial public service values that underpin the work of the health service:

2.2.1. **Accountability** – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct;

2.2.2. **Probity** – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff, and suppliers, and in the use of information acquired in the course of NHS duties**;**

2.2.3. **Openness** – there should be sufficient openness about NHS activities to promote confidence between the ICB Board, Members of the ICB, its staff, and patients and the public.

2.3. **General Principles**

2.3.1. **Public service values matter** in the NHS and those who work in it have a duty to conduct NHS business with probity. They have a responsibility to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

2.3.2. The success of the Code depends on vigorous and visible examples from Members of the Board of the ICB, and the consequent influence on the

behaviour of all those who work within the organisation. Members of the board of the ICB, have a clear responsibility for corporate standards of conduct, and acceptance of the Code informs and governs decisions and conduct.

2.4 Openness and Public Responsibilities

2.4.1 The ICB understands the requirement to consult upon major changes before decisions are reached and will be open with the public, patients and staff. Information supporting decisions will be made available in a way that is understandable and responses to requests for information in accordance with the Freedom of Information Act 2000 will be provided in this spirit.

2.4.2 Our business will be conducted in a way that is socially responsible, forging an open and positive relationship with the local community and in consideration of the impact of the organisation's activities on the environment.

2.4.3 The confidentiality of personal and individual patient information must be respected at all times.

3. Accountability- Code of *Accountability*

3.1. This code of practice is the basis upon which NHS organisations seek to fulfil the duties and responsibilities conferred upon them by the Secretary of State for Health.

3.2. The ICB will co-operate fully with the Department of Health, the National Audit Office and the Care Quality Commission when required to account for the use it has made of public funds, the delivery of patient care and compliance with the statutes, directions, guidance and policies of the Secretary of State. The Public Accounts and Public Administration Select Committees scrutinise the work of the health service.

3.3. In addition, the ICB will be accountable to NHS England for how we fulfil our statutory duties. The ICB will also account to our local community for how we commission high quality health care, the Norfolk health and well-being board and the Suffolk health and well-being Board for how we deliver the joint health and well-being strategy and Norfolk County Council and Suffolk County Council in their overview and scrutiny role for the services we are commissioning.

3.4 Reporting and Controls

3.4.1 The Code requires that a balanced and readily understood assessment of the ICB's performance be presented to NHS England, the National Audit Office and the local community by means of timely publication of the Annual Report and Annual Accounts. The detailed financial guidance issued by the NHS England in this regard, including the role of internal and external auditors, must be scrupulously observed.

4. The Board

4.1 The Board of the ICB comprises:
4.1.1 Independent Chair;
4.1.2 Chief Executive;
4.1.3 Non-Executive Members;
4.1.4 Director of Nursing, Director of Finance and a Medical Director;
4.1.5 Partner Members; and
4.1.6 Other members including VCSE Board Member and an ICP Member

4.2 Members of the Board share corporate responsibility for all decisions made, with a clear division of responsibility between the Chair and the Chief Executive.

4.3 The Chief Executive is directly accountable to the Board for meeting the ICB's objectives and to the Chief Executive of NHS England for the performance of the organisation. The Chair and non-executive members are responsible for monitoring the executive management of the organisation and are responsible to NHS England for the discharge of these responsibilities.

5 Probity

5.1 The ICB considers integrity and honesty as key public service values. These are central to the operations of the ICB and those that work within it. It is recognised that the ICB should not only act with probity in all its processes but also be perceived to have acted in this way. Accordingly, the ICB has adopted a stringent conflict of interest policy as set out in its Conflict of Interest Policy and in the ICB's Constitution at section 6.

5.2 Adherence to Conflicts of Interest requirements is mandatory and any breaches will be reported and published on the ICB's website; disciplinary action may also be taken.

6 Openness

6.1 The ICB will promote transparency at all times by:

6.1.1 Ensuring early engagement on proposed commissioning plans with patients and the public, Norfolk Health and Well-being Board, Suffolk Health and Well-being Board, current and potential providers and clinical networks;

6.1.2 Setting out clearly in the Constitution the way in which decisions will be made;

6.1.3 Holding Board meetings in public (except where this would not be in the public interest) and also holding a public meeting to present the Annual Report and considering whether they wish to hold any other meetings in public;

6.1.4 Publishing details of expenditure over £25,000;

6.1.5 Publishing information about remuneration for senior staff;

6.1.6 Have a Register of Interests for:

- Board members;
- Employees
- Committee members; and
- Any individual directly involved with the business or decision making of the ICB;

6.1.7 Having systems to declare interests.

6.2 This will enable patients to see what services are being commissioned and how the quality of these services is being constantly improved as well as how public money is being spent. The ICB also has a communications and engagement strategy which further sets out how it will communicate with Members of the ICB, providers, and patients, the public and other stakeholders.

6.3 In addition, the ICB understands the requirement to consult upon major changes before decisions are reached and will be open with the public, patients and staff. Information supporting decisions will be made available in a way that is

understandable and responses to requests for information in accordance with the Freedom of Information Act 2000 will be provided in this spirit.

6.4 Our business will be conducted in a way that is socially responsible, forging an open and positive relationship with the local community and in consideration of the impact of the organisation's activities on the environment.

7 Code of Conduct for NHS Managers

7.1 This Code, in addition to those already described, forms a key part of the contract held by Very Senior Managers – those executive members of the Board. Very Senior Managers undertake to:

7.1.1 *'make the care and safety of patients my first concern and act to protect them from risk;*

7.1.2 *respect the public, patients, relatives, carers, NHS staff, and partners in other agencies;*

7.1.3 *be honest and act with integrity;*

7.1.4 *accept responsibility for my own work and the proper performance of the people I manage;*

7.1.5 *show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community; and*

7.1.6 *take responsibility for my own learning and development'.*

8 Standards of Business Conduct for NHS Staff, HSG (93) 5- Amended, in part, by the Bribery Act 2010.

8.1 All NHS Staff are expected to:

8.1.1 ensure that the interests of patients remain paramount at all times;

8.1.2 be impartial and honest in the conduct of their official business;

8.1.3 use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.

8.2 It is the responsibility of staff to ensure that they do not:

8.2.1 abuse their official position for personal gain or to benefit their family or friends (including but not limited recruitment of family or friends);

8.2.2 seek advantage or further private business or other interests, in the course of their official duties.

8.3 Registration of Interests

8.3.1 It is the responsibility of all staff to ensure that they register their interests and declare all real or perceived conflicts of interests as a matter of course and on an ongoing basis. Staff should ensure that the register of interests is updated as soon as an interest or conflict is known.

8.3.2 That they do not seek advantage of a non-pecuniary personal benefit where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (e.g. a

reconfiguration of hospital services which might result in the closure of a busy clinic next to an individual's house).

8.3.3 An interest should remain on the public register for a minimum of 6 months.

9 The Nolan Principles[1]

9.1 The Code of Conduct and Code of Accountability in the NHS reflect the Committee for Standards in Public Life's Seven Principles of Public Life – also known as the Nolan Principles (set out below). The Nolan Principles of business conduct have been adopted by the ICB and apply to all staff employed by the ICB.

- **Selflessness**
  Holders of public office should act solely in terms of the public interest.

- **Integrity**
  Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

- **Objectivity**
  Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

- **Accountability**
  Holders of public office are accountable to the public for their decisions and actions and must admit themselves to the scrutiny necessary to ensure this.

- **Openness**
  Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

- **Honesty**
  Holders of public office should be truthful.

- **Leadership**
  Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

10 Standards for NHS Boards and ICB Board Members

10.1 All members of NHS boards and ICB Boards must understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities.

[1] Source: Standards Matter. A review of good practice in promoting good behaviour in public life, January 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228884/8519.pdf

10.2 **Members must commit to promoting:**

- the values of the NHS Constitution;
- equality; and
- human rights

in the treatment of patients and service users, their families and carers, the community, colleagues and staff, and in the design and delivery of services for which they are responsible.

10.3 **They must seek:**

- excellence in clinical care, performance, patient experience, and the accessibility of services;
- to make sound decisions individually and collectively;
- long-term financial stability and the best value for the benefit of patients, service users and the community;
- to ensure their organisation is fit to serve its patients and service users, and the community;
- to be fair, transparent, measured, and thorough in decision-making and in the management of public money; and
- to be ready to be held publicly to account for their organisation's decisions and for its use of public money.

11 Managing Conflicts of Interest: General

11.1 To ensure the integrity and probity of decision-making the ICB is required to make arrangements to manage conflicts of interest and potential conflicts of interest so that decision making is taken and seen to be taken without possibility of the influence of external or private interest[2]. Individuals must declare any interest they have in writing to the Board as soon as practicable after the person becomes aware of it and in any event no later than 28 days of becoming aware. The Board will instruct the Director of Corporate Affairs and ICS Development to update the Registers of Interests accordingly. Members of the Board of the ICB, its committees and staff will act impartially and will not be influenced by social or business relationships; no-one will use their public position to further their private interests. Where there is potential for private interests to be material and relevant to NHS business, these will be declared, recorded in the relevant minutes, and entered into the Register of Interests, which is available for public inspection on our website at www.improvinglivesnw.org.uk and available on request from our headquarters.

11.2 Members of the Board of the ICB, its committees and staff will declare, and keep up to date, details of any personal or business interests, which may influence, or may be *perceived* to influence, their judgement. As a minimum the Register of Interests will be reviewed on an annual basis.

11.3 **Interests can be captured in four different categories**:

11.3.1 Financial interests: This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:

- A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. This includes involvement with a potential provider of a new care model;
- A shareholder (or similar ownership interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations;
- A management consultant for a provider; or
- A provider of clinical private practice.

This could also include an individual being:

- In employment outside of the ICB;
- In receipt of secondary income;
- In receipt of a grant from a provider;
- In receipt of any payments (for example honoraria, one-off payments, day allowances or travel or subsistence) from a provider;
- In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and
- Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).

11.3.2 Non-financial professional interests: This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:

- An advocate for a particular ICB of patients;
- A GP with special interests e.g., in dermatology, acupuncture etc.
- An active member of a particular specialist professional body (although routine GP membership of the Royal College of General Practitioners (RCGP), British Medical Association (BMA), Royal College of Nursing or a medical defence organisation would not usually by itself amount to an interest which needed to be declared);
- An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE);
- Engaged in a research role;
- The development and holding of patents and other intellectual property rights which allow staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas; or
- GPs, other healthcare professionals and practice managers, who are members of the Board or committees of the ICB, should declare details of their roles and responsibilities held within their GP practices.

11.3.3 Non-financial personal interests: This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:

- A voluntary sector champion for a provider;
- A volunteer for a provider;
- A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation;
- Suffering from a particular condition requiring individually funded treatment;
- A member of a lobby or pressure group with an interest in health.

11.3.4 Indirect interests: This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above) for example, a:

- Spouse / partner
- Close family member or relative e.g., parent, grandparent, child, grandchild or sibling;
- Close friend or associate; or
- Business partner.

A declaration of interest for a "business partner" in a GP partnership should include all relevant collective interests of the partnership, and all interests of their fellow GP partners (which could be done by cross referring to the separate declarations made by those GP partners, rather than by repeating the same information verbatim).

Whether an interest held by another person gives rise to a conflict of interests will depend upon the nature of the relationship between that person and the individual, and the role of the individual within the ICB.

11.4 If in doubt whether a conflict exists, the individual concerned should assume that a potential conflict of interest exists.

12 Arrangements for Managing Conflicts

12.3 The Board will ensure for every interest declared arrangements are in place to manage the conflict. The Board can take advice on this role from the Director of Corporate Affairs and ICS Development. Where a conflict of interest is seen to exist there are a number of ways in which the conflict may be managed depending on the magnitude of its impact. These actions include but are not limited to the Board confirming to the individual in writing:

12.3.2 permission to participate and contribute to a discussion but not allowed to count towards the quorum for any decision or vote;

12.3.3 permission to observe the discussion, but prohibited from participating in the discussion and not allowed to count towards the quorum for any decision or vote;

12.3.4 Permission to receive relevant meeting papers but be excluded from the meeting for the relevant item. The individual(s) may be called back to the meeting following conclusion of all discussion in relation to that item. However, should the same item be raised in later discussions they should be excluded again;

12.3.5 Prohibiting access to papers relating to the relevant item and exclusion from the meeting for the relevant item

12.4 Where no arrangements have been confirmed the Chair of the meeting may require the individual to withdraw from the meeting or part of it, in accordance with section 10.1.3 above. The individual will comply with these arrangements which must be recorded in the minutes of the meeting.

12.5 Managing Meetings

12.5.2 Before attending any meeting, Members of the Board or committee members and staff will consider whether they have a conflict of interest pertaining to the meeting's agenda; they will declare such interests as soon as they are recognised, (preferably in writing) and have an on-going duty to consider whether a conflict of interest exists.

12.5.3 If the conflict has been declared previously and a plan for management has been put in place by the Board in accordance with section 10.1 above, this should be followed. If this is a new conflict of interest, this must be discussed with the Chair of the meeting who will determine if it represents a material conflict.

12.5.4 Where a conflict is of such magnitude or will persist for such a significant period of time that in the view of the Chair in consultation with the Chief Executive that it will materially impact on the ability of the affected member to carry out his duties effectively, then the affected member can be asked to either stand down from the Board or other committee or to make arrangements to end the conflict of interest for example by resigning from another post.

13 Failure to comply with Conflicts of Interest requirements

13.1 If an individual fails to comply with this policy and as set out in section 6 of the ICB Constitution, the individual will be subject to the ICB Disciplinary Policy. The matter, if considered appropriate, may also be referred to the Anti- Crime Specialist, for investigation, and may lead to criminal proceedings being commenced.

14 Failure to Disclose / Declare

14.1 The ICB is committed to the national Code of Conduct and Code of Accountability in the NHS (revised 2004) and as such takes the failure to disclose such information as required by this policy seriously. It is an offence under the Fraud Act 2006, for personnel to fail to disclose information to the ICB in order to make a gain for themselves or another or to cause a loss or expose the organisation to a loss. Therefore, where personnel have failed to disclose relevant and material information, the policy on Counter Fraud, Bribery and Corruption should be consulted and an appropriate referral made to the ICB's Anti-Crime Specialist, Lisa George on 07825 827024 or via email on lisa.george@tiaa.co.uk or lisa.george4@nhs.uk.

15 Procurement

Providing Assurance: Transparent Commissioning

15.1 The template attached at Appendix 1 sets out the factors that will provide assurance to the Board and the Audit and Risk Committee – and other interested parties including local communities, the Health and Wellbeing Board and auditors – that services have been commissioned in a consistent and transparent way; that they meet local needs and priorities; and that a robust process has been followed.

15.2 The details of all contracts awarded following procurement will be published on appropriate websites (for example Contracts Finder, OJEU).

Managing Conflicts of Interest: Commissioning Services from GP Practices

15.3 It is an essential feature of reforms that ICBs should be able to commission a range of community-based services, including primary care services, to improve quality and outcomes for patients. Where the provider for these services might be a GP practice, the ICB will demonstrate that those services:

15.3.1 clearly meet local health needs and have been planned appropriately;

15.3.2 go beyond the scope of the GP contract; and that

15.3.3 the appropriate procurement approach is used.

Procurement and Register of procurement decisions

15.4 Any ICB staff or Board members involved in procurement, their family, or if there is someone known to them that stands to benefit personally from awarding the contract, they should declare this immediately. They must declare and record on the Register of Staff Interests any monetary interest (or other relevant personal or professional material benefit) which may influence, (or may be construed by others to influence) their impartiality in the procurement decision making process. Relevant and material interests are defined by the Policy as:

15.4.1 Directorships, including non-executive directorships held in private companies or PLC's (with the exception of those of dormant companies);

15.4.2 Ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possible seeking to do business with the NHS;

15.4.3 Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

15.4.4 A position of authority in a charity or voluntary organisation in the field of health and social care;

15.4.5 Any connection with a voluntary or other organisation for NHS services or commissioning NHS services;

15.4.6 To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the ICB, including but not limited to lenders or banks.

15.5 If staff have any doubt about the relevance or materiality of an interest, this should be discussed with the Director of Corporate Affairs and ICS Development. In any instance where staff wilfully choose not to inform the Director of Corporate Affairs and ICS Development and is later found to have benefitted personally from the award of a

contract the Director of Corporate Affairs and ICS Development will seek to follow the ICB disciplinary procedure and the matter may also be referred to the Anti-Crime Specialist for investigation.

15.6 The ICB will maintain a register of procurement decisions taken, including the details of the decision; who was involved in making the decision (e.g. Board or committee members and others with decision-making responsibility); and a summary of any conflicts of interest in relation to the decision and how this was managed by the ICB. The register will form part of the ICB's annual accounts and will be signed off by external auditors.

15.7 The ICB recognises the importance of managing any conflicts or potential conflicts of interest that may arise in relation to procurement. The Procurement, Patient Choice and Competition Regulations 2013 place requirements on commissioners to ensure that they adhere to good practice in relation to procurement, do not engage in anti-competitive behaviour that is against the interest of patients, and protect the right of patients to make choices about their healthcare. The regulations set out that commissioners' must manage conflicts and potential conflicts of interests when awarding a contract by prohibiting the award of a contract where the integrity of the award has been, or appears to have been, affected by a conflict; and keep appropriate records of how they have managed any conflicts in individual cases.

16 Bribery Act 2010

16.1 The ICB has a responsibility to ensure that all its employees including Members of the ICB, Board and any committee members are made aware of their duties and responsibilities under the Bribery Act 2010. Under this act there are four offences:

16.1.1 Bribing or offering to bribe another person (section1)

16.1.2 Requesting, agreeing to receive, or accepting a bribe (section 2)

16.1.3 Bribing, or offering to bribe a foreign public official (section 6)

16.1.4 Failing to prevent bribery (section 7)

16.2 All the ICB's employees, including Members of the board of the ICB, and any committee members should be aware of the Bribery Act 2010 and should refer to the sections below on acceptance of gifts and hospitatlity for further guidance.

17 Acceptance of Gifts

17.1 Under the Bribery Act 2010, it is an offence for personnel corruptly to accept any gifts or consideration as an inducement or reward for:

17.1.1 doing, or refraining from doing, anything in their official capacity; or

17.1.2 showing favour or disfavour to any person in their official capacity.

17.2 Under the Bribery Act 2010, any money, gift, or consideration received by a person engaged in public service from a person or organisation holding or seeking to obtain a contract will be deemed by the courts to have been received corruptly unless the employee proves the contrary.

In cases of doubt personnel should decline the gift or hospitality or consult with the Director of Corporate Affairs and ICS Development prior to accepting.

Staff and organisations should be mindful that even gifts of a small value may give rise to perceptions of impropriety and might influence behaviour if not handled in an appropriate way.

A gift means any item of cash or goods, or any service which is provided for personal benefit, free of charge, or at less than its commercial value.

17.3 **Overarching principles**

- Gifts should not be accepted that may affect, or be seen to affect, their professional judgement. This overarching principle should apply in all circumstances;

- Any personal gift of cash or cash equivalents (e.g. vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the ICB) must always be declined, whatever their value and whatever their source, and the offer which has been declined must be declared to the Director of Corporate Affairs and ICS Development and recorded on the register.

18 Gifts from suppliers or contractors

18.1 Gifts from suppliers or contractors doing business (or likely to do business) with the ICB should be declined, whatever their value (subject to this, low cost branded promotional aids may be accepted and not declared where they are under the value of a common industry standard of £6[3]). The person to whom the gifts were offered should also declare the offer to the Director of Corporate Affairs and ICS Development so the offer which has been declined can be recorded on the register.

Gifts from other sources (e.g. patients, families, service users)

18.2 ICB staff, Board and committee members and individuals within GP member practices should not ask for any gifts.

18.3 Modest gifts under a value of £50 may be accepted and do not need to be declared.

18.4 Gifts valued at over £50 should be treated with caution and only be accepted by the Chief Finance Officer on behalf of the ICB and not in any personal capacity. These should be declared.

18.5 A common sense approach should be applied to valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

[3] The ABPI Code of Practice for the Pharmaceutical Industry. http://www.pmcpa.org.uk/thecode/Pages/default.aspx.

18.6 Multiple gifts from the same source over a 12-month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

19 Acceptance of Hospitality

19.1 Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of 'traditional' working hours. As a result, ICB staff will sometimes appropriately receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviour.

19.2 Hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events etc.

19.3 Overarching principles

- ICB staff, Board or committee members, should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors, these can be accepted if modest and reasonable, but individuals should always obtain senior approval and declare these.

19.4 Meals and Refreshments

- Under a value of £25 may be accepted and need not be declared.
- Of a value between £25 and £75[4] may be accepted and must be declared.
- Over a value of £75 should be refused unless (in exceptional circumstances) senior approval is given in writing by the Chief Finance Officer. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

19.5 Travel and Accommodation

[4] The ABPI Code of Practice for the Pharmaceutical Industry: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest or are of a type that the ICB itself might not usually offer, need approval by the Chief Finance Officer in writing and should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded the register(s) of interest as to why it was permissible to accept travel and accommodation of this type.
- A non-exhaustive list of examples that are not acceptable includes:
  - Offers of business class or first-class travel and accommodation (including domestic travel); and
  - Offers of foreign travel and accommodation.

19.6 Failure to disclose gifts or hospitability in line with the procedures set out above could lead to criminal, civil or disciplinary sanctions being applied as described in paragraph

20 Commercial Sponsorship

21.1. Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures their ability to take place benefiting NHS staff and patients. Without this funding there may be fewer opportunities for learning, development and partnership working. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services. As a result, there should be proper safeguards in place to prevent conflicts occurring.

21.2 When sponsorships are offered, the following principles must be adhered to:

- Sponsorship of ICB events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefit for the ICB and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the ICB's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified in the interest of transparency.
- The ICB should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff should declare involvement with arranging sponsored events to their ICB.

21.3 Offers of sponsorship may be accepted only if:

21.3.1 they are reasonably justifiable and in accordance with the principles set out in this policy.

21.3.2 Permission must be obtained from the Chief Finance Officer in writing, in advance using the form attached at Appendix 2 and will be recorded in the Gifts & Hospitality Register. The Chief Finance Officer should obtain permission from the Chief Officer.

21.4 Acceptance of corporate sponsorship should not in any way compromise commissioning or procurement decisions of the ICB or be dependent upon the purchase or supply of goods or services.

21.5 All offers of commercial sponsorship whether accepted or declined must be declared and included in the ICB's Register of Interests.

21.6 For the avoidance of doubt the ICB will adhere to the principles set out in the Managing Public Money document issued by HM Treasury dated July 2013 or any future iterations of the document.

21.7 **Other forms of sponsorship**

Organisations external to the ICB or NHS may also sponsor posts or research. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage, or if sponsored posts cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition. There needs to be transparency and any conflicts of interest should be well managed. For further information see Managing Conflicts of Interest in the NHS: Guidance for staff and organisations.

22. Suppliers and Contractors

22.1 All ICB staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign purchase orders or enter into contracts for goods and services are expected to adhere to professional standards in line with those set out in the Code of Ethics of the Chartered Institute of Purchasing and Supply[5].

22.2 All ICB staff must treat prospective contractors or suppliers of services to the ICB equally and in a non-discriminatory way and act in a transparent manner.

22.3 The ICB staff involved in the awarding of contracts and tender processes must take no part in the selection process if a personal interest or conflict of interest is known. Should such an interest become apparent, it must be declared using the ICB's Declaration of Interest Form as soon as possible. ICB staff should not at any time give undue advantage to any private businesses or other interests in the course of their duties.

22.4 The ICB has legal duties under the both European and UK procurement law and ICB staff must comply with the ICB's Procurement Strategy, Prime Financial Policies, and any relevant detailed financial policy in all contract opportunities.

[5] Code of Ethics of the Chartered Institute of Purchase and Supply available at https://www.cips.org/CIPS-for-Business/supply-assurance/Corporate-Ethical-Procurement-and-Supply/Corporate-Code-of-Ethics/

22.5 ICB staff must not seek, or accept, preferential rates or benefits in kind for private transactions carried out with companies they have official dealings with on behalf of the ICB. This does not apply to member benefit scheme schemes offered by the NHS or Trade Unions.

22.6 Every invitation to tender to a prospective bidder for ICB business must require each bidder to give a written undertaking, not to engage in collusive tendering or other restrictive practice and not to engage in canvassing the ICB, its employees or officers concerning the contract opportunity tendered.

23 Reporting/Raising Concerns and Breaches

23.1 There may be occasions when interests have not been identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of deliberate actions. All ICB management, staff and members should speak up about any genuine concerns in relation to compliance this policy. Officers can raise these concerns directly with their own line manager or alternatively with the Head of Corporate Governance.

23.2 All reported concerns will be treated with the appropriate confidentiality and investigated in line with the relevant ICB policies and procedures.

23.3 The Head of Corporate Governance will take a report on breaches and responses to the Audit and Risk Committee and the Board on an annual basis.

23.4 All staff must report any suspicions of fraud, bribery and corruption as soon as they become aware of them to the ICB's Counter Fraud Specialist (CFS), Lisa George to ensure that they are investigated appropriately and to maximise the chances of financial recovery. The CFS can be contacted on 07825 827024 or via email on lisa.george@tiaa.co.uk or lisa.george4@nhs.uk. Alternatively staff can contact the NHS Fraud and Corruption Reporting Line on 0800 028 40 60 or report the fraud online at https://cfa.nhs.uk/reportfraud

23.5 Officers may wish to report concerns using the internal Freedom to Speak Up: Raising Concerns Policy.

24. Secondary Employment

24.1 Employees, committee members, contractors and others engaged under contract with the ICB are required to obtain prior permission from their department Director to engage in any employment or consultancy work in addition to their work with the ICB in line with the Secondary Employment Policy.

24.2 This is to ensure that the ICB is aware of any potential conflict of interest. Examples of work which might conflict with the business of the ICB, including part-time, temporary and fixed term contract work include:

- Employment with another NHS body;
- Employment with another organisation which might be in a position to supply goods/services to the ICB;
- Directorship of a GP federation; and
- Self-employment, including private practice, in a capacity which might conflict with the work of the ICB or which might be in a position to supply goods/services to the ICB.

24.3 The ICB reserves the right to refuse permission where it believes a conflict will arise and cannot be effectively managed.

24.4 In the event that secondary employment is permitted, this should be declared on the persons declaration of interest.

25 Personal Conduct

a. Lending or borrowing

i. The lending or borrowing of money between staff should be avoided, whether informally or as a business, particularly where the amounts are significant.

ii. It is a particularly serious breach of discipline for any member of staff to use their position to place pressure on someone in a lower pay band, a business contact, or a member of the public to loan them money.

b. Gambling

No member of staff may bet or gamble when on duty or on ICB premises, with the exception of small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National among immediate colleagues.

c. Trading on official premises

Trading on official premises is prohibited, whether for personal gain or on behalf of others. Canvassing within the office by, or on behalf of, outside bodies or firms (including non-ICB interests of staff or their relatives) is also prohibited. Trading does not include small tea or refreshment arrangements solely for staff.

d. Collection of money

Charitable collections must be authorised by Corporate Services. Other flag day appeals are not permitted, and collection tins or boxes must not be placed in offices. With line management agreement, collections may be made among immediate colleagues and friends to support small fundraising initiatives, such as raffle tickets and sponsored events. Permission is not required for informal collections amongst immediate colleagues on an occasion like retirement, marriage or a new job.

e. Bankrupt or insolvent staff

Any member of staff who becomes bankrupt or insolvent must inform their line management and Human Resources as soon as possible. Staff who are bankrupt or insolvent cannot be employed in posts that involve duties which might permit the misappropriation of public funds or involve the handling of money.

f. Arrest or conviction

A member of staff who is arrested and refused bail or convicted of any criminal offence must inform their line management and Human Resources as the earliest opportunity.

26 References

a. Relevant polices and reference material that should be read in conjunction with this policy include:

- The ICB's Constitution;
- Managing Conflicts of Interest: Revised Statutory Guidance for CCGs, first published March 2013, updated June 2017;
- Conflicts of Interest in Primary Care: CAT A and B;
- NHS England, *Code of Conduct: Managing Conflicts of Interest where GP practices are potential providers of ICB-commissioned services,* first published June 2012;
- Policy on Fraud, Financial Irregularities and Corruption;
- Code of Conduct and Code of Accountability in the NHS (2004);
- Code of Conduct for NHS Managers 2002;
- Standards of Business Conduct for NHS Staff – HSG (93) 5 - Amended, in part, by the Bribery Act 2010;
- Code of Ethics of the Chartered Institute of Purchase and Supply;
- Standards for members of NHS boards and CCG Governing Bodies in England (2012)

Managing Public Money issued by HM Treasury dated July 2013.

Annex G: Procurement checklist

Service:

Question	Comment/ Evidence
1. How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the ICB's proposed commissioning priorities? How does it comply with the ICB's commissioning obligations?	
2. How have you involved the public in the decision to commission this service?	
3. What range of health professionals have been involved in designing the proposed service?	
4. What range of potential providers have been involved in considering the proposals?	
5. How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?	
6. What are the proposals for monitoring the quality of the service?	
7. What systems will there be to monitor and publish data on referral patterns?	
8. Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers?	
9. In respect of every conflict or potential conflict, you must record how you have managed that conflict or potential conflict. Has the management of all conflicts been recorded with a brief explanation of how they have been managed?	
10. Why have you chosen this procurement route e.g., single action tender?[i]	
11. What additional external involvement will there be in scrutinising the proposed decisions?	

SECTION 10
Petitions Policy

Revision History

Document Control Sheet

Revision Date	Summary of changes	Author(s)	Version Number

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1

Document Control Sheet

Policy title	Petitions Policy
Policy area	This Policy has been prepared and reviewed by the Corporate Affairs team.
Who is it aimed at and which settings?	.
Approved by	
Effective date	
Review date	Every two years or sooner if required by changes in legislation or guidance.

1. Introduction

A petition represents the expression of the views of the people who sign it. For the NHS Norfolk and Waveney Integrated Care Board ("the ICB"), petitions are an important mechanism for local people to have a voice on local health matters.

To ensure that voices are heard appropriately and in order to avoid the danger of listening only to active lobby groups, petitions will not be viewed in isolation but as one piece of evidence and information which contributes to an overall picture of public opinion. Petitions can be raised as a discrete statement by the signatories or as a response to a public consultation or proposal being made by the ICB.

This policy outlines how the ICB will handle any petitions received from the local community.

2. Scope

This policy relates to the receipt and management of either hard copy or e- petitions.

Petitions may be pro-active e.g. unsolicited; where there is public opinion that a new service may be required to fill a perceived gap in service provision or re-active i.e. in response to an ICB initiated proposal to change an existing service.

The policy sets out how petitions will be received whether outside a formal consultation period or during a formal consultation period.

For the purpose of this policy a petition is considered to be a written document signed by a number of people demanding some form of action from the ICB.

3. There is currently no clear, legally binding guidance to the NHS on handline petitions.

When considering the receipt and management of e-petitions, the ICB wishes to ensure that it follows best practice and has drawn on published terms and conditions for submitting e-petitions utilised by HM Government.

4. Criteria for the consideration of petitions

In order to be received for consideration, petitions should meet the criteria outlined below:

- A petition amounting to any number of signatures will be considered by the ICB in their commissioning decisions. The sentiment indicated in the petition will be forwarded to the most appropriate internal commissioning process. This will be determined by the subject of the petition e.g. the petition may be passed to the relevant commissioning manager to incorporate into a service specification and/or relevant subgroup or committee for consideration.

- Where a petition, with significant support (with a minimum of 1000 signatures) has been received by the ICB, the Chief Executive Officer shall consult with the Chair of the Board as to whether the petition should be included as a specific item for the agenda and consideration of the next meeting of the Board to agree any appropriate actions.

- Petitions may be received in paper or electronic (e.g. email, web based or social media) format.

- Petitions should be addressed to NHS Norfolk and Waveney ICB and include a statement of petition which should include:

  - the proposition which is being promoted by the petition
  - the timeframe over which the petition has been collected

- The following information about each petitioner should be included:

  - Name
  - Postcode
  - Signature (in the case of a written petition)
  - Email address (in the case of an electronic petition). If this data is not collected due to the data controller not sharing the data eg a social media (eg Facebook), the petition will only be acknowledged as an indicator of public sentiment.

- The name and address of the petition organiser, who must be resident within the Norfolk and Waveney area, should be provided on the first page of the petition.

5. Acceptance of Petitions

An acknowledgement of receipt of the petition will be provided to the lead petitioner within 5 clear working days of receipt with a clear explanation about what will happen next.

Petitions will not be considered if they are repeated, vexatious or if they concern issues which are outside the ICB's remit. Petitions will also not be considered if the information contained is confidential, libellous, false, defamatory or offensive.

A petition will be considered as a repeat petition if:

a) it covers the same or substantially similar subject matter to another petition received within the previous six months;
b) it is presented by the same or similar individuals or groups as another petition received within the previous six months.

A petition will be considered as a vexatious petition if:

c) it focuses on an individual grievances
d) it focuses on the actions or decisions of an individual and not the organisation

A petition will be considered as outside the CCGs' remit if:

e) it focuses on a matter relevant to another organisation
f) it requests information available via Freedom of Information legislation
g) its aim is to correspond on personal issue(s) with an individual(s)
h) signatories are not based in the UK

A petition will be considered as confidential, libellous, false or defamatory if:

i) it contains information which may be protected by an injunction or court order
j) j) it contains material which is potentially confidential, commercially sensitive, or which may cause personal distress or loss

A petition will be considered as offensive if:

k) it contains language that may cause offence, is provocative or extreme in its views

Where a petition does not meet the requirement set out in the criteria above then the ICB will respond in writing within **ten working days** to confirm that the petition has been received and that, as the petition does not meet the criteria. The reason for rejection will be given clearly and explicitly.

5.1 Petitions received outside formal consultation period

For petitions received outside a formal consultation period, the Chief Executive Officer may delegate responsibility for receiving a petition to a nominated representative. The Chief Executive Officer or nominated representative may arrange for a short private meeting with the petition organiser to formally receive the petition. All photographic opportunities may be politely declined by the ICB during this meeting.

Once received, the Chief Executive Officer or nominated representative will ensure that the petition receives appropriate and proportionate consideration and that a response is made in writing.

5.2 Petitions received during a formal consultation period

If a petition relates to a subject, proposal or matter about which the ICB is actively seeking public opinion, and if the petition is submitted before the publicised close date of the engagement or consultation process, the petition will be considered as an item of correspondence, in the same way that any other response would be considered. Petitions will be considered as valid for consideration as part of the consultation if they meet the requirements set out in the criteria outlined in this policy.

6. Management of Petitions

When a report on the outcome of consultation is prepared, the following issues will be taken into account when considering a petition:

- If a petition is raised about a perceived lack of or missing service, consultation is not a public referendum or public vote. Influence will be afforded to the most cogent ideas and arguments, based upon clinical effectiveness, quality, patient safety, clinical and cost effectiveness and not necessarily to the views of the most numerous stakeholders.

- The petition should be relevant to the subject of the consultation. It may not necessarily use the same words, but it should have a bearing on the proposal(s) that the ICB has put forward.

- The petition should reflect the latest proposals and policy statements being made by the ICB and not relate to issues that are no longer under consideration. This is particularly relevant when considering the timescale during which signatures have been collected.

- The petition should provide an accurate reflection of the proposals in the consultation, rather than including misleading information or statements.

- The petition should relate to the consultation and to the proposed action of the ICB (and/or its stakeholders), rather than to broader policy agenda beyond the scope of the consultation.

- The petition's concerns will be assessed in relation to the aims being put forward in the consultation, and the rationale and constraints behind it. For example, a petition that proposes a realistic alternative option will normally be given greater weight than a petition that simply opposes an option that has been put forward for valid reasons.

- The petition's concerns will also be assessed in relation to the impact on other populations if these demands were accepted. This assessment could take into account views expressed in other petitions (which may conflict) or in more direct responses to the consultation.

The organiser of the petition will receive correspondence from the ICB as the body that has initiated the consultation, in the same manner as other respondents (e.g. acknowledgement, an outcome letter describing how the issues raised during consultation have or will influence the decisions made following consultation) within 28 days of receipt of the petition.

Petitions will be formally acknowledged in the analysis of consultation responses, along with all the other responses. If what Petitioners call for is accepted or rejected, the reasons for this should be given.

Hard copy and electronic petitions will be stored in a secure place within the ICB for 3 years and will then be destroyed as Confidential Waste (in the case of hard copies) or deleted (e-petitions.).

7. Return of petitions

Hard copy petitions should be addressed to:

The Chief Executive Officer
C/o Associate Director for Communication & Engagement
NHS Norfolk and Waveney Integrated Care Board
Norfolk County Council
County Hall
Norwich

Electronic petitions should be addressed to:
nwicb.contactus@nhs.net

8. Duties and responsibilities

Board	The Board has responsibility for establishing a scheme of governance for the formal review and approval of such documents.

Chief Executive Officer	The Chief Executive Officer has overall responsibility for the operational management, including ensuring that ICB process documents comply with all legal, statutory and good practice guidance requirements.
All Staff	All staff, including temporary and agency staff, are responsible for: • Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training / awareness sessions when provided

9. Implementation

This policy will be available to all staff for use and be aware of.
All directors and managers are responsible for ensuring that relevant staff within their own directorates and departments have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

10. Training Implications

It has been determined that there are no specific training requirements associated with this policy/procedure.

11. Related Documents

Other related policy documents

ICB People and Communities Approach.

Legislation and statutory requirements

There is currently no clear, legally binding guidance to the NHS on handling petitions. The CCG has drawn upon published terms and conditions for submitting e-petitions, utilised by HM Government.

12. Monitoring, review and archiving

Monitoring

The Executive Committee will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

Review

The Director of Corporate Affairs and ICS Development will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Director of Corporate Affairs and ICS Development will consider the need to review the policy or procedure outside of the agreed timescale for revision.

Archiving

The Director of Corporate Affairs and ICS Development will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: Code of Practice for Health and Social Care 2016.

SECTION 11

Eligible nominating PMS (GMS/APMS) Providers

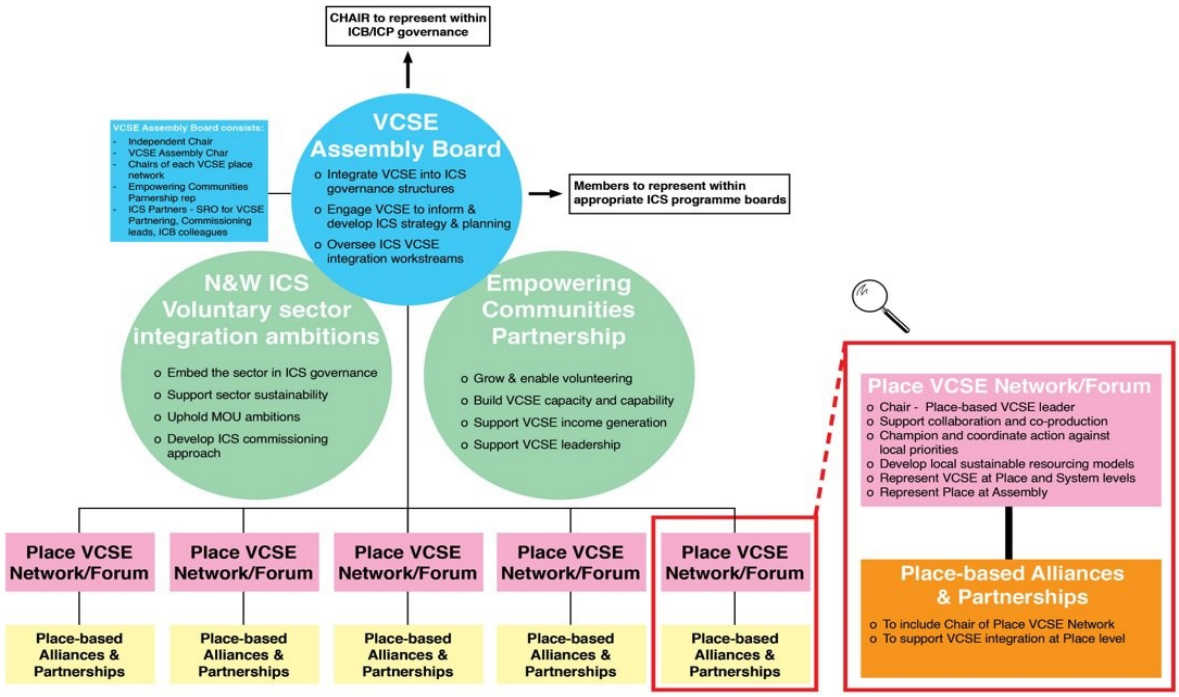
Acle Medical Partnership	Kirkley Mill Surgery
Aldborough Surgery	Lakenham Surgery
Alexandra Road Surgery	Lawson Road Surgery
Andaman Surgery	Litcham Health Centre
Attleborough Surgery	Long Stratton Medical Partnership
Bacon Road Medical Centre	Longshore Surgeries
Beaches Medical Centre	Ludham & Stalham Green
Beccles Medical Centre	Manor Farm Medical Centre
Beechcroft Surgery (inc. Old Palace)	The Market Surgery Aylsham
Birchwood Medical Practice	Mattishall & Lenwade Surgeries – Dr Jones & Partners
Blofield Surgery	Millwood Surgery
Boughton Surgery	Mundesley Medical Centre
Bridge Road Surgery	Nelson Medical Centre
Bridge Street Surgery	Norwich Practices Ltd
Brundall Medical Partnership	Oak Street Medical Practice
Bungay Medical Practice	Old Catton Medical Practice
Burnham Market Surgery	Old Mill & Millgates Medical Practice
Campingland Surgery	Orchard Surgery
The Castle Partnership	The Parish Fields Surgery
Chet Valley Medical Practice	Park Surgery
Church Hill Surgery	Paston Surgery
Coltishall Medical Practice	Plowright Medical Centre
Cromer Group Practice	Prospect Medical Centre
Cutlers Hill Surgery	Reepham & Aylsham Medical Practice
Drayton, St Faiths & Horsford	Rosedale Surgery
East Harlings & Kenninghall	Roundwell Medical Centre
East Norfolk Medical Practice	School Lane Practice
East Norwich Medical Partnership	School Lane Surgery, Thetford
Elmham Surgery	Sheringham Medical Practice
Fakenham Medical Practice	Shipdham Surgery
Feltwell Surgery	Sole Bay Health Centre – Dr Castle and Partners – Sole Bay Health Centre
Fleggburgh Surgery	Southgate Medical Centre
Great Massingham Surgery & Docking Surgeries	St James Medical Practice
Grimston Medical Centre	St Stephens Gate Medical Practice
Grove Surgery	Terrington St Johns Surgery
Harleston Medical Practice	The Coastal Villages Practice
Heacham Group Practice	The Hollies Surgery
Heathgate Medical Practice	The Humbleyard Practice
Hellesden Medical Practice	The Lawns Medical Practice

High Street Surgery	The Magdalen Medical Practice
Hingham Surgery	The Staithe Surgery
Holt Medical Practice	The Taverham Partnership
Hoveton & Wroxham	The Woottons Surgery
Howdale Surgery	Theatre Royal Surgery
Theatre Royal Surgery	Watlington Medical Centre
Thorpewood Surgery	Watton Medical Practice
Toftwood Surgery	Wells Health Centre
Trinity & Bowthorpe	Wensum Valley Medical Practice
UEA Medical Centre	West Pottergate
Upwell Health Centre	Windmill Surgery
Victoria Road Surgery	Woodcock Road Surgery
Vida Healthcare	Wymondham Medical Practice
Village Heath - St Clements Surgery	Yare Valley Medical Practice (Lionwood)

SECTION 12

Working with Voluntary, Community and Social Enterprise organisations

The diagram below sets out how the VCSE sector is embedded and works to inform the Integrated Care Board's planning and decision making.



APPENDIX A

Norfolk and Waveney Integrated Care Partnership (ICP)

Terms of Reference and Procedure Rules

1. Context and Role of the Integrated Care Partnership

The role of the Integrated Care Partnership (ICP) in Norfolk and Waveney is to promote the close collaboration of the health and care system, building on the existing Norfolk Health and Wellbeing Board and other partnerships with the expanded geography that includes Waveney, to ensure better health and care outcomes for all our residents.

It provides a forum for stakeholders to come together as equal partners to discuss and resolve crosscutting issues. The ICP is a statutory committee of both the Integrated Care Board and Norfolk and Suffolk County Council's under the Health and Care Act 2022, it plays a central role in the planning and improvement of health and care in Norfolk and Waveney and will support place-based partnerships.

It drives and enhances integrated approaches and collaborative behaviours at every level and promotes an ethos of working in partnership with people and communities, and between organisations to address challenges that the health and care system cannot address alone.

Together, the ICP will generate an Integrated Care Strategy to improve health and care outcomes and experiences for our residents, for which all partners will be accountable.

2. Principles

The Norfolk and Waveney ICP will operate under these guiding principles:

1. Partnership of equals – to find consensus and make decisions including working though difficult issues, where appropriate.
2. Collective model of accountability – partners hold each other mutually accountable for shared and individual organisational contributions to objectives.
3. Improving outcomes for communities – including improving health and wellbeing, supporting people to live more independent lives, reducing health inequalities, and tackling the underlying social determinants.
4. Collaboration and integration – a culture of broad collaborations and integration at every level of the system to improve outcomes and reduce duplication and inefficiency.
5. Co-production and inclusivity – create a learning system which makes decisions based on evidence and insight.

3. Membership

The Membership of the ICP mirrors the existing Norfolk Health and Wellbeing Board, with additional membership to consider Waveney and place partnerships. Whilst it is important for the ICP to engage with a wide range of stakeholders and understand the differing viewpoints across the system and communities, membership will be kept to a productive level.

The membership for the Norfolk and Waveney ICP is attached at appendix A.

4. Appointment of Chair

The Chair of the ICP will be selected from among the members of the ICP and agreed jointly by the ICB, Norfolk and Suffolk Local Authorities.

This appointment process will take place at the start of the meeting with an officer informing members of the need to elect a chair. Nominations will then be called and then seconded. If more than one nomination is received this will be dealt with by way of a majority vote of those present. If only one nomination is forth coming the officer will then ask for any objections, if objections are received a vote will take place which will be carried by a majority vote by those present. Once this process takes place and the nomination is passed, then the Chair commences the meeting. If the nomination is rejected the whole process will commence again until agreement by majority of those present is reached.

The Chair will be appointed at the first meeting of the ICP and annually at a meeting of the ICP thereafter.

The Chair will be expected to:-

- be able to build and foster strong relationships in the system
- have a collaborative leadership style
- be committed to innovation and transformation
- have expertise in delivery of health and care outcomes
- be able to influence and drive delivery and change

The ICP will appoint three Vice Chairs drawn from its membership. These will also be appointed at the first meeting of the ICP and annually thereafter.

5. Duties and Responsibilities

The ICP is a core part of the Norfolk and Waveney Integrated Care System, driving their direction and priorities.

The ICP will be rooted in the needs of people, communities, and places.

The ICP will help to develop and oversee population health strategies to improve health outcomes and experiences.

The ICP will support integrated approaches and subsidiarity.

The ICP will take an open and inclusive approach to strategy development and leadership, involving communities and partners to utilise local data and insights.

The ICP will work to embed safeguarding as everyday business across the Norfolk and Waveney Integrated Care System

The ICP will develop an Integrated Care Strategy which the ICB, Norfolk and Suffolk County Council's will be required by law to have regard to when making decisions, commissioning, and delivering services.

The ICP is expected to highlight where coordination is needed on health and care issues and challenge partners to deliver the action required. These include, but are not limited to, helping people live more independent, healthier lives and safer lives

for longer, free from abuse and harm, taking a holistic view of people's interactions with services across the system and the different pathways within it, addressing inequalities in health and wellbeing outcomes; experiences and access to health services; improving the wider social determinants that drive these inequalities, including employment, housing, education environment, safeguarding, and reducing offending; improving the life chances and health outcomes of babies, children and young people, and improving people's overall wellbeing and preventing ill-health.

The ICP will provide a forum for agreeing collective objectives, enable place-based partnerships and delivery to thrive alongside opportunities for connected scaled activity to address population health challenges.

The ICP will set the strategic directions and workplans for organisational, financial, clinical, and informational integration, as well as other types.

6. Authority, Accountability, Reporting and Voting Arrangements

The ICP is tasked with developing a strategy to address the Health, Social Care and Public Health needs of their system, and of being a forum to support partnership working. The ICB and Local Authorities will have regard to ICP Strategies when making decisions. The ICP has no executive powers, other than those specifically delegated in these terms of reference. Individual members will be able to act with the level of authority and the powers granted to them by way of their constituent bodies' policies and make decisions on that basis. The ICP is able to discuss and agree recommendations for approval by the constituent members' statutory bodies. Its role is primarily one of oversight and collective co-ordination.

The aim will be for decisions of the ICP to be achieved by consensus decision making. Voting will not be used, except as a tool to measure support, or otherwise, for a proposal. In such a case, a vote in favour would be non-binding. The Chair will work to establish unanimity as the basis for all decisions.

Meetings of the ICP will be open to the public unless the matter falls within one of the categories of information, outline in Appendix B. In this instance the ICP may determine public participation will be withdrawn for that item.

Meetings will be live streamed and recorded, to be made available to the public afterwards.

Minutes of the meeting will be taken and approved at the next meeting of the ICP.

Final minutes will be made available on the websites of the ICB, Norfolk and Suffolk County Councils.

7. Attendance

Members are expected to attend 75% of meetings held each year. It is expected that members will prioritise these meetings.

Where it is not possible for a member to attend, they may nominate a named deputy to attend meetings in their absence and must notify the Secretariat, at nwbchairman@norfolk.gov.uk, who that person will be.

Members and those presenting must attend meetings in person.

The quorum, as described at section 8, must be adhered to for all meetings including urgent meetings.

Attendance will be recorded within the minutes of each meeting and monitored annually.

8. Quorum

A quorum will be reached when at least the Chair and four members from different partnership organisations are present.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no recommendations for decision by the constituent member bodies may be taken.

In the unlikely event that a member has been disqualified from participating in the discussion of an item on the agenda, for example by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

Nominated deputies attending a meeting on behalf of a member may count towards the quorum.

9. Notice and Frequency of Meeting

Generally, meetings will be held four times a year but more frequently if required for specific matters.

As a matter of routine, an annual schedule of meetings will be prepared and distributed to all members. In other specific instances, or in cases where the date or time of a meeting needs to be changed, notice shall be sent electronically to members at least five working days before the meeting. Exceptions to this would be in the case of emergencies or the need to conduct urgent business.

An agenda and any supporting papers specifying the business proposed to be transacted shall be delivered to each member and made available to the public five working days before the meeting, potential exception being in the case of emergencies or the need to conduct urgent business. Supporting papers, shall accompany the agenda.

Secretariat support to the ICP will be provided by Norfolk County Council.

10. Public Questions

The public are entitled to ask questions at meetings of the ICP and questions should be put in writing and sent by email at least three working days before the meeting. If the question relates to urgent matters, and it has the consent of the Chair to whom the question is to be put, this should be sent by 4pm on the day before the meeting.

Questions should be sent to the Chair, at hwbchairman@norfolk.gov.uk, and will be answered as appropriate, either at the meeting or in writing.

The Chair on behalf of the ICP may reject a question if it:

a) is not about a matter for which the ICP has collective responsibility or particularly affects the ICP; or

b) is defamatory, frivolous, or offensive or has been the subject of a similar question in the last six months or the same as one already submitted under this provision.

Who may ask a question and about what

A person resident in Norfolk and Waveney, or who is a non-domestic ratepayer in Norfolk and Waveney, or who pays Council Tax in Norfolk and Waveney, may ask at a public meeting of the ICP through the Chair any question within the terms of reference of the ICP about a matter for which the ICP has collective responsibility or particularly affects the ICP. This does not include questions for individual ICP members where responsibility for the matter sits with the individual organisation.

Rules about questions:

Number of questions – At any public ICP meeting, the number of questions which can be asked will be limited to one question per person plus a supplementary. No more than one question plus a supplementary may be asked on behalf of any one organisation. No person shall be entitled to ask in total under this provision more than one question, and a supplementary, to the ICP in any six-month period.

Other restrictions – Questions are subject to a maximum word limit of 110 words. Questions that are in excess of 110 words will be disqualified. The total time for public questions will be limited to 15 minutes. Questions will be put in the order in which they are received.

Supplementary questions – One supplementary question may be asked without notice and should be brief (fewer than 75 words and take less than 20 seconds to put). It should relate directly to the original question or the reply. The Chair may reject any supplementary question s/he does not consider compliant with this requirement.

Rules about Responses:

The Chair shall exercise his/her discretion as to the response given to the question and any supplementary.

Not attending – If the person asking the question indicates they will not be attending the ICP meeting, a written response will be sent to the questioner.

Attending – If the person asking the question has indicated they will attend, response to the questions will be made available at the start of the meeting and copies of the questions and answers will be available to all in attendance. The responses to questions will not be read out at the meeting.

Supplementary questions – The Chair may give an oral response to a supplementary question or may require another Member of the ICP or Officer in attendance to answer it. If an oral answer cannot be conveniently given, a written response will be sent to the questioner within seven working days of the meeting.

Written response – If the person who has given notice of the question is not present at the meeting, or if any questions remain unanswered within the 15 minutes allowed for questions, a written response will be sent within seven working days of the meeting.

Rejection of a question

A question may be rejected if it:

a) is not about a matter for which the ICP has collective responsibility or particularly affects the ICP; or

b) is defamatory, frivolous, or offensive or has been the subject of a similar question in the last six months or the same as one already submitted under this provision; or

c) requires the disclosure of confidential or exempt information, as defined in the Access to Information Procedure Rules.

11. Managing Conflicts of Interest

A conflict of interest may be 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”.

The ICP specifically recognises and acknowledges that its members have legal responsibilities to the organisations which they represent and that this may give rise to conflicts of interest being present. However, discussions at the meetings are to be focussed on the needs of the Norfolk and Waveney population and health and care. Therefore, members will not be excluded from engaging in discussions that will benefit the system as a whole.

Members of the ICP shall adopt the following approach for managing any actual or potential material conflicts of interest:

- To operate in line with their organisational governance framework for managing conflicts of interest/probity and decision making.
- For the Chair to take overall responsibility for managing conflicts of interest within meetings as they arise.
- To work in line with the ICS system objectives, principles, and behaviours.
- Members are to ensure they advise of instances where the register of members interest for the Norfolk and Waveney system requires updating in relation to any interests that they have.

In advance of every ICP 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 action will be led by the Chair with support from their governance advisor.

At the beginning of each meeting of the ICP, members and attendees will be required to declare any interests that relate specifically to a particular item under consideration. If the existence of an interest becomes apparent during a meeting, this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.

Elected members will be bound by their own codes of conduct and provisions for declaration of interests.

12. Working groups

To assist with performing its role and responsibilities, the ICP is authorised to establish working groups and to determine the membership, role, and remit for each working group. Any working group established by the ICP will report directly to it.

13. Other Boards

As a key part of the health and care system the ICP will seek active engagement and collaboration with the Norfolk and Waveney ICB, Norfolk and Suffolk HWBs, Place Boards, Health and Wellbeing Partnerships, Safeguarding Adults Boards, Safeguarding Childrens Partnerships, County Community Safety Partnerships, Autism Partnership Boards, and the Learning Disabilities Partnership Boards.

14. Review

The ICP will review these terms of reference at least annually or more regularly if needed, considering policy changes in respect of the Integrated Care System.

Appendix A

Membership of the Integrated Care Partnership

1. Borough Council of King's Lynn & West Norfolk
2. Breckland District Council
3. Broadland District Council
4. Cambridgeshire Community Services NHS Trust
5. Chair of the Voluntary Sector Assembly
6. East Coast Community Healthcare CIC
7. East of England Ambulance Trust
8. East Suffolk Council
9. Great Yarmouth Borough Council
10. Healthwatch
11. James Paget University Hospital NHS Trust
12. Norfolk Care Association
13. Norfolk Community Health & Care NHS Trust
14. Norfolk Constabulary
15. Norfolk County Council, Cabinet member for Adult Social Care, Public Health and Prevention
16. Norfolk County Council, Cabinet member for Childrens Services and Education
17. Norfolk County Council, Director of Public Health
18. Norfolk County Council, Executive Director Adult Social Services
19. Norfolk County Council, Executive Director Children’s Services
20. Norfolk County Council, Leader (nominee)
21. Norfolk & Norwich University Hospital NHS Trust
22. Norfolk & Suffolk NHS Foundation Trust
23. Norfolk & Waveney ICB, Chair
24. Norfolk & Waveney ICB, Chief Executive Officer
25. North Norfolk District Council
26. Norwich City Council
27. Police and Crime Commissioner
28. Place Board Chairs for each Place Board area
29. Primary Care representatives (1)
30. Primary Care representatives (2)

31. Primary Care representatives (3)
32. Primary Care representatives (4)
33. Primary Care representatives (5)
34. Queen Elizabeth Hospital NHS Trust
35. South Norfolk District Council
36. Suffolk County Council, Cabinet Member for Adult Care
37. Suffolk County Council, Executive Director of People Services
38. Voluntary sector representatives (1)
39. Voluntary sector representatives (2)

Appendix B

Categories of Information

Information relating to any individual.

Information which is likely to reveal the identity of an individual.

Information relating to financial or business affairs of any particular person (including the authority holding that information).

Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising.

Information relating to any action taken or to be taken in connection with the prevention, investigation, or prosecution of crime.

APPENDIX B

NHS Norfolk and Waveney Integrated Care Board

Audit and Risk Committee

Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
16.12.2022			1.1

Approvals

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1

1. Constitution

The Audit and Risk Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

The Audit and Risk Committee is authorised by the Board to:

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference;
- Commission any reports it deems necessary to help fulfil its obligations;
- 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. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD:

3. Purpose

To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.

The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

The Audit and Risk Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4. Membership and attendance

Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than three members of the Committee including two who are Non-Executive Members of the Board. Other members of the Committee need not be members of the Board, but they may be.

Neither the Chair of the Board, nor employees of the ICB will be members of the Committee.

Members will possess between them knowledge, skills and experience in: accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

Members of the Committee will be:

- Non-Executive member with a lead for Audit and Risk (Chair)
- A minimum of 2 but up to 3 Non-Executive members other than the Chair, 2 of whom must be on the Board of the ICB.

Chair and vice chair

In accordance with the constitution, the Committee will be chaired by an Independent Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

The Chair of the Committee shall be independent and therefore may not chair any other committees. In so far as it is possible, they will not be a member of any other committee.

Committee members may appoint a Vice Chair.

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

Attendees

Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Director of Finance or their nominated deputy;
- Representatives of both internal and external audit;
- Individuals who lead on risk management and counter fraud matters;
- Director of Corporate Affairs and ICS Development
- Head of Corporate Governance
- Director of Commissioning Finance
- Associate Director of Financial Management

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.

The Chief Executive should be invited to attend the meeting at least annually.

The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

The Medical Director may also be invited to attend one meeting each year prior to year end to give an oversight of risks.

Attendance

Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

Access

Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management providers will have full and unrestricted rights of access to the Audit and Risk Committee.

5. Meetings Quoracy and Decisions

The Audit and Risk Committee will meet at least four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, Chair or Chief Executive may ask the Audit and Risk Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

For a meeting to be quorate a minimum of two Non-Executive Members of the Board are required, including the Chair or Vice Chair of the Committee.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. The decision will be reported at the next meeting of the Committee.

6. Responsibilities of the Committee

The Committee's duties can be categorised as follows.

Integrated governance, risk management and internal control

To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.

To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.

To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks.

To have oversight of system risks where they relate to the achievement of the ICB's objectives.

To ensure consistency that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.

To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

To identify opportunities to improve governance, risk management and internal control processes across the ICB.

Internal audit

To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved;
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
- Considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources;
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and

- Monitoring the effectiveness of internal audit and carrying out an annual review.

External audit

To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit;

- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;

- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and

- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other assurance functions

To review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.

To review the work of other committees in the ICB, whose work can provide relevant assurance to the Audit and Risk Committee's own areas of responsibility.

To review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.

To review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, CQC; and

- Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

Counter fraud

To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Requirements of the Government Functional Standard GovS 013: Counter Fraud – management of counter fraud, bribery and corruption activity, Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

To be responsible for ensuring that the counter fraud service submits an Annual Report and the Counter Fraud Functional Standard Return (CFFSR) Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Requirements of the Government Functional Standard GovS 013: Counter Fraud – management of counter fraud, bribery and corruption activity.

To report concerns of suspected fraud, bribery and corruption to the NHSCFA.

Freedom to Speak Up

To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

Information Governance (IG)

To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

To approve the arrangements for ensuring the appropriate safekeeping and confidentiality of records and for the storage management and transfer of information and data.

Financial reporting

To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.

To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

To review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the Financial Statements;
- Significant judgements and estimates made in preparing of the Financial Statements;
- Significant adjustments resulting from the audit;

- Letter of representation; and
- Qualitative aspects of financial reporting.

Approval of the ICB's banking arrangements

Review of ICB risk sharing or risk pooling arrangements

Conflicts of Interest

The Chair of the Audit and Risk Committee will be the nominated Conflicts of Interest Guardian.

The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

Management

To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.

To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's standing orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

Communication

To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.

To develop an approach with other committees, including the Integrated Care Partnership, to ensure the relationship between them is understood.

7. Behaviours and Conduct

ICB values

Members will be expected to conduct business in line with the ICB values and objectives.

Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, Scheme of Reservation and Delegation, Conflicts of Interest Policy and Standards of Business Conduct Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

8. Accountability and reporting

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary

The Chair will provide written assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

The Audit and Risk Committee will provide the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

- The fitness for purpose of the assurance framework;
- The completeness and 'embeddedness' of risk management in the organisation;
- The integration of governance arrangements;
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements; and
- The robustness of the processes behind the quality accounts.

9. Secretariat and Administration

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and 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;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

10. Review

The Committee will review its effectiveness at least annually.

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 Board for approval.

Date of approval:

Date of review:

APPENDIX C

NHS Norfolk and Waveney Integrated Care Board

Remuneration, People and Culture Committee

Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
07.03.2023		EO	1.1

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1

1. Constitution

The Remuneration, People and Culture Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.
The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

The Remuneration, People and Culture Committee is authorised by the Board to:

- Investigate any activity within its terms of reference;
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference;
- 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. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;
- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and SoRD but may /not delegate any decisions to such groups.

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private.

3. Purpose

The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary:

- Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including staff on very senior managers grade, including all board members, excluding the Chair and Non-Executive Members.

The Board has also delegated the following functions to the Committee, please see section 6 below.

4. Membership and attendance

Membership
The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than three members of the Committee including two independent members of the Board.

The Chair of the Audit and Risk Committee may not be a member of the Remuneration, People and Culture Committee.

The Chair of the Board may be a member of the Committee but may not be appointed as the Chair.

No employee may be a member of the Committee

When determining the membership of the Committee, active consideration will be made to diversity and equality.

The members of the Committee are:

- Three non-executive members of the ICB who are not the Chair of the Audit and Risk Committee.

The following attend the Committee for Part 1 only.

- One other member appointed from the wider Norfolk and Waveney system with the relevant experience as to people and culture.
- Director of Nursing or nominated deputy

Chair and Vice Chair

In accordance with the constitution, the Committee will be chaired by a non-executive member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.
Committee members may appoint a Vice Chair from amongst the members.
In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.
The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Attendees

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.
Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

- The ICB's most senior HR Advisor or their nominated deputy
- The ICB's People Director or their nominated deputy
- Director of Finance or their nominated deputy
- Chief Executive or their nominated deputy
- Director of Corporate Affairs and ICS Development or nominated deputy

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

No individual should be present during any discussion relating to:

- Any aspect of their own pay;
- Any aspect of the pay of others when it has an impact on them.

5. Meetings Quoracy and Decisions

The Committee will meet in private.
The Committee will meet at least twice each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.
The Board, Chair or Chief Executive may ask the Remuneration, People and Culture Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.
In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.
Quorum
For a meeting to be quorate a minimum of two of the non-executive members is required, including the Chair or Vice Chair.
If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.
If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting
Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.
Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.
Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

6. Responsibilities of the Committee

The Committee will hold a **part 1** meeting to cover issues as to system people and culture priorities only. This section of the meeting will contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the strategic People and culture agenda for the ICB and its partner constituents.

It will do this by scrutinising the delivery of the strategic people priorities in order to provide assurance to the ICB Board that risks to the delivery of the people agenda are being managed appropriately. The committee will receive relevant risks from the Board Assurance Framework (namely those relating to People and Culture agenda) to review assurance on risk mitigation and controls including any gaps in control for the risks allocated to the Committee;

The Committee will also have oversight and provide assurance to the Board that the ICS is delivering against the ten outcomes based functions with their partners in the ICS against an agreed set of Key Performance Indicators; namely:

1. Supporting the health and wellbeing of all staff

2. Growing the workforce for the future and enabling adequate workforce supply:
3. Supporting inclusion and belonging for all, and creating a great experience for staff
4. Valuing and supporting leadership at all levels, and lifelong learning
5. Leading workforce transformation and new ways of working
6. Educating, training, and developing people, and managing talent
7. Driving and supporting broader social and economic development
8. Transforming people services and supporting the people profession
9. Leading coordinated workforce planning using analysis and intelligence
10. Supporting system design and development:

It will also play a key role in ensuring that NHS partner organisations meet expectations in relation to the system people and culture strategic priorities and committee will ensure compliance against any obligations outlined in the NHS People Plan.

The part 1 duties of the Committee will be driven by the system's objectives, performance, and the associated risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

The Committee will also hold a **part 2** meeting to consider matters as set out below which include remuneration, terms and conditions for the ICB, its employees, members of the Board and Clinical Advisors.

The Committee's duties are as follows:

For the Chief Executive, Members of the Board 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;
- Determine arrangements for termination of employment and other contractual terms and non-contractual terms.

For all staff:

- Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change);
- Oversee contractual arrangements;
- 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;
- Oversee the development of:
    1. an ICB culture and Organisational Development plan, taking into account national People and OD frameworks, and recognising the changing needs of our people to ensure the ICB is the best place to work
    2. The ICB EDI workplan
    3. The ICB staff engagement action plans (based on the staff survey)
    4. the CQC well led agenda
    5. the ICB H&W action plans
    6. the ICB people dashboard

For Clinical Advisors:

- Determine ICB pay policy

- Oversee contractual arrangements

For the avoidance of doubt, remuneration for the ICB Chair and Non-Executives will not be considered by the Remuneration, People and Culture Committee.

The Committee will also be responsible for:

- Approval of the nominations and appointments process for Board members;
- Oversight of executive board member performance.
- Assurance as to succession planning for the Board;
- 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).
- Approve human resources policies for employees and for other persons working on behalf of the ICB.
- Approval of the arrangements for discharging the CCG's statutory duty associated with its commissioning functions to promote education and training for persons who are employed or are considering becoming employed in an activity which is connected with the health service.

7. Behaviours and Conduct

Benchmarking and guidance
The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.
ICB values
Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.
Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.
Equality diversity and inclusion
Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

8. Accountability and Reporting

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.
The minutes of the meetings shall be formally recorded by the secretary.
The Remuneration, People and Culture Committee will submit a report to the Board following each of its meetings. Where reports identify individuals, they will not be made public and will be presented at part 2 of the Board. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

9. Secretariat and Administration

The Committee shall be supported with a secretariat function. Which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;

- Records of members' appointments and renewal dates and 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;

- The Committee is updated on pertinent issues/ areas of interest/ policy developments; and

- Action points are taken forward between meetings.

10. Review

The Committee will review its effectiveness at least annually.
These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval:

Date of review:

APPENDIX D

Norfolk and Waveney Integrated Care Board
Patients and Communities Committee
Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1

1. CONSTITUTION

The Patients and Communities Committee ("the Committee") is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE OF THE COMMITTEE

The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that meets the needs of patients and communities, that is based on engagement and feedback from local people and groups, and that takes account of and reduces the health inequalities experienced by individuals and communities.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care.

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

3. DELEGATED AUTHORITY

The Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. MEMBERSHIP AND ATTENDANCE

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than four members of the Committee, including one who is a Non-Executive Member of the Board (from the ICB). Other attendees of the Committee need not be members of the Board, but they may be.

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Conflicts of Interest
The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

Chair and Deputy chair

If a Chair has a conflict of interest then the co-chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Members

The Members of the Committee are as follows

- Non-Executive Member of the ICB Board (Chair)
- Non- Executive Member of the ICB Board
- VCSE Board Member on the ICB Board
- Patients and Communities Director, NHS Norfolk and Waveney ICB
- Medical Director Norfolk and Waveney ICB or the Director of Nursing
- A person with primary care experience
- Senior Public Health Officer Norfolk County Council
- A representative from the Place Boards
- A representative from the Health and Wellbeing Partnerships
- A representative from Healthwatch
- Two experts by experience from local communities

5. MEETING QUORACY AND DECISIONS

The Committee shall meet at least bi-monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

The quorum for the meeting will be 3 Members including at least on Chair or Deputy Chair and one ICB executive

Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf. For the avoidance of doubt the deputy will be counted as part of the quorum.

If any member of the Committee has been disqualified from participating in an item

on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out below may be followed.

Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee or their nominated deputy may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent decisions

In the event that an urgent decision is required, if it is not possible for the Committee to meet virtually an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum one other member).

The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification and noted in the minutes.

6. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

Complaints

- Approve the ICB's arrangements for handling complaints
- Receive regular reports about complaints received by the ICB and performance against the organisation's Complaints Policy.
- Oversee the sharing of lessons learnt from complaints received by the ICB across the organisation and the Integrated Care System.

- Provide assurance to the ICB Board regarding the organisation's performance against its Complaints Policy and processes.

Listening to, engaging and working with people and communities

- Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote the involvement of patients, their carers and representatives in decisions about their healthcare.

- Approve an annual communications and engagement plan for the ICB that sets out how the organisation will help to deliver Integrated Care System's approach to working with people and communities in Norfolk and Waveney.

- Receive regular reports setting-out the ICB's implementation of its annual communications and engagement plan and the organisation's contribution to delivering the Integrated Care System's approach to working with people and communities in Norfolk and Waveney.

- Consider how the ICB and the Integrated Care System could improve how we listen to, engage and work with people and communities.

- Oversee the sharing of insight gained from engagement with people and communities across the ICB and the Integrated Care System.

- Provide assurance to the ICB Board regarding the effectiveness of the organisation's approach to listening to, engaging and working with people and communities.

Addressing health inequalities

- Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to have regard to the need to reduce inequalities

- Receive regular reports from the Norfolk and Waveney Health Inequalities Oversight Group about the Integrated Care System's work to reduce health inequalities.

- Consider how the ICB and the Integrated Care System could improve its work to address health inequalities.

- Provide assurance to the ICB Board regarding the effectiveness of the organisation's work to address health inequalities.

Integration with the voluntary, community and social enterprise sector

- Receive regular reports about the work of the ICB and the Integrated Care System to improve integration between the statutory and voluntary, community and social enterprise sectors.

- Consider how the ICB and the Integrated Care System could improve integration between the statutory and voluntary, community and social enterprise sectors.

Development funding

- Agree how the ICB should use development funding received from NHS England.

- Agree how the ICB should use any funding received by the ICB as a result of bids to external bodies with regard to health inequalities or patient engagement.

Place

- Review and approve arrangements as to the delegations to place boards or place Directors.

7. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a written report on assurances received, escalating any concerns where necessary.

The Committee will receive scheduled assurance reports from any delegated groups. Any delegated groups would need to be agreed by the ICB Board.

8. BEHAVIOURS AND CONDUCT

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. DECLARATIONS OF INTEREST

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

10. SECRETARIAT AND ADMINISTRATION

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

- The agenda and papers are prepared and distributed in in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and 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;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

11. REVIEW

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.
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 Board for approval.
The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval:

Date of review:

APPENDIX E

Finance Committee
Terms of Reference

NHS Norfolk and Waveney Integrated Care Board

1. Contents

2. Purpose

The Finance Committee is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

Its main purpose is to contribute to the overall delivery of the ICS objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan and strategy, consistent with the ICS Strategic Plan and its operational deliverables.

The Finance Committee will be run in two separate parts (with differing core membership for each element), this includes:

- Financial performance of NHS organisations within the formal ICS footprint – system control total (Part 1)
- Financial performance of the ICB (Part 2)

3. Authority

The Finance Committee is authorised by the Board to:

3.1 investigate any activity within its terms of reference

3.2 seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference

3.3 commission any reports it deems necessary to help fulfil its obligations

3.4 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. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice

3.5 create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups

3.6 Advise the Board and / or any of its committees of findings and insights it considers are relevant for noting or discussion

4 Remit and Responsibilities

The Committee will hold a part 1 meeting to cover system wide issues and a part 2 meeting to consider issues internal to the ICB.

The Committee's duties are as follows:

System financial management framework

4.1 to set the strategic financial framework of the ICB and ICS and monitor performance against it

4.2 to develop the system financial information systems and processes to be used to make recommendations to the Board on financial planning in line with the strategy and national guidance

4.3 to ensure health and social inequalities implications are taken into account in financial decision-making

Resource allocation (revenue)

4.4 to develop an approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on the ICS strategy

4.5 to advise on the process regarding the deployment of system wide transformation funding and monitor the financial impact of transformation initiatives

4.6 to work with ICS partners to identify and allocate resources where appropriate to address financial performance, quality and safety related issues that may arise and to ensure Value for Money in that resource allocation

4.7 to work with ICS partners to consider major investment/disinvestment business cases for material service change or efficiency schemes (smaller of 3% of organisational annual expenditure and £5m with a de-minimus level of £1m) and to agree a process for sign off where system funding is required

National framework

4.8 to advise the ICS member organisations on any changes to NHS and non-NHS funding regimes and consider how the funding available to the ICS can be best used within the system to achieve the best outcomes for the local population

4.9 to oversee national ICB and ICS level financial submissions

4.10 to ensure the required preparatory work is scheduled to meet national planning timelines

Financial monitoring information

4.11 to develop a reporting framework for the ICB (using the chart of accounts devised by NHS England and the integrated single financial environment (ISFE)) and the ICS as a system of bodies

4.12 to articulate the financial position and financial impacts (both short and long-term) to support decision-making

4.13 to work with ICS partners to agree common approaches across the system such as financial reporting, estimates and judgements

4.14 to work with ICS partners to seek assurance over the financial reports from system bodies and providing feedback to them

4.15 to oversee the development of financial and activity modelling to support the ICB and ICS priority areas

4.16 to develop a medium- and long-term financial plan, consistent with strategic and operational plans

4.17 to develop an understanding of expenditure run rates across a system, system cost drivers and the impacts of service change on costs

4.18 to ensure appropriate information is available to challenge and manage financial issues, risks and opportunities across the ICS

4.19 to manage financial and associated risks by developing and monitoring a finance risk register

4.20 to leverage the use of non-financial data to triangulate against financial insights, and vice versa

Financial Performance

4.21 to oversee the management of the system financial target and the ICB's own financial targets

4.22 to agree key outcomes to assess delivery of the ICS financial plan and strategy

4.23 to monitor and report to the board overall financial performance against national and local metrics, highlighting areas of concern

4.24 to monitor and report to the board key service performance which should be taken into account in assessing the financial position

System efficiencies

4.25 to ensure system efficiencies are identified and monitored across the ICS, in particular opportunities at system level where the scale of the ICS partners together and the ability to work across organisations can be leveraged

4.26 to ensure financial resources are used in an efficient way to deliver the objectives of the ICS and to monitor and support resource utilisation that is consistent with long term financial sustainability

4.27 to review exception reports on any material breaches of the delivery of agreed efficiency improvement plan including the adequacy of proposed remedial action plans

Communication

4.28 to co-ordinate and manage communications on financial governance with stakeholders internally and externally

4.29 to develop an approach with partners, including the ICS health and care partnership, to ensure the relationship between cost, performance, quality and environment sustainability are understood

People

4.30 to develop a system finance staff development strategy to ensure excellence by attracting and retaining the best finance talent

4.31 to ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements

Capital

4.32 to develop the system estates strategy and plan to ensure it properly balances clinical, strategic and affordability drivers (if not covered by separate strategic estates forum)

4.33 to monitor the system capital programme against the capital envelope and take action to ensure that it is appropriately and completely used

4.34 to gain assurance that the estates, digital and clinical strategic plans are built into system financial plans and strategy to ensure effective oversight of future prioritisation and capital funding bids

Committee Development

4.35 to provide a programme of development to ensure Committee members are able to fulfil their committee duties, through a combination of training, education and information sharing sessions

5 Accountability and Reporting

5.1 The Finance Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities

5.2 The Chair will provide assurance reports to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require Board action

5.3 The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference and give details on progress and a summary of key achievements in the delivery of its responsibilities

6 Membership

6.1 The Finance Committee members shall be appointed by the Board in accordance with the ICB Constitution

6.2 When determining the membership of the Finance Committee active consideration will be made to diversity and equality. Members of the committee may be co-opted to ensure diversity of thinking in decision making

6.3 The board will appoint no fewer than four members of the Committee including one who is an Non-Executive Member of the Board. Other members of the committee need not be members of the board but may be

6.4 Members should possess between them knowledge, skills and experience in accounting, risk management and technical or specialist issues pertinent to the ICB's business.

6.5 The members of the Committee are as follows:

- Non-Executive member with the lead for Finance (Chair)
- Non-Executive
- ~~ICB Executive Board Member (Either the Chief Executive Officer, Director of Nursing or Medical Director)~~
- Director of Finance
- Director of Performance, Transformation and Strategy

The following members attend the Committee for Part 1 only and bring their own delegation (where applicable from their own organisations.)

- Acute Chief Finance Officer (a serving Norfolk & Waveney Chief Finance Officer with current experience in an acute NHS provider setting)

- Non-acute Chief Finance Officer (a serving Norfolk & Waveney Chief Finance Officer with current experience in a non-acute NHS provider setting)
- Non-Executive Director (from NHS provider organisation)
- A clinical person with primary care experience.
- A clinical person from a provider, active within the Norfolk & Waveney locality
- A finance lead from Local Authority
- A person with financial expertise from the VCSE or wider community.

6.6 There will be a standing invitation to a finance representative from the NHS England regional team. They will not have voting rights at the meeting

6.7 Where a conflict of interest is deemed to exist, the Chair (or vice-Chair) can ask the member not to attend the meeting (or part thereof) or allow the member to attend but not vote

6.8 Meetings will take place on a minimum of 10 occasions throughout any given financial year

6.9 Members should make reasonable endeavours to attend meetings and are expected to attend at least 90% of meetings held each year to ensure consistency, unless agreed with the chair in extenuating circumstances.

6.10 Where a member is unable to attend, efforts should be made to ensure a suitable representative attends, as nominated by the member and agreed with the Chair

Chair and Vice Chair

6.11 In accordance with the constitution, the Committee will be chaired by an Independent Non-Executive Member of the Board appointed on account of their specific knowledge, skills and experience making them suitable to chair the Committee

6.12 The Chair of the Committee shall be independent

6.13 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting

6.14 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference

Attendees

6.15 Only members of the Finance Committee have the right to attend meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the committee. Other individuals may be

invited to attend all or part of any meeting as and when appropriate to assist it with discussions on any particular matter

6.16 The Chair may ask any or all of those who normally attend, but are not members, to withdraw to facilitate open and frank discussion on particular matters

6.17 The Chair of the ICB may also be invited to attend one meeting a year in order to gain an understanding of the committee's operations

7 Secretary and Administration

7.1 The Finance Committee shall be supported with a secretariat function, led by the ICB Director of Commissioning Finance, which will ensure that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Records of members' appointments and renewal dates and the Committee 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
- The Finance Committee is updated on pertinent issues/ areas of interest/ policy developments
- Action points are taken forward between meetings and progress against those is monitored
- Attendance of those invited to each meeting is monitored and the Chair is made aware as soon as possible of those meetings that do not meet the minimum quoracy requirements

8 Meeting Quoracy and Decision

8.1 For a meeting to be quorate a minimum of 50% voting members are required, including the Chair or Vice Chair

8.2 If any member of the Committee has been disqualified from participating on item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken

Decision Making and Voting

8.4 Decisions will be taken in according with the Standing Orders. The Finance Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote

8.5 Only members of the Finance Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter

8.6 Where there is a split vote, with no clear majority, the Chair of the Finance Committee will hold the casting vote

8.7 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. Where such action has been taken between meetings, then these will be reported to the next meeting

9 Conduct of the Finance Committee

Benchmarking and Guidance

9.1 The Finance Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations

Conflict of Interest

9.2 In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to the NHS guidance on managing conflicts of interest

9.3 All conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and

submitted to the Board. If a conflict of interest arises, the Chair may require the affected member to withdraw at the relevant point

ICB Values

9.4 Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB

9.5 Members of, and those attending, the Finance Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy

Equality, Diversity and Inclusion

1.1 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make

10 Review

10.1 The Finance Committee will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership

Date Approved:	
Next Review:	

APPENDIX F

Norfolk and Waveney Integrated Care Board
Primary Care Commissioning Committee
Terms of Reference

1 Constitution

1.1 The Primary Care Commissioning Committee (the Committee) is established by the Norfolk and Waveney Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2 Authority

2.1 The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Create a Primary Medical Services Delivery Group and a Dental Services Delivery Group that will undertake specific agreed tasks and decision making as set out in the ICB Governance. The Committee shall appoint the Chair and agree the membership and terms of reference of these groups in accordance with the ICB's constitution, standing orders and SoRD.

2.2 For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the SoRD.

3 Purpose

3.1 To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care.

3.2 The duties of the Committee will be driven by the ICB's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year, however this will be flexible to new and emerging priorities and risks.

3.3 The Committee has no executive powers, other than those delegated in the SoRD and

specified in these terms of reference.

4 Membership and attendance

Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than 4 members of the Committee based on their specific knowledge, skills and experience.

4.3 The members of the Committee who will attend Part 1 and Part 2 meetings are:

- A Local Authority Partner Member from the ICB Board (Chair)
- Non-Executive Director (Deputy Chair)
- Director of Nursing or their nominated deputy
- Director of Finance or their nominated deputy

4.4 Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Committee Chair. The nominated deputy will count in the quorum for the meeting and be able to cast a vote if required.

Chair and Vice Chair

4.5 The Chair of the ICB will appoint a Chair of the Committee who has the specific knowledge, skills and experience making them suitable to chair the Committee.

4.6 Committee members may appoint a Vice Chair from amongst the members.

4.7 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

4.8 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

Attendees

4.9 Only members of the Committee have the right to attend Committee meetings. The following individuals, who are attendees and not members of the Committee, will be invited to attend Part 1 and Part 2 meetings subject to s.4.10:

- ICB Board Partner Member – Providers of Primary Medical Services
- Local Representative Committee members – Local Medical Committee, Local Dental Committee, Local Pharmacy Committee and Local Optical Committee
- Director of Patients and Communities
- Director of Primary Care
- One practice manager (or other suitably experienced individual) from primary medical services and one from (NHS) primary dental

The following attendees will be invited to attend Part 1 meetings only:

- Healthwatch Norfolk
- Healthwatch Suffolk
- Health and Wellbeing Board representative – Norfolk
- Health and Wellbeing Board representative – Suffolk

4.10 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.11 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Boards, Secondary and Community Providers.

Attendance

4.12 Where an attendee of the Committee who is not a member of the Committee is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5 Meetings Quoracy and Decisions

5.1 The Committee will meet at least 4 times a year in public subject to the application of 5.4 below. The Committee will operate in accordance with the ICB's Standing Orders. The Secretary to the Committee will be responsible (or delegate where appropriate) for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each voting member and non-voting attendee at least 7 calendar days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he/they shall specify. Additional meetings may take place as required in public or private as appropriate for the nature of the business to be transacted.

5.2 The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.3 In accordance with the Standing Orders, the Committee will normally meet virtually unless a face to face meeting is deemed necessary.

5.4 The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity 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.

Quorum

5.5 For a meeting to be quorate a minimum of 3 Members of the Committee are required, including the Chair or Vice Chair of the Committee.

5.6 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.7 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out at 5.11 and 5.12 may be followed.

Decision making and voting

5.8 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.9 Only members of the Committee or nominated deputy may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.10 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote or in their absence the Vice Chair.

Urgent Decisions

5.11 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

5.12 In the event that an urgent decision is required, if it is not possible for the Committee to meet virtually an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).

5.13 The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification and noted in the minutes.

6 Responsibilities of the Committee

6.1 NHS England has delegated to the ICB authority to exercise the primary care commissioning and dental functions in accordance with section 13Z of the NHS Act with specific obligations set out in Schedule 2 of the Delegation Agreement and general obligations set out below:

Schedule 2A: Primary medical services

- decisions in relation to the commissioning and management of Primary Medical Services;
- planning Primary Medical Services in the Area, including carrying out needs assessments;
- undertaking reviews of Primary Medical Services in respect of the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2B: Primary dental services and prescribed dental services

- decisions in relation to the commissioning and management of Primary Dental, Services; for clarity this includes primary care, community care/special care dental services and secondary care dental services;
- planning Primary Dental Services in the Area, including carrying out needs assessments;
- undertaking reviews of Primary Dental Services in the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2C: Primary ophthalmic services

Ophthalmic services are hosted by Hertfordshire and West Essex Integrated Care Board (H&WE ICB) on behalf of the ICB. In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will report general optometry services matters to the Committee including information to support decision making as and when matters arise. The ICB remains responsible and accountable for the provision of this service.

- decisions in relation to the management of Primary Ophthalmic Services;
- undertaking reviews of Primary Ophthalmic Services in the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2D: Pharmaceutical services and local pharmaceutical services

Pharmaceutical services are hosted by HWE ICB on behalf of the ICB.

NHS England has established mandated local committees to be known as Pharmaceutical Services Regulations Committees (PSRC). The PSRC is an ICB committee with representatives from all East of England ICBs attending. NHS England has delegated decision making to each PSRC in relation to matters under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 as amended.

H&WE ICB will coordinate and host the PSRC to agreed Terms of Reference as set out in the NHS England Pharmacy Manual (https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-manual/).

In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will provide quarterly reports to the Committee on decisions made at the PSRC.

Applications and Notifications will be made by H&WE ICB on behalf of the ICB to the PSRC for determination.

The ICB remains responsible and accountable for the provision of this service.

6.2 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the ICB acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

- Management of conflicts of interest (section 14O);
- Duty to promote the NHS Constitution (section 14P);
- Duty to exercise its functions effectively, efficiently and economically (section 14Q);
- Duty as to improvement in quality of services (section 14R);
- Duty in relation to quality of primary care services. The Committee has the remit for reviewing primary care quality. Due to the interface with other services, however, the Quality and Safety Committee will maintain oversight of issues which may require more system wide assurance and support.;
- Duties as to reducing inequalities (section 14T);
- Duty to promote the involvement of each patient (section 14U);
- Duty as to patient choice (section 14V);
- Duty as to promoting integration (section 14Z1);
- Public involvement and consultation (section 14Z2).

6.3 The functions of the Committee are undertaken in the context of a desire to promote increased quality, efficiency, productivity and value for money and to remove administrative barriers.

6.4 The role of the Committee shall be to carry out the functions relating to the commissioning of primary services under the NHS Act and detailed in the Delegation Agreement with NHS England.

6.5 In performing its role, and in particular when exercising its commissioning responsibilities, the Committee shall take account of:

a) The recommendations of the executive management team, the relevant Delivery Group and other Board committees;

b) The needs assessment and plan for primary medical care services in the areas covered by the ICB including the resilience of all primary care providers;

c) The co-ordination of a common strategic and operational approach to the commissioning of primary care services generally including supporting developments in respect of integration with providers and local authority services including co-location of services;

d) The management of the budget for commissioning of primary care services in the area covered by the ICB;

e) In accordance with its duties to reduce inequalities,14T, in the exercise of its functions, the Committee will have regard to the need to:

- Reduce inequalities between patients with respect to their ability to access health services, and
- reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services

7 Behaviours and Conduct

ICB values

7.1 Members will be expected to conduct business in line with the ICB values, objectives and follow the seven principles of public life (the Nolan Principles), comply with the standards set out in the Professional Standards Authority guidance.

7.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy and Conflicts of Interest Policy.

Equality and diversity

7.3 Members must demonstrably consider the equality and diversity implications of decisions they make.

Conflicts of Interest

7.4 Members and those attending a meeting of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

7.5 A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Conflicts of Interest Policy.

Confidentiality

7.6 Issues discussed at Committee meetings held in private, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8 Accountability and reporting

8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

8.2 The Chair of the Committee, if not a member of the ICB Board, may be invited to attend Board meetings at the request of the Chair of the ICB.

8.3 The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the Committee.

8.4 The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary. A report of the Committee's work will be submitted to the Board following each meeting.

8.5 The Committee Chair shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

9 Secretariat and Administration

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Committee Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored, highlighting to the Chair those that do not meet the minimum requirements.
- 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.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.

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

10 Review

10.1 The Committee will review its effectiveness annually.

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

Date of approval:

Date of review:

APPENDIX G

Norfolk and Waveney Integrated Care Board
Quality and Safety Committee
Terms of Reference DRAFT v0.4

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
21/10/2022	Side by side review against SNEE and C&P terms. Membership queries highlighted.	KW & EK	v0.7 & v0.8
08/11/2022	Review against final version in ICB Governance Handbook. Changes to membership and quoracy. Meeting to confirm changes with Corporate.	EK & AB	v0.9
09/11/2022	Version for Committee review.	EK & AB	v0.10
11/01/2023	Final version for Committee review. Highlighted all amends to the version approved by Board.	EK	v0.11

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1

CONSTITUTION

The Quality and Safety Committee ("the Committee") is established by the Integrated Care Board ("the Board" or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive chaired committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

PURPOSE OF THE COMMITTEE

The Quality and Safety Committee has been established to provide the ICB with assurance that is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out by the National Quality Board 'Shared Commitment to Quality' and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, of an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care. The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

See the appendix to these terms for an overview of Committee objectives for 2023-2024.

DELEGATED AUTHORITY

The Quality and Safety Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time. The Quality and Safety Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

MEMBERSHIP AND ATTENDANCE

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than four members of the Committee including two who are Non-Executive Members of the Board (from the ICB). Other attendees of the Committee need not be members of the Board, but they may be.

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion and the voice of clinical workforce.

The Chair may ask any or all attendees, who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Chair and Vice Chair

The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest. If a Chair has a conflict of interest, then the Deputy Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Members

The Members attending Part 1 and Part 2 meetings of the Committee are as follows (please see Section 6 below with regard to Part 1 and Part 2 meetings):

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- ICB Director of Nursing
- ICB Medical Director
- ICB Primary Medical Services Partner Member
- ICB Local Authority Partner Member

The following Members attend the Committee for Part 1 only and bring their own delegation (where applicable from their own organisations):

- 1 Acute Provider Member
- 1 Community Provider Member
- 1 Mental Health Member
- 2 Local Authority Members (Norfolk and Suffolk)
- 1 VCSE Assembly Member
- 1 Independent Provider Partner
- 1 Hospice Provider Partner

Additional attendees will be called upon by the Chair as required and will include representation from the Urgent & Emergency Care system as well as the voluntary sector and other providers and provider collaboratives. The ICB Chief Executive Officer is routinely invited to attend.

MEETING QUORACY AND DECISIONS

The Quality and Safety Committee shall meet on a monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

There will be a minimum of one Non-Executive Member, plus at least the Director of Nursing or Medical Director. Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

Decision Making and Voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication.

RESPONSIBILITIES OF THE COMMITTEE

The Committee will hold a Part 1 meeting to cover system wide issues and a Part 2 meeting to consider issues internal to the ICB.

The responsibilities of the Quality and Safety Committee are authorised by the ICB. It is expected that the Quality and Safety Committee will:

- Be assured that there are robust processes in place for the effective management of quality.

- Scrutinise structures in place to support quality planning, research, control and improvement, to be assured that the structures operate effectively and timely action is taken to address areas of concern.

- Agree and put forward the key quality priorities that are included within the ICB strategy and annual plan, including priorities to address variation and inequalities in care.

- Oversee and monitor delivery of the ICB key statutory requirements.

- Review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner

- Oversee and scrutinise the ICB's response to all relevant Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSE and other regulatory bodies and external agencies (e.g., CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.

- Maintain an overview of changes in the methodology employed by regulators and changes in legislation and regulation and assure the ICB that these are disseminated and implemented across all ICB sites.

- Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes.

- Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place.

- Ensure that patient outcomes from care are collected and measured, to inform outcomes-based commissioning for quality.

- Receive assurance that the ICB identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded.

- Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from deaths (including coronial inquests and Reports to Prevent Future Deaths).

- Receive assurance that the ICB has effective and transparent mechanisms in place to monitor the quality of Children, Maternity and Neonatal care.

- To be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities.

- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children.

- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control.

- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for research and evaluation.

- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services.

- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.

- Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality and Safety Committee (e.g., System Quality Group and Infection Prevention and Control).

- Approve ICB arrangements including supporting policies to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality research and patient outcomes.

- Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to act with a view to securing continuous improvements to the quality of services.

ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Quality and Safety Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The Committee will advise the Audit and Risk Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

BEHAVIOURS AND CONDUCT

ICB Values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and Diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

DECLARATIONS OF INTEREST

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

SECRETARIAT AND ADMINISTRATION

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

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Executive lead;

- Attendance of those invited to each meeting is monitored and that those that do not meet the minimum requirements are highlighted to the Chair;

- Member appointments and renewal dates are recorded, and the Board is prompted to renew membership and identify new members where necessary;

- 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 maintained;

- The complete agenda pack will be circulated at least five calendar days before the date of the meeting. The draft minutes and action log will be shared with all Committee members within five calendar days following the meeting.

- The Chair is supported to prepare and deliver a report of each Committee meeting to the Board;

- The Committee is updated on pertinent issues, areas of interest and policy developments;

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

REVIEW

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

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 Board for approval.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: **Date of review:**

APPENDIX: Committee Objectives for 2023-2024

- To seek assurance that the Norfolk and Waveney system has a unified approach to quality governance and internal controls that support it to effectively deliver its strategic objectives and provide sustainable, high-quality care and to have oversight of local implementation of the NHS National Patient Safety Strategy.

- To be assured that these structures operate effectively, that timely action is taken to address areas of concern, and to respond to lessons learned from all relevant sources including national standards, regulatory changes, and best practice.

- To oversee and monitor delivery of the ICB key statutory requirements, including scrutiny of the robustness and effectiveness of its arrangements for safeguarding adults and children, infection prevention and control, medicines optimisation and safety, research and evaluation and equality and diversity. To ensure that patient outcomes from care are collected and measured, to inform outcomes-based commissioning for quality.

- To review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to quality, and the delivery of safe, timely, effective and equitable care. To consider the effectiveness of proposed mitigations and to escalate concerns to risk owners and operational leads/forums as agreed by Committee Members.

- To approve ICB arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and secure continuous improvement in quality. To seek assurance that commissioning functions act with a view to supporting quality improvement; developing local services that promote wellbeing and prevent adverse health outcomes, equitably, across all patients and communities in Norfolk and Waveney.

APPENDIX H

Norfolk and Waveney Integrated Care Board

Performance Committee

Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
26 May 2022	Originate document	A Palmer	1
6 Sept 2022	Attendee's following EMT decision	T Litherland	2

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1

1. CONSTITUTION

The Performance Committee ("the Committee") is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE OF THE COMMITTEE

The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that ensures a high performing system.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB regarding the delivery of key performance standards by commissioned providers, performance of the system against the NHS Outcomes Framework and progress with improving wider population health outcome measures.

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

3. DELEGATED AUTHORITY

The Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. MEMBERSHIP AND ATTENDANCE

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than three members of the Committee including at least two who are Members or Participants of the ICB Board. Other attendees of the Committee need not be Members or Participants of the Board, but they may be.

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Conflicts of Interest

The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

Chair and Deputy chair

If a Chair has a conflict of interest then the co-chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Members

- ICB Board Partner Member, Primary Medical Services (Chair)
- Director of Performance, Transformation and Strategy (Deputy Chair)
- Non- Executive Member
- Nursing Director or nominated deputy
- Patient and Communities Director or nominated deputy
- NHSEI Director or nominated deputy (to discharge NHSEI's statutory responsibilities in relation to provider undertakings or other SOF requirements, from time to time the NHSEI Director may need to chair an extraordinary part 2 of the committee)

Other attendees will vary from time to time and may include:

- Director of Population Health Management (ICB)
- Head of System Transformation (ICB)
- Chief Executive Officer (JPUH) or nominated deputy
- Chief Executive Officer (NNUH) or nominated deputy
- Chief Executive Officer (QEH) or nominated deputy
- Chief Executive Officer (NCHC) or nominated deputy
- Chief Executive Officer (ECCH) or nominated deputy
- Chief Executive Officer (NSFT) or nominated deputy
- Public Health representative or nominated deputy
- Primary Care representative (PCN CD) or nominated deputy
- County Council representative(s)

- Representative of the ICB performance team
- Representative of the ICB business intelligence team
- ICB Non Executive Member

5. MEETING QUORACY AND DECISIONS

The Committee shall meet at least six times a year (to be determined by the ICB). Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

The quorum for the meeting will be three members, one of which must be the Chair or Deputy Chair.

Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf. For the avoidance of doubt the deputy will be counted as part of the quorum.
If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out at 5.10 and 5.11 may be followed.

Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee or their nominated deputy may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent decisions

In the event that an urgent decision is required, if it is not possible for the Committee to meet virtually an urgent decision may be exercised by the Committee Chair and

relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum one other member).

The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification and noted in the minutes.

6. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

a) Conduct and lead oversight of both system and commissioned provider performance, including evaluation of health services, provider resilience and failure and performance review and management.

b) Hold the system's Groups, Place(s) and Providers to account and provide challenge to the system where this is required to address opportunities to improve performance and outcomes.

c) Determine where a Peer Review approach is required to support improvement in the system; overseeing the subsequent review and ensuring the learning is implemented.

d) Determine where a 'deep dive' is required on a particular measure and relevant to one or more providers.

e) Facilitate targeted national support through the System Improvement Director (SID).

f) In line with the System Oversight Framework (SOF) and the system's associated SOF segmentation, where relevant, agree with the SID a Service Improvement Plan (SIP).

g) Direct improvement resources when required in the system, including defining the parameters of any new improvement plans, peer review of existing plans where expected outcomes are not delivered and coordinating with regulators where formal improvement or intervention support is required.

h) Approve the KPIs and outcome metrics for use across the system.

i) Agree the scope and approve the development plan for the system's Integrated Performance Report (IPR) for use at System, Place and Provider level.

j) Negotiate any metrics or improvement trajectories with NHSE/I, relevant to SOF segmentation as may be required from time to time.

k) Support innovation and best practice to be consistently adopted across the system.

l) Ensure the system is optimally using benchmarking data for performance improvement.

m) Work jointly with NHSE/I to lead the oversight of place-based arrangements and individual organisations in line with SOF principles.

n) Agree and coordinate any support and intervention carried out by NHSE/I, other than in exceptional circumstances.

o) Participate in any place-based system, functional or organisational support and intervention carried out by NHSE/I.

p) Create robust cross-organisational arrangements to tackle the systemic challenges that the health and care system is facing.

q) Act as a leadership cohort, demonstrating what can be achieved with strong local leadership, operating with increased freedoms and flexibilities

7. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a written report on assurances received, escalating any concerns where necessary.

The Committee will receive scheduled assurance reports from any delegated groups. Any delegated groups would need to be agreed by the ICB Board.

8. BEHAVIOURS AND CONDUCT

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. DECLARATIONS OF INTEREST

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

10. SECRETARIAT AND ADMINISTRATION

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

- The agenda and papers are prepared and distributed in in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and 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;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

11. REVIEW

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

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 Board for approval.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval:

Date of review:

APPENDIX I

Norfolk and Waveney Integrated Care Board

Conflict of Interest Sub Committee

Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
27 January 2023	Amendments to references and roles and responsibilities of the Committee	Corporate Affairs	2

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1

Conflict of Interest Sub Committee - Terms of Reference

Introduction

1.1 The Conflicts of Interest Sub Committee (the 'Sub Committee') is a Sub Committee of the Board of the NHS Norfolk and Waveney Integrated Care Board ("the ICB").

1.2 The Sub Committee is established in accordance with the NHS Norfolk and Waveney ICB Constitution. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Sub Committee.

1.3 The committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Audit and Risk Committee on the adequacy and effectiveness of conflict of interest processes within the ICB.

2 Membership

The Committee members shall be appointed by the board in accordance with the ICB's Constitution. Members of the Sub Committee are:

2.1.1 Non-Executive Member (Chair)

2.1.2 At least one further Non Executive Member from the Board

2.1.3 Executive Director of Finance (Deputy Chair)

2.1.4 Executive Medical Director

2.2 The Chair of the Sub Committee shall be the Non-Executive Member who Chairs the Audit and Risk Committee.

2.3 In the absence of the Chair the Director of Finance will preside.

2.4 A Sub Committee member shall cease to hold office if:

2.4.1 He/she ceases to meet the eligibility criteria for their role as set out in the Constitution;

2.5.1 Only members of the Committee have the right to attend meetings. However, meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

- Head of Governance
- Corporate Affairs Manager
- Any individual required to present matters to the Committee for consideration if called upon by the Committee Chair

2.5.2 The Chair may ask any or all of those who normally attend, but are not members, to withdraw to facilitate open and frank discussion on particular matters.

2.5.3 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from Health and Wellbeing Board(s), secondary care and community providers.

3 Secretary

3.1 The Director of Corporate Affairs and ICS Development shall be secretary to the Sub Committee and will provide administrative support and advice. The duties of the secretary in this regard shall include but are not limited to:

3.1.1 Supporting the Chair in management of the Sub Committee's business;

3.1.2 Agreement of the agenda with the chair of the Sub Committee together with the collation of connected papers;

3.1.3 Taking of the minutes and keeping a record of matters arising and issues to be carried forward;

3.1.4 Advising the Sub Committee as appropriate on best practice, national guidance and other relevant documents.

4 Quorum

4.1 A quorum shall be one Non-Executive Members and one of the Executive Directors (Director of Finance or Medical Director).

5 Decision Making

5.1 Sub Committee members may participate in meetings by the use of telephone, video conferencing facilities and/or webcam where such facilitates are available (subject to the approval of the Chair). Participation via remote technology as described above shall be deemed as presence in person at the meeting.

5.2 Generally it is expected that the Sub Committee's decisions will be reached by consensus. Should this not be possible then a vote of members will be required, the process for which is set out below:

5.2.1 **Eligibility** – Each member as provided in section 2 who is physically present at the meeting or present in accordance with section 5.2 above is entitled to one vote;

5.2.2 **Majority necessary to confirm a decision** – Each question put to the vote at a meeting shall be determined by a majority of votes of those members voting on the question;

5.2.3 **Casting vote** - In the case of an equal vote, the Chair of the meeting shall have an additional and casting vote;

5.2.4 **Dissenting views** – Should a vote be taken, the outcome of the vote, along with any dissenting views, must be recorded in the minutes of the meeting.

6 Frequency and notice of meetings

6.1 Meetings will be held as and when required.

6.2 Items of business to be transacted and all supporting papers for such items for inclusion on the agenda need to be notified to the Chair of the meeting wherever possible at least one week before the meeting takes place.

6.3 The agenda and supporting papers will be circulated wherever possible at least one week before the date the meeting will take place.

6.4 With the agreement of the Chair, items of urgent business may be added to the agenda after circulation of papers to members.

6.5 Members may participate in meetings by the use of telephone, video conferencing facilities and/or webcam where such facilities are available (subject to the approval of the Chair). Participation in a meeting in any of these ways will count towards the quoracy of the meeting subject to the approval of the Chair.

7 Remit and responsibilities of the Sub Committee

7.1 The Sub Committee is authorised to make decisions on behalf of the ICB with regard to issues which cannot be decided by the Board due to the Board not being quorate as a result of conflicts of interest.

7.2 The Committee has the responsibility for overseeing the ICB's policies and procedures with regard to conflicts of interest. This includes, but is not limited to, receiving reports and making decisions on potential breaches of policy.

7.3 The Sub Committee has authority to act in accordance with the ICB's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.

7.4 The Sub Committee is authorised by the Board to commission any reports or surveys it deems necessary to help it fulfil its obligations.

7.5 The Sub Committee shall seek assurance on the ICB's delivery of conflicts of interest in accordance with corporate objectives and actions plans. This will involve receiving reports and carrying out tests of the ICB's resilience to effectively manage conflicts of interest management plans.

8 Relationship with the Board

8.1 The minutes of Sub Committee meetings shall be formally recorded by the Secretary of the Sub Committee. A report of the Sub Committee's work will be submitted to the Audit and Risk Committee following each meeting. The Sub Committee shall however act independently of the Audit and Risk Committee.

8.2 The ICB's annual report shall include a section describing the work of the Sub Committee in discharging its responsibilities.

9 Policy and best practice

The Sub Committee will apply best practice in the decision-making process for example by following Conflicts of Interest guidance published by NHS England and NHS Improvement. The Sub Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

10 Conduct of the Sub Committee

10.1 The Sub Committee will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice, including the Nolan Principles.

10.2 Declarations of interest will be a standing item on all meeting agendas.

10.3 Members who have any direct/indirect financial or personal interest in a specific agenda item will declare their interest. The Chair of the meeting will decide the course of action required, which may include exclusion from participation in the discussion and decision making.

10.4 All declarations of interest and actions taken in mitigation will be recorded in the minutes.

10.5 The Sub Committee will assess its performance, membership and terms of reference annually and draw up its own plans for improvement. The Board will approve any subsequent amendment to the terms of reference.

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 13

Subject:	**Board Assurance Framework (BAF)**
Presented by:	**Karen Barker, Executive Director of Corporate Affairs and ICS Development**
Prepared by:	**Martyn Fitt, Corporate Affairs Manager**
Submitted to:	**Board**
Date:	**28 March 2023**

Purpose of paper:

To present the Board with a copy of the ICB's Board Assurance Framework (BAF).

Executive Summary:

The Board is presented with a copy of the ICB's Board Assurance Framework and the associated risk visual.

Effective risk management is an essential part of the ICB's system of internal control and supports the provision of a fair and well-illustrated Annual Governance Statement.

The BAF categorises risks around its three aims:

1. To make sure that people can live as healthy a life as possible
2. To make sure that you only have to tell your story once
3. To make Norfolk and Waveney the best place to work in health and care

The BAF is reviewed monthly by the ICB's Executive Management Team. Accordingly, the Board is asked to note the following updates that have been made since the BAF was last presented to Board in January 2023:

- **BAF03 – Provider is in CQC '*Inadequate*' Special Measures (NSFT).** The risk title has been amended to reflect the change in CQC rating.

- **BAF11 - Achieve the 2022/23 Financial Plan:** This risk has decreased to a mitigated risk rating of 2x4=8.

- **BAF12 – Impact on Business Continuity in the event of a successful ransomware cyber-attack**. The risk has closed following the creation of BAF12a and BAF12b which has split the risk into two separate themes.

- **BAF18 - Transition and delegation of Primary Care Services (Dentistry, Optometry and Community Pharmacy) including complaints service and potential transition of Contact Centre for these areas.** This risk has decreased to a mitigated risk rating of 3x4=12

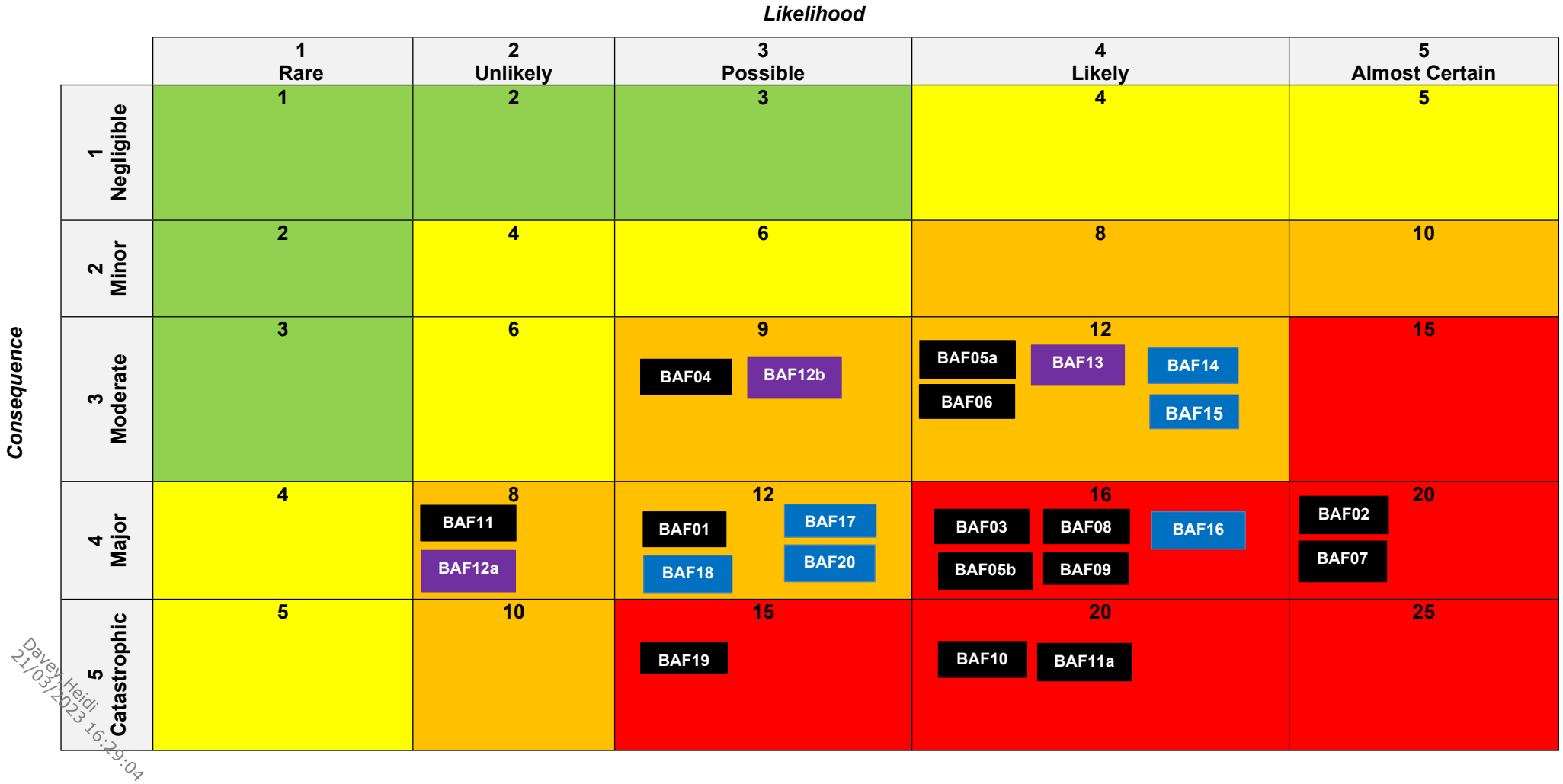
Recommendation to Board:

The Board is asked to receive and review the risks presented on the Board Assurance Framework.

Key Risks	
Clinical and Quality:	None
Finance and Performance:	None
Impact Assessment (environmental and equalities):	None
Reputation:	It is important the Board is apprised of the key risks in the organisation currently.
Legal:	N/A
Information Governance:	N/A
Resource Required:	Corporate Affairs risk management resource
Reference document(s):	None
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	See table.

APPENDIX 2: RISK VISUAL

Key	Aim
	To make sure that people can live as healthy a life as possible
	To make sure that you only have to tell your story once
	To make Norfolk and Waveney the best place to work in health and care



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Norfolk and Waveney
Integrated Care Board

NHS Norfolk and Waveney ICB – Board Assurance Framework (BAF)

Version:	4	Date:	20 March 2023

Norfolk and Waveney ICB aim: To make sure that people can live as healthy a life as possible

Principal risk: That people in Norfolk will experience poor health outcomes due to suboptimal care.

Summary of risks

Ref.	Risk Title	Risk Owner / Operational Lead	Date risk identified	Target delivery date	2022-2023 Monthly Risk Rating											
					1	2	3	4	5	6	7	8	9	10	11	12
BAF01	Living with COVID-19	Tricia D'Orsi / Karen Watts	01/07/22	31/03/23				12	12	12	12	12	12	12	12	12
BAF02	System Urgent & Emergency Care (UEC) Pressures	Mark Burgis / Ross Collett / Karen Watts	01/07/22	31/03/23				16	16	16	20	20	20	20	20	20
BAF03	Providers in CQC Special Measures (NSFT)	Tricia D'Orsi / Karen Watts	01/07/22	31/12/23				16	16	16	16	16	16	16	16	16
BAF04	Cancer Diagnosis and Treatment	Dr Frankie Swords / Mark Lim	01/07/22	31/03/23				9	9	9	9	9	9	9	9	9
BAF05a	Barriers to Full Delivery of the Mental Health Transformation Programme (Adult)	Jocelyn Pike / Mark Payne	01/07/22	31/03/23				12	12	12	12	12	12	12	12	12
BAF05b	Barriers to Full Delivery of the Mental Health Transformation Programme (CYP)	Jocelyn Pike	01/07/22	31/03/23				12	12	12	16	16	16	16	16	16
BAF06	Health Inequalities and Population Management	Dr Frankie Swords / Mark Burgis	01/07/22	31/03/23				12	12	16	16	16	12	12	12	12
BAF07	RAAC Planks	Steven Course	01/07/22	31/03/23				20	20	20	20	20	20	20	20	20

Ref.	Risk Title	Risk Owner / Operational Lead	Date risk identified	Target delivery date	2022-2023 Monthly Risk Rating											
					1	2	3	4	5	6	7	8	9	10	11	12
BAF08	Elective Recovery	Dr Frankie Swords / Janice James	01/07/22	31/03/23				20	20	20	20	20	16	16	16	16
BAF09	NHS Continuing Healthcare	Tricia D'Orsi/Paul Benton	01/07/22	31/03/23				16	16	16	16	16	16	16	16	16
BAF10	EEAST Response Time and Patient Harms	Tricia D'Orsi / Mark Burgis	01/07/22	31/03/23				16	20	20	20	20	20	20	20	20
BAF11	Achieve the 2022/23 Financial Plan	Steven Course / Emma Kriehn Morris	01/07/22	31/03/23				16	16	16	16	16	12	12	8	8
BAF11a	Underlying Deficit Position	Steven Course / Emma Kriehn Morris	01/07/22	31/03/23				20	20	20	20	20	20	20	20	20
BAF19	Discharge from inpatient settings	Tricia D'Orsi	25/10/22	31/03/23								15	15	15	15	15

BAF01

Risk Title	Living with COVID-19			
Risk Description	There is continued risk that new variants may contribute to increase in transmission and alter severity of illness. The local healthcare system is currently going through a period of high system pressure set against recovery, and compliance with robust Infection Prevention and Control Measures.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Tricia D'Orsi	Quality & Safety	Karen Watts	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	3	15	4	3	12	2	3	6

Controls

- Local testing options reflect national guidance.
- A system approach to managing positive and asymptomatic patients has been agreed reflecting national guidance with local risk assessment as required.
- The vaccination programme has been accelerated and is delivering against national plan.
- Vaccination sites are managing their capacity against need. There is a mixed model of vaccination delivery that is inclusive of harder to reach groups and wherever possible, Flu vaccinations have been co-administered.
- Protect NoW is focusing on health inequalities and outreaching to vulnerable groups.
- System has collaborated on the approach to planned visits to inpatient areas and local risk assessments regarding national guidance around testing and use of face coverings.
  1.Pension abatement 'end date' of national extension agreed until end of March 2025 to help retain experienced reservists.

Assurances on controls

Internal: Vaccination Programme Board, Daily Operational Touchpoint, Clinical Directors Meeting, ICB Executive Management Team (EMT), System EMT, Quality & Safety Committee, ICB Board.

External: Regional Vaccination Operational Cell, Regional COVID-19 and Flu Operational Group, NHSE regional and national oversight.

Gaps in controls or assurances

- Numbers of COVID-19 positive patients circulating in the community are not fully understood due to changes in testing.
- Retention of workforce continues to be the key risk to delivery. Staff wellbeing and resilience continues to be impacted.
- The system must continue to be prepared by further waves and seasonal pressures.

Updates on actions and progress

Date Opened	Action / Update	BRAG	Target Completion
17/06/22	Continue to utilise local and regional outbreak surveillance to enable risk assessment and response.		31/03/23
25/08/22	Delivery of the COVID-19 September booster programme is on target to begin, in conjunction with Flu		Complete
04/11/22	Dedicated system-wide red capacity in development by NCH&C. Action superseded by individual organisational plans.		Complete
10/01/23	Delivery of the COVID-19 Winter booster and flu vaccination programme is on target.		31/03/23

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				12	12	12	12	12	12	12	12	12
Change				New	→	→	→	→	→	→	→	→

BAF02

Risk Title	**System / Urgent & Emergency Care (UEC) Pressures**			
Risk Description	There is a risk that the Norfolk and Waveney health and social care system does not have sufficient resilience or capacity to meet the urgent and emergency care needs of the population whenever a need arises. This can result in longer than acceptable response times to receive treatment, delays in being discharged from hospital and as a result potentially poorer outcomes for our patients with associated clinical harms. The above risk manifests itself as worsening ambulance response times for patients with a life threatening and / or life changing condition and an increasing number of patients remaining in hospital when they no longer meet the nationally prescribed 'criteria to reside', The associated increase in longer lengths of stay and higher occupancy levels in all acute and community hospitals results in delays in admitting patients from our emergency departments (EDs) into a bed, this in turn congests the EDs slowing down ambulance handover leading to more crews outside hospital who are unable to be released to respond to 999 calls.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Mark Burgis	Patients and Communities Quality and Safety	Ross Collett & Karen Watts	01/07/2022	31/03/2023

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**5**	**20**	**4**	**5**	**20**	**3**	**4**	**12**

Controls	**Assurances on controls**

• **Strategic Oversight:** UEC Programme Board oversees non-elective flow and monitors a system wide transformation programme to improve the responsiveness of our Urgent and Emergency Care pathways to ensure patients receive the right treatment in the right place at the right time; that timely discharge for non-elective patients from inpatient hospital and community beds takes place and that appropriate discharge capacity is available to meet the discharge demand from health settings.
• **Business Continuity:**
  ○ All Trusts, including community, 111 and primary care have business continuity plans in place to manage the operational response to in-year peaks in demand and periods where demand exceeds 'business as usual' levels.
  ○ A seven-day System Control Centre (SCC) and East of England Ambulance Service (EEAST) System Oversight Cell (SOC) are in place. The SCC and SOC work alongside Providers to coordinate operational responsiveness when individual or multiple providers are unable to meet patient demand in a timely and safe way and to escalate to appropriate levels of management when decisions to mobilise additional resources are needed.
  ○ Interim Winter Director in post until end of May to manage the SCC; act as a point of system escalation for operational pressures including management of any critical or major incidents for the ICS and the associated reporting to NHSE; coordinate mutual aid and support between providers at Exec level, and to lead the planning and implementation of non-recurrent "winter funding".
Specific controls to appropriately manage urgent and emergency care demand ensuring patient's needs are met:
	Internal: ICB Executive Management Team; Norfolk and Waveney UEC Steering Group; Emerging 'Place' UEC Steering Groups; System Control Centre (SCC)
	
	External: ICS Executive Management Team (CEOs Group); Trust Boards; NHSE Regional Strategic Oversight

• **Hospital 'Admissions Avoidance':** A range of 'Admissions Avoidance' schemes are in place across N&W to ensure that those patients who have an 'urgent' need but do not need the full range of services of an acute hospital but may be at risk of an inappropriate admission are managed safely in a community setting, the core services are: o **111 / GP led Clinical Advice Service (CAS):** This service provides advice to healthcare professionals and the general public triaging and referring patients to the most appropriate service and setting that will best meet their needs. o **Urgent Community Response (UCR):** Patients that have been triaged can be referred to this service which provides a face-to-face response within 2 hours for those patients that need this 'urgent' intervention who would otherwise be at risk of admission to hospital. This community led service is underpinned by a plethora of discrete services across each 'place' that the UCR team can access to ensure the immediate need is met and that patients are referred onto appropriate health or social care services that can provide support to prevent or reduce the risk of further exacerbation. o **GP Streaming (ED Front Door):** is in place at all three acute hospitals to reduce the urgent care (minors) demand flowing through our EDs by providing a primary care led service to patients who walk-in to our EDs as well as redirecting them to other appropriate services in the community. o **Call before convey service (MDT Open Room):** Patients that have an urgent need but choose to ring 999 are held in the 999 'stack' for significant periods of time as there are insufficient resources available that can be mobilised by the ambulance service due to handover delays at hospital. The MDT Open which we are aiming to develop into a pre-hospital urgent care hub allows the transfer of these patients to appropriate community services for response both health and social care. o **Same Day Emergency Care (SDEC):** All three acute hospitals have SDECs in place. These are being further developed to include a wider range of symptom groups and referral routes to increase their effectiveness in avoiding 'avoidable' admissions to hospital o **Virtual Ward:** Virtual Ward Project established in Q3 22/23. The project intends to increase the level of acuity of patients that can safely be managed in the community by increasing community capability in a "step up" model. See "discharge" for further information on VW project and "step down". • **Creation of surge / escalation capacity:** o **Cohorting:** A range of cohorting measures are available at acutes to provide ED surge capacity and reduce waiting to handover at hospital. o **Rapid Ambulance Offload:** Arrangements in each ED enable a limited number of additional rapid ambulance handovers to release waiting ambulance crews to attend very urgent community calls where there is an extreme risk of adverse clinical outcome from delay. o Escalation / Surge Beds: Acute and community providers have created additional escalation / surge beds through	

internal operational changes and using some winter funding ○ All acute hospitals have ambulance handover plans to improve handover performance and accommodate surges in demand. • **Specific controls to improve discharge (cross-reference with BAF19):** ○ Discharge Director is supporting Trusts ti ensure best practice is in place via a 30,60,90-day plan and 100-day discharge challenge. ○ Capacity and Demand modelling work is taking place and funding made available to support an increase in capacity using non-recurrent winter funding. ○ Circa 210 beds and 190 domiciliary packages of care equivalent to an acute bed have been mobilised across N&W until 31st March 2023.	

Gaps in controls or assurances

- Clearly defined cross-reference to PHM Strategy that will reduce latent demand for urgent and emergency care through better long-term conditions management reducing condition exacerbation
- Limited alignment with Mental Health non-elective strategy and plans including the mitigation of the impact of Covid 19 which in turn will reduce latent demand on acute hospital EDs
- Central 'Winter Funding' ends on 31st March 2023 and mobilised bed stock and domiciliary care provision will reduce leading to delayed discharges from in-patient hospital and community beds, resulting in an adverse impact on flow and reduction in responsiveness of the community to meet urgent and emergency care needs.
- Winter Director and Discharge Director secondments will end on 31st May and 31st March respectively leaving a gap in system level capacity whilst UEC structure is reviewed.
- Assumptions made by our acute hospitals in the current round of operational planning highlights capacity in wider community (primary care, community, 111/CAS, 999) will be unable to meet the pre-hospital and discharge needs of our population accessing the non-elective pathways
- Insufficient capacity in social care to meet the needs of our population who require timely discharge to complete their onward care journey

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
03/10/22	Management of Operational Pressures (Critical Incident) Critical incident stood down on 26th January 2023.	G	31/03/23
10/01/23	Pre-Hospital Winter Initiatives Most planned schemes implemented and monitored through SCC in terms of impact, some only partially implemented due to operational capacity	A	31/03/23
16/03/23	National UEC Recovery Strategy - Reduce LoS in inpatient settings. This is a core action in the Joint Forward Plan (JFP) to rebalance system flow and meet operational planning target of 76% A&E 4 hour performance. Baseline avge LoS is currently 8.1days for non-elective pathway	A	31/03/24
16/03/23	National UEC Recovery Strategy – Recover Ambulance category 2 response time to minimum 30mins. This is a core action in the Joint Forward Plan (JFP). Recovering to this performance will be underpinned by a range of Admissions Avoidance and Discharge initiatives to ensure we have the capacity to release ambulances to respond to category 2 calls	A	31/03/24
16/03/23	National UEC Recovery Strategy – This is a core action in the Joint Forward Plan (JFP) Meet our Virtual ambition to achieve 40 beds per 100,000 population (368 beds). This initiative will support Admissions Avoidance and Early Supported Discharge to meet the 76% A&E 4 hour target	A	31/03/23

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				16	16	16	20	20	20			
Change				New	→	→	↑	→	→			

BAF03

Risk Title	**Providers in CQC Special Measures (NSFT)**
Risk Description	There is a risk that services provided by Norfolk & Suffolk Foundation Trust (NSFT) do not meet the required standards in a timely and responsive way. If this happens, people who use our services will not receive access to services and care that meets the required quality standard. This may lead to clinical harm, poor patient experience and delays in treatment or services.

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Tricia D'Orsi	Quality & Safety	Karen Watts	01/07/2022	31/12/2023

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**4**	**4**	**16**	**2**	**4**	**8**

Controls	**Assurances on controls**
• The report published on 28/04/22 gave an overall reduced rating of inadequate. The Trust was able to provide adequate assurance to mitigate the need for a Section 31 enforcement notice during the inspection. • The Trust's Improvement Plan is over seen by an Improvement Board with a focus on the areas set out in the section 29a letter and Must Do's issued in April 2022. Stakeholder engagement has been strengthened. Evidence Assurance Panel established with attendance by ICB MD and DoN. • Regular NHSE/I Oversight, and Assurance Group in place. Dedicated senior NHSE/I and ICB support has been taken up. • Staff engagement events have taken place across Trust sites and staff groups, with support from the Norfolk & Waveney and Suffolk ICBs. • Weekly internal Performance Board is driving progress. NHSE and ICB are working collaboratively to support the Trust. • Transformation plans continue to progress alongside Quality Improvement. • Strengthened leadership to support key clinical areas. • The ICB MH Strategic Commissioning Team are attending 'pillar' meetings around Culture, Leadership & Governance, Safety, Demand & Capacity and Service Offer. Each pillar is led by an NSFT Executive SRO, supported by an external consultant supporting delivery of the overarching improvement plan. ICB staff are participating in working groups. • ICB supporting Trust with data validation, completion of dashboard and South Norfolk community capacity pilot. • ICB attending Trust Quality and Safety Reviews (QSR) with frontline teams and working closely with NHSE on a governance review.	**Internal:** Clinical Governance Meetings, Quality and Safety Committee, ICB Executive Management Team (EMT), System EMT, and ICB Board. Trust CQC Evidence Panel chaired by ICB. **External**: ICB attendance at Key Trust Meetings, Care Quality Commission, System Quality Group, Norfolk and Suffolk Healthwatch organisations, NHSE/I Oversight and Assurance Group, NSFT Quality Improvement Board, NSFT Quality Pillars and NSFT Quality Committee.

• Evidence Assurance Panel is in place, chaired and supported by ICB Medical Director.	

Gaps in controls or assurances

- There is an increase in people presenting with Mental Health problems without previous history, as well as those already engaged with services, as a result of the pandemic. High levels of patient acuity are being reported. Capacity is not currently able to meet demand.
- There is variation in clinical governance processes across the Trust, which means that some service areas are less sighted on their levels of risk to care quality than others.
- Workforce pressures. Staff sickness and absence combined with unfilled vacancies and difficulties recruiting to key posts. Impact of 'inadequate' rating on staff wellbeing and morale.
- 12hr 'decision to admit' breaches reported for patients presenting to hospital Emergency Departments, who require a Mental Health bed, which requires a systemwide health and social care solution.
- There is a risk that progress may be delayed or diluted if Norfolk and Suffolk commissioners are not aligned in their transformation programme, where relevant.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
03/11/21	Progress on the Trust's Integrated Quality Improvement Plan is reported into the weekly internal Improvement Board and to the external Overview and Assurance Group. Ongoing transformation of current pathways for both adults and children to improve access to services.	G	31/03/23
17/12/21	Additional programme governance has been put in place around 12Hr ED breaches in order to meet the requirement for SOF 4 recovery. This brings together commissioners, service providers and other key stakeholders to implement a system recovery plan looking at early intervention and crisis support, front and back door hospital processes and the 'flow' between these areas.	G	31/03/23
03/11/22	The ICB supports multidisciplinary meetings for complex patients, where there are difficulties accessing ongoing care for example patients with eating or disorder eating	G	31/03/23
13/05/22	Quality Service Improvement Review visits supported by ICB continue to all inpatient areas, revisiting where required. Reviews extended to include community teams.	G	31/03/23
13/05/22	Staff engagement visits have been undertaken across sites, supported by the Norfolk and Waveney and Suffolk ICBs.	G	31/03/23
13/05/22	Large scale recruitment events have continued with successful recruitment of support workers.	G	31/03/23
17/06/22	Trust in dialogue with NHSE regarding SOF 4 exit criteria, agreed.	G	31/03/23
17/06/22	Staff engagement with CYPM Team to support quality initiatives.	G	31/03/23
25/08/22	Trust reported 80% completion of Must Do's as of end of July 2022. Evidence Panel has been set up to review compliance with Section 29a.	A	31/03/23
25/08/22	CQC re-inspection of Section 29a completed, Well-led took place in November 2022; publication due in January-February 2023.	A	31/03/23

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				16	16	16	16	16	16	16	16	16
Change				New	→	→	→	→	→	→	→	→

BAF04

Risk Title	Cancer diagnosis and treatment			
Risk Description	Sustained increase in demand on urgent suspected cancer pathways post Covid pandemic is creating capacity and demand pressure on the diagnostic and treatment capacity. This puts patients at risk of delayed diagnosis and treatment potentially leading to worse long term clinical outcomes.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Dr Frankie Swords	Quality & Safety	Maggie Tween	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	3	9	2	3	6

Controls

- Cancer transformation resources supporting diagnostic and treatment capacity to address the backlogs to support recovery and streamlining 2ww pathways and processes to meet the nationally defined optimal pathways.
- GP webinar programme.
- Cancer rapid diagnostic service in place for patients with non specific symptoms.
- Targeted lung health checks in GYW, accelerated roll out for 23/24 focused on deprived communities.
- National Grail trial
- Transformation projects to increase capacity (cytosponge and colon capsule).
- Mutual aid process and clinical prioritisation via Elective Recovery Board.
- SRO has requested monthly update from each trust between Dec 22 and Mar 23 regarding Secretary of State letter priorities.
  PHM techniques used to target groups at highest risk

Assurances on controls

Internal:

- Uncommitted transformation funds re-purposed to support recovery.
- System Mutual Aid policy in place now via ERB. Single PTL for cancer still in progress.
- Screening, diagnostic and treatment backlogs continue to be monitored via the system Cancer Programme Board
- Referral pathways continue to experience high demand impacting on diagnostic and treatment capacity.
- WLI in progress, though with workforce challenges.
- National Tiering Approach for NNUH and QEH, linking to Elective Recovery Board and System Performance Committee continues. QEH tiering now reduced Feb 23
- Support/system oversight/assurance for National Tiering Process for NNUH, continued supportive approach for all three trusts due to high operational pressures.
- Single harm review policy across all providers to assess all patients for physical or psychological harms and to reprioritise if risk of harm identified

External: PHE, NHSE/I, Regional Cancer Network

Gaps in controls or assurances

- There may be additional harm from undiagnosed patients including excess mortality. This will have been exacerbated by pandemic related changes in health behaviours. EOE Cancer Alliances have quantified this risk, with approximately 600 fewer cancer diagnoses made in N&W than expected during the pandemic.
- Environmental and staffing challenge of providing cancer services during continued COVID and UEC pressures compounded by industrial action and BMA rate card related impact on additional activity.
- Significant pressure on breast, colorectal and prostate cancer diagnostic pathways and treatment capacity at the local cancer centre.
- Additional requirement to safely manage backlog and waiting lists across cancer, elective care and diagnostics is leading to increased pressure on administrative processes impacting on transformative list management Surges and variability in two-week wait (2ww) demand further affecting performance, notably: Breast, Colorectal and prostate diagnostic pathways.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
03.2023	**QEH removed from national tiering**	G	31.03.2023

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				9	9	9	9	9	9	9	9	9
Change				New	→	→	→	→	→	→	→	→

[BAF05A](#)

Risk Title	**Barriers to full delivery of the Mental health transformation programme (Adults)**
Risk Description	There is a risk that during a period of unprecedented mental health demand and acuity of need current system capacity and models of care are not sufficient to meet the need If this happens individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Jocelyn Pike	Quality & Safety	Mark Payne	01/07/2022	31/03/2023

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**3**	**4**	**12**	**2**	**4**	**8**

Controls	**Assurances on controls**
• System wide governance framework (currently under review by N&W ICB MH Partnership Board aiming to develop System Collaborative) • Acting Director of Mental Health Transformation appointed to lead development of system collaborative, working closely with stakeholders and MH SRO • 22/23 N&W Planning submission agreed by NHS England & Improvement • Finance working group meets monthly to drive robust financial arrangements Working group and process in place to manage financial slippage and deliver planned MHIS investment • System commitment to increase knowledge skills and expertise and develop additional capacity through use of digital • MH Workforce Lead and Programme Manager working with system partners to implement the N&W MH workforce strategy/ transformation • Ongoing work with Population health management team to proactively contact and offer support/ physical health assessment and vaccination • Co-developed eating disorder strategy to direct implementation of national ambitions	**Internal:** SMT, EMT, Board **External**: N&W ICB MH Partnership Board, HWBs Norfolk and Suffolk, NW Health and Care partnership MH Forum, HOSC, Norfolk and Suffolk NHSE/I Regional MH Board and subgroups, NHSEI System Improvement and Assurance Group

Gaps in controls or assurances

- Impact of pandemic and cost of living crisis on mental health and well-being of population leading to increased need for support and adding to capacity pressures and resilience of providers
- Impact of continued CQC rating of inadequate for NSFT following CQC visit in November 21, and revisit September 22. Currently awaiting publication of report. NB Associated negative MH publicity
- Impact of continued CQC rating of the well-led domain. Publication of the recent reinspection awaited.
- Organisational development required to drive forward internal cultural change. Cultural shift required as a system to enable successful transformation and ensure mental health is better understood and regarded as 'everyone's business'.
- Cultural, digital and operational collaboration to enable access and easily navigable mental health services, is at an early stage of development
- Conflicting priorities across complex system transformation agenda
- Intra-system Electronic Patient Record connectivity, especially at the interface of primary/secondary/social care and third sector provision, remains a challenge and priority to address
- Ability to recruit, retain and train a viable number of staff to enable service expansion and meet the MH and well-being needs of the N&W population

- Limited influence on alternative provision within a tightly prescribed IAPT model – National NHSEI and HEE guidance is restrictive and does not allow local flexibility
- The ICB Mental Health Strategic Commissioning Team is predominantly staffed with fixed term posts ending in 2023-24.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
29/04/22	Increased programme management support (ICB and NSFT), to support operational and clinical leads to plan and deliver transformation. Near to full recruitment in current structure.	G	31/03/23
29/04/22	Joint approach between ICB and NSFT needs to be established and embedded to support response to CQC concerns and joining up the transformation programme plan to deliver sustainable change. Awaiting CQC response following September 22 visit and planned Well-led visit in November to determine next steps.	R	31/03/23
21/10/22	Proposed governance framework to oversee work on collaboration in progress. Agreement with the MH Partnership Board to amend the terms of reference to include oversight and support to/of the collaborative discussion. A task and finish group to design and implement an engagement strategy met 20/10/22. The engagement will initially focus on revisiting the themes of 2019 mental health strategies for continued relevance (delivery due date April 23). A further task and finish group looking at legislative arrangements and models of collaboration will be set up in due course (delivery due date October 23).	G	31/03/23
29/04/22	Continuing work to develop effective partnerships and system ownership of the N&W MH Transformation Programme Plan. Co-production with Experts by Experience and Reference Group is central to initiating and sustaining positive change. Programme Assurance Group purpose and structure under review as part of current governance review and transition to System Collaborative by October 2023. Proposing an overarching Transformation Delivery group instead to report into MH Partnership Board.	G	31/03/23
29/04/22	Collaborative annual planning process supported by regular (i.e., monthly) review of priority areas, ensuring governance structure and oversight are effectively managing inter-dependencies and risk. Rated amber as NHSE 23/24 planning guidance is delayed following national period of mourning and political upheaval. Planning guidance received; draft local plan is being socialised.	G	31/03/23
24/08/21	MH Digital Working Group established, co-led by ICB and Provider Leads, involving partners to scope and identify solutions which align to MH Digital priorities. Rated amber as some work has stalled, currently reviewing priorities in context of operational demands.	A	31/03/23
29/04/22	MH Workforce lead driving development of workforce dashboard, and transformation programme. Working with system partners, to set up 4 focused work groups that will implement the N&W MH workforce strategy.	G	31/03/24
29/04/22	IAPT N&W System leads working with Regional NHSEI and HEE leads, in conjunction with EofE system leads to work up a proposal to influence a revised approach to IAPT training provision at national level. IAPT currently operating within a 24-month tender waiver which expires on 31st August 2024. EMT paper in development to decide next steps to secure future service.	G	31/03/23
29/04/22	Developed Recovery Improvement Plans with support from NHSEI to work towards recovery of trajectories for the following: increasing Physical Health Checks for people with Severe Mental Illness, improving Dementia Diagnosis and reducing Out of Area Placement OAP). All negatively impacted by the pandemic which has increased demand and limited opportunity for early intervention. This will enhance support for areas of activity where N&W do not yet meet the national standard. Rated amber	A	31/03/23

	to reflect difficulties reducing use of OAP beds and eradicating 12-hour breaches during a time of extraordinary demand and pathway pressures. Joint planning of the Pre-assessment Unit is progressing within the 12-hour DTA working group with the MH SRO supporting partnership discussion. Work is continuing across all areas.		
20/10/22	Community Transformation: Working with North Norfolk and Norwich locality leads and practices who are keen to act as pilot sites for the 'MH Integrated Care Interface'. This is a working title for the newly forming primary care-based MH Multi-disciplinary team, a group of professionals from different organisations (NSFT, NCC, VCSE and primary care) that will work together to assess and direct people to the most beneficial service according to their need.	**G**	31/03/23

Visual Risk Score Tracker												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score				**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**
Change				**New**	→	→	→	→	→	→	→	→

BAF05B

Risk Title	**Barriers to full delivery of the Mental health transformation programme (CYP)**
Risk Description	There is a risk that during a period of unprecedented mental health demand and acuity of need current system capacity and models of care are not sufficient to meet demand. If this happens individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Jocelyn Pike	Quality & Safety	Rebecca Hulme	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	4	16	2	4	8

Controls	Assurances on controls
• Dedicated CYP strategic commissioning team now in place • Effective System wide governance framework • Collaboration with system partners to understand demand and capacity has begun and the shared resource is better understood. • Development of robust understanding of the financial envelope available to drive the transformation, and investment necessary, including appropriate measures to reconcile these is still in process. • System approach to increasing knowledge skills and expertise across agencies and developing additional capacity through use of digital. Greatly assisted by digital appointing a digital lead. Digital workstream initiated • Financial slippage is being mitigated against protecting our ability to maintain MHIS investment • Implementation of system wide transformation programme • Commitment from system partners to adopting Thrive approach – mental health needs being considered and addressed in wider health and social care settings • Additional partnership working with VCSE	**Internal:** SMT, EMT, Integrated Care Board, Finance Committee, Quality Committee, **External**: CYPMH Executive Management Group, CYP Strategic Alliance Board, HWBs Norfolk and Suffolk, NW Health and Care partnership MH Board, NHSE/I Regional MH Board and subgroups, HOSC Norfolk and Suffolk, System Improvement and Assurance Group

Gaps in controls or assurances

- Capacity and commitment within providers to support transformation and collaboration impacted by increased demand and historical backlog
- Capacity within the substantive CYP integrated commissioning team to deliver on the scale of transformation required.
- Conflicting priorities across complex system transformation agenda
  Intra-system Electronic Patient Record connectivity, especially at the interface of primary/secondary/social care and third sector provision, remains a challenge and priority to address.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
23/12/21	Schemes for £800K Winter funding to support Urgent and Emergency Care and discharge put forward. Region keen for schemes to continue next year if successful using SDF and MHIS	G	31/12/22
23/12/21	CYP Senior Programme Manager now in post to lead on the development and mobilisation of the CYP Integrated Front Door which will improve efficiencies and flow through the system	G	30/06/22

23/12/21	Continued work to address significant historical CYP waits across providers. Current system waits for treatment circa 2500 reduced from 3500 March 2021	G	31/03/22
02/05/22	Six out of ten CYP Integrated Commissioning Team posts are now substantive. Remaining four are fixed term and will be reviewed once Community transformation work is completed	G	31/03/23
02/05/22	Intensive Day Support for CYP with eating disorders is due to open this month for 5 CYP and their families on a six month test & learn basis before expanding support offer to 12 CYP.	G	30/11/23
02/05/22	CYP team secured £800K in slippage to support system wide waiting list initiatives, enhanced support for 18-25 and trauma informed training	G	31/03/22
02/05/22	£180K of winter funding secured to support CYP on acute paediatric wards, development of an integrated practice model and respite for CYP with NDD and their families	G	31/06/22
02/05/22	Development of Integrated Front Door progressing well, dedicated team in place to develop model, ensure pathways and capacity sitting behind front door will meet the need, procurement process has begun with an expected go live date early 2023. Talking Therapies collaborative being developed as part of model to increase capacity	G	31/03/23
02/05/22	Mobilisation of three focussed waiting list initiatives to support circa 1000 CYP on waiting lists.	A	31/12/22
02/05/22	Working alongside adult commissioning team to enhance support offer for 18-25 year olds in wellbeing hubs. Task and finish group set up to improve IAPT offer for 16-25 to improve access, engagement and outcomes.	A	31/03/23
02/05/22	Increased funding to CYP Crisis team to increase capacity, expand skill mix and increase level of seniority. Scoping out options to meet 24/7 crisis assessment and support offer, in line with NHS Long Term Plan ambition. Update 10/01/23 – some successful recruitment to crisis team. Anticipated that capacity will be begin to improve in Q4 22/23 as staff complete induction.	A	31/03/23
06/11/22	Recruitment remains challenging in core secondary care services. New staff in post but staff leavers nullifying effect. Requirement to address urgent presentations and increased community acuity reducing routine capacity to reduce waiting times.	R	31/03/23
06/11/22	Some mitigations through expansion of VCSE provision, successful procurement of Integrated Front Door Provider, new provider for Mental Health Support Teams and talking Therapies Collaborative – now mobilising in advance of 2023 planned start	A	31/03/23
06/11/22	Current uncertainty following CQC visit, and imminent Well Lead review impacting on capacity and focus to deliver transformation	R	31/03.23
10/01/23	Collaborative working with Suffolk and Norfolk systems to introduce short breaks provision. Capital funding in use to develop estates	G	31/03/23
10/01/23	System planning to ensure alignment of provision in Waveney with Suffolk system colleagues. Task and finish group established	G	31/03/23
10/01/23	Engagement exercise commenced to revisit ambitions and transformation plan with Norfolk and Waveney stakeholders	G	31/03/23
10/01/23	System review of provision commenced across Norfolk and Suffolk – further development of Alliance approach to ensure support accessible in most appropriate part of the system	G	31/03/23

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				12	12	12	16	16	16	16	16	16
Change				New	→	→	↑	→	→	→	→	→

BAF06

Risk Title	**Health inequalities and Population Health Management**
Risk Description	Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. Some groups of our population are at risk of poorer health outcomes due to these structural inequalities in how health and care is provided as well as the wider determinants of health. This has been exacerbated due to the long-term impact of the COVID pandemic and cost of living pressures putting more people at risk of poor outcomes.

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Dr Frankie Swords	Quality and Safety	Dr Frankie Swords	01/07/2022	31/03/2023

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**3**	**4**	**12**	**1**	**4**	**4**

Controls

- NHSE/I 5 Action areas to address inequalities, embedded into recovery plans, and JFP.
- ICS Health Inequalities Oversight Group (HIOG) established with key workstreams identified:
  - Data and insight
  - Vaccine
  - Core20+5
  - Community engagement
  - Inclusion health
  - NHS Anchors
  - Population health management
  - Mental health inequalities
- Health Improvement Transformation Group (HITG) established with key priorities:
  - Development of system strategy for health improvement & prevention
  - Reduction in smoking
  - Reduction in physical inactivity rates

Protect NoW successfully used to target multiple groups to address inequalities et to improve uptake of diabetes prevention, weight management, cancer screening, vaccination,

Assurances on controls

Internal:
Progress against key national delivery timelines reported and led by appropriate governance structures: Health Inequalities Oversight Group (HIOG), PHM oversight group and PH and Inequalities board.
Health Improvement Transformation Group (HITG), Inclusion Health Group, Integration & Partnership team,
Protect NoW/PHM team
Elective Recovery board monthly report on waiting lists per decile of deprivation index
NCC PH team analysis of patients on admitted elective waiting lists has not detected any systemic health inequalities
External: Health & Wellbeing Partnerships, Place Boards, Clinical and Operational steering groups
Protect NoW used as exemplar at NHSE national prevention round table

Gaps in controls or assurances

- Population Health Management oversight group and PH and HI board not met yet to set and steer strategy
- PHM roadmap agreed but PHM and HI strategies not yet completed
- N&W Inclusion groups not yet defined to be developed by HIOG and then agreed through PHI board.
- Duplication of effort, energy and resources at Place and system level – lack of coordination of all mechanisms to address inequalities, further alignment required for ICS governance structures such as HITG/HIOG/ECRB
- Capacity – lack of programme oversight of health inequalities across the system, particularly with reference to Core20+5 & VCSE integration agenda, resources in wider system (i.e. local government) to support agenda, and lack of integration with Public Health
- Resources – Health Inequalities NHSE funding allocations not ring-fenced resources to support emerging work programmes and respond to system priorities, non-recurrent funding arrangements for existing workstreams, prioritisation of prevention in resourcing strategies.

Evaluation methodology for key work programmes – support required to ensure impact measurement

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
03/03/23	Deputy Director of public health and PH medicine consultants have joined team on secondment from NCC to provide strategic leadership	B	Complete
03/03/23	Population Health and Inequalities Board and oversight groups to start April 23	G	04.23

Visual Risk Score Tracker – 2022/23												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				12	12	16	16	16	12	12	12	12
Change				New	→	↑	→	→	↓	→	→	→

BAF07

Risk Title	**RAAC Planks**
Risk Description	There is a risk of failure of the current roofing structures at two Norfolk and Waveney Acute Trusts due to their composition with RAAC Planks which are now significantly beyond their initial intended lifespan. This could affect the safety of patients, visitors and staff. The rolling programme of inspections and remedial work to detect and mitigate this also presents a risk to the system through the requirement to close areas for remedial work, further impacting patient and staff experience as well as the ability to deliver timely urgent, emergency and elective care to our patients.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Steven Course	Board/Finance Committee	Steven Course	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	5	25	4	5	20	3	5	15

Controls	Assurances on controls
• Trusts have robust plans in place to manage a possible incident; however these only cover immediate evacuation and not reprovision • Regional RAAC response plan is established • Regular surveys and assessments are being carried out to determine the severity of the issue and to identify and address signs of deterioration. • Region-wide scoping piece commissioned to look at ongoing service transition and recovery. • Current work ongoing to address issues found on inspection as issues identified. Each issue is separately risk assessed using NHSE led guidelines for 'Best Buy' hospitals and a RAACter Scale used to assess level of issue. • Legal position and recommendations provided by Browne Jacobson on ICB responsibilities should there be a catastrophic failure at either acute.	**Internal:** SMT, EMT, ICB Board **External**: ICS Boards, Estates, NHSE/I, Individual trust boards RAAC related exercises have been undertaken to provide assurance of plans and procedures in responding to an evacuation of a RAAC impacted trust. • Feb 22 - Exercise Farthing • Jun 22 – Exercise Walker • Nov 22 – Exercise Fox EPRR Core Standards incorporated a Deep Dive on health providers Evacuation and Shelter arrangements specifically due to the RAAC risk

Gaps in controls or assurances

- QEH not currently in line for HIP2 support

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
16/02/22	Scoping piece to assess service transition and recovery post RAAC failure to concluded	G	ongoing

Visual Risk Score Tracker

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				20	20	20	20	20	20	20	20	20
Change				New	→	→	→	→	→	→	→	→

BAF08				
Risk Title	**Elective recovery**			
Risk Description	The number of patients waiting for elective treatment in Norfolk and Waveney grew significantly during the pandemic. There is a risk that this cannot be reduced quickly enough to a level that meets NHS Constitutional commitments. This would also contribute to poor patient experience, and may lead to an increased clinical harms for individual patients resulting from prolonged waits for treatment.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Dr Frankie Swords	Quality & Safety	Sheila Glenn	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**5**	**4**	**16**	**3**	**4**	**12**

Controls	Assurances on controls
• The Elective Recovery Board meets bi-weekly to oversee all workstreams to improve performance and reduce harm. • Each Provider has completed waiting list clinical validation and all patients have been clinically prioritised. • Workstreams are in place to expand capacity, share learning, maximise efficiency and reduce variation in waiting times between different providers, including through mutual aid, and to transform care pathways to accelerate elective recovery, each led by a chief operating officer or medical director. • Unified process of clinical harm review and prioritisation in line with national guidance in place across all providers to ensure that patients' care is undertaken in order to clinical priority and to prevent harm where this is identified as a risk. • EoE funding secured for mutual aid administrative support to contact long wait patients to confirm availability, signpost to While You Wait website and confirm if transfer to alternative provider via mutual aid • National and local patient resources in place to support patients waiting for elective care: https://www.myplannedcare.nhs.uk/ https://norfolkandwaveneyICB.nhs.uk/while-you-wait	**The initial focus to clear all patients waiting 104 weeks or more across our system by 1 July 2022 was met with data confirmed by NHSEI.** **Internal:** Weekly and monthly performance metrics for each workstream scrutinised at biweekly elective recovery board. **External**: Trust Board Governance processes and returns to NHSEI, National contract monitoring by NHSEI and Elective Recovery Board. Weekly Tiering KLOE return from Trusts to system, region and national teams, monitored through fortnightly Tiering meetings.
Gaps in controls or assurances	

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
03/01/23	Deep dive of all patients at risk of breaching 78 weeks by end of March completed with region, patients contacted to instigate the system and national Mutual Aid processes	**B**	30/01/23

Visual Risk Score Tracker – 2022/23												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score				**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**20**
Change				**New**	→	→	→	→	→	→	→	→

BAF09

Risk Title	**NHS Continuing Healthcare**
Risk Description	There is a risk that NHS Continuing Healthcare (CHC) funded packages will not be filled by the provider either due to the complexity of the care required and/or their capacity or the proposed cost of care. If this happens significant pressures will be placed on the CHC nurses to source a package of care. Staff vacancies and absences may increase and the infrastructure to support provision of safe and effective care packages will be compromised. This may lead to increased financial cost to secure a care package, could impact on hospital discharges and admissions and poor outcomes for people requiring NHS funded care in the community.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi	Quality & Safety	Dawn Newman	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**3**	**3**	**9**

Controls	Assurances on controls
• Recruiting to vacant posts within the CHC team to support assessments and care sourcing. • Commence work with finance team and contract team in NWICB and Local Authorities (LAs) to work to stabilise the market. • Link with Local Authority (LA) workforce teams to support care providers in additional training and support required. • Regular financial updates to Finance Committee and Executive Management Team (EMT) to monitor impact of cost of care packages. • Monthly operational finance meetings for Quality in Care (QiC) team. • Monitoring of time taken to secure complex care packages and escalation process for CHC team if unable to source. • Attendance at regional meetings to support feedback and sharing of good practice and innovation. • CHC Business Intelligence (BI) has developed relevant pictorial data sets for analysis which are included in the monthly QiC Quality report for the Quality & Safety Committee. • Weekly meetings held with Norfolk and Suffolk NHS Foundation Trust (NSFT) and NCC to improve communication and partnership working around discharge planning. Complex discharges from acute mental health hospital beds are progressively delayed by lack of suitable complex care in the local provider market. Contracting, Finance and CHC teams collaborating to share relevant information regarding uplifts.	**Internal:** Senior Management Team (SMT); EMT; Quality & Safety Committee; Finance Committee; Board **External**: NHS England/Improvement; Regional CHC Team, Joint Collaborative Forum (Norfolk County Council (NCC)), Care Market Cell (Suffolk County Council), System partners

Gaps in controls or assurances

- Ability to source and retain suitable workforce for either the NWICB CHC team or care provider market
- Lack of a whole system Care Workforce Strategy
- Ability to stabilise the care market post Covid-19 and EU Exit
- Capacity of CHC team to source or revise care packages
- From 30/06/22, funded Discharge to Assess pathway 3 ceases. CHC team does not have staff resources to manage the extent of workload that will require progressing.

Following the CHC contract procurement in October 2022, as at 02/09/22, there are 125 CHC eligible individuals with ICB commissioned care who do not have a provider with a current NHS contract. We currently continue to commission new packages of care with some of these providers. Full details are within Quality and Safety risk QiC-CHC-027 'Care providers without contracts'.

Updates on actions and progress		
Date opened	**Action / update**	**BRAG**	**Target completion**
11/02/22	Active recruitment into newly established roles to enhance the team's capacity and maximise clinical functionality of the team. Eight new commissioning support officers and two nurses.	**A**	31/03/23
14/04/22	NSFT Discharge to Assess model to continue; currently funded through CHC. Case made to make this BAU, costing and evidence of effectiveness, shared with executive team.	**G**	31/03/23

Visual Risk Score Tracker												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score				**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**
Change				**New**	→	→	→	→	→	→	→	→

BAF10

Risk Title	EEAST Response Time and Patient Harms			
Risk Description	Clinical risks to patients awaiting ambulances in community – C1 and C2 response times including inability to undertake rapid release of ambulances. System-wide pressures continue affecting ambulance handover and inter-facility transfers resulting in patient harms.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Tricia D'Orsi / Mark Burgis	Quality & Safety	Karen Watts	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	5	4	20	3	3	9

Controls	Assurances on controls
• Daily sit-rep ensures ICB is sighted on real-time demand and resource. • HALO role across all Acute sites to support Emergency Departments (ED). • 999 / 111 multi-disciplinary approach via CAS at IC24 to manage some ambulance calls and dispositions • Pre-alert and 'drop and go' processes in place with safety netting for patients waiting to be seen. Ambulance revalidations embedded. • Proactive public comms to promote appropriate use of NHS service options. This is reinforced across seasonal campaigns. UEC Tactical Group continues to review system-wide SIs and identify trends / themes.	**Internal:** EMT, N&Q Senior Team, ICB Clinical Lead for UEC and UEC Commissioning Team, ICB Quality and Safety Committee, ICB Board, Provider Governance Forum. **External**: Regional Commissioning Consortium, NHSE Regional Team, OAG and CQC.

Gaps in controls or assurances

- The Trust has seen prolonged periods of high activity which continues to fluctuate from REAP Level 4 and Surge Levels 2 to 4. System has been in a critical incident level 2 since October 2022. System-wide pressures impact on the ability of ambulances to handover patients at Emergency Departments (ED) and release to respond to new calls in a timely way. Incidents have been reported by Primary Care, where Health Care Professionals have assessed the need for an ambulance and experienced a significant delay in response. Incidents have also occurred where inter-facility transfers e.g., from local acute hospitals to tertiary centres for specialist care have been delayed.
- Patient harms increased in July 2022, which triggered an increase in risk rating.
- Discharge pressures, with high numbers of patients with no criteria to reside, impacting on patient flow through the acute hospitals.
- Significant challenge in social care re: capacity and workforce required to support packages of care in the community.

EEAST continues to experience workforce challenges in relation to recruitment, retention, wellbeing and morale. System pressures are compounding this leading to significant risk to the resilience of teams and moral injury.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
21/09/21	Monitoring of Serious Incidents and associated harms. System-wide operational meetings in place daily with on-call arrangements to manage system pressures. System-wide focus on handover delays due to risk of harm to patients. UEC Tactical Group in place to enable systemwide learning and solutions. Critical incident declared on 03/10/22 and daily rhythm of Gold Command meetings in place.	G	31/03/23
04/11/22	Five core management pillars (cross-reference BAF02) are in place to support a system response, using a critical incident framework.	G	31/03/23
10/01/23	Decompression measures continue to be utilised at each site (cross-reference BAF02).	G	31/03/23

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				16	20	20	20	20	20	20	20	20
Change				New	↑	→	→	→	→	→	→	→

BAF11

Risk Title	Achieve the 2022/23 financial plan			
Risk Description	If the ICB does not deliver the 2022/23 Financial Plan of a break-even position, then the ICB may not be able to maintain spending on current levels of service, or to continue with plans for further investment. This may lead to a reduction in the levels of services available to patients			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Steven Course	Finance	Emma Kriehn Morris	01/07/2022	31/03/2023

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**2**	**4**	**8**	**2**	**4**	**8**

Controls	**Assurances on controls**
• Monthly monitoring of risks and mitigations, reported to NHSE/I. • Detailed plan for 2022/23 approved by Board and submitted to NHSE/I as part of the break-even system plan. Monthly Finance Report presented to Finance Committee and Board.	**Internal:** Board Reports and Minutes, Audit Committee reports and Internal Audit work plan, Finance Committee reports, Budget manager review. **External**: ICB assurance process, early flagging of risk with NHSE/I.

Gaps in controls or assurances

- Identification of risks and associated mitigations reviewed on a monthly basis;
- Escalation to EMT, Finance Committee and Board if appropriate, should total unmitigated risks crytalise;
- No contingency reserve in plan;
- £5.4m of unmitigated risk in the plan.
  £1.3m of uncrystallised net risks identified at M10 (January 2023). This is a reducing position from £1.4m reported in M10.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
09/02/23	Review of M10 year to date performance and assess forecast out-turn evaluated risks and mitigations.	G	Ongoing
12/10/22	Monitor the NHSE guidance which is due to be released (by the end of October) to ascertain the process for moving away from a break-even forecast out-turn position		30/10/22

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				16	16	16	16	16	12	12	8	8
Change				New	→	→	→	→	↓	↓	↓	→

BAF11A

Risk Title	Underlying deficit position
Risk Description	If the ICB underpins its financial position via non-recurrent funding, then, this provides a risk to future years financial sustainability due to lower allocations based on historic expenditure.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Steve Course	Finance	Emma Kriehn Morris	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	5	4	20	3	4	12

Controls	Assurances on controls
• Analysis and understanding of underlying recurrent position, including drivers of the deficit. ICS Medium Term Financial Model has been developed that suggests an improving position over future years	**Internal:** Board Reports and Minutes, Audit Committee reports and Internal Audit work plan, Finance Committee reports. **External:** ICB assurance process, early flagging of risk with NHSEI.

Gaps in controls or assurances

- The ICB has an underlying deficit position of c.£71m at M10 with no plan at present to bring to a break even position in the short term.

Development and approval of Medium Term Financial Plan is not yet complete, however, first draft has been prepared to represent a baseline position.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
06/09/22	Develop ICS (and ICB) medium term financial strategy to assess achievability of a break-even position. This requires significant levels of efficiencies to be delivered over a continuous time frame.	A	31/11/22
08/09/22	Understanding of the key drivers of the underlying deficit identified and work continues to attempt to reduce this position.	B	Complete

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				20	20	20	20	20	20	20	20	20
Change				New	→	→	→	→	→	→	→	→

BAF19

Risk Title	**Discharge from inpatient settings**
Risk Description	There is increased risks to patients no longer meeting the "Criteria to Reside" in both acute and community hospitals. The causes are many including significant vacancies in discharge hubs; variation in the quality of discharge documentation; a 40% shortfall in the availability of Pathway 1 domiciliary care services; insufficient resources on wards to keep people active; and insufficient pathway 2 & 3 beds. These delays leaving hospital lead to a syndrome of deconditioning as people significantly reduce their activity (less than 400 steps a day) leading to reduced functional ability, muscle wasting etc as well as worsening cognition and mood negatively impacting on the activities of daily living.

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Tricia D'Orsi	Quality and Patient Safety Committee	Mark Shepperd	25/10/22	31/03/23

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**3**	**15**	**5**	**3**	**15**	**2**	**3**	**6**

Controls	**Assurances on controls**
• Daily review in provider of discharges • Escalation process for problems • Creation of additional capacity 295 additional beds or bed equivalents • Winter plan • Discharge Director promoting best practice via 30-60-90 day plans, and the Acute Hospital Discharge programme Key Lines of Enquiry • End of PJ paralysis programme • Tour de East of England • Reconditioning the nation programme • Single agreed system dashboard established • New Transfer of Care form and processes approved for use across system Patient Transport meeting weekly x3 (one for each site)	**Internal:** ICB Executive Management Team; UEC Board; Discharge Programme Board; Discharge Steering Group; ICB Quality and Safety Committee; Bi weekly discharge touchpoint meeting. Daily IMT and weekly Patient Transport Meetings. **External:** Trust Boards; 3 x Acute System Operations, Resilience and Transformation Boards; Serious Incident Gold Group; Serious Incident Tactical Group; NHSE Board Assurance Framework.

Gaps in controls or assurances

- Single agreed system dashboard
- Insufficient capacity within existing care market
- Transfer of Care form and processes
- Patient Transport
- Workforce pressures. Staff sickness and absence combined with unfilled vacancies and difficulties recruiting to key posts.
- Criteria led discharge
- Identifying complex discharge early
- 7-day working needs to embed fully

Managing workforce capacity in community settings to meet changes in demand and surges

Updates on actions and progress

Date opened	**Action / update**	**BRAG**	**Target completion**
1/11/22	All wards to participate in Recondition national initiative.	G	31/03/23
1/11/22	Discharge hub funding established for 2022-23.	G	31/03/23
1/11/22	Deep dive into hubs their systems and processes completed. Outcome report sitting with system CEOs awaiting next steps.	G	31/01/23
1/11/22	Deep dive into fast-track process for end of life patients has commenced.	A	28/02/23
1/11/22	Daily deep dive into Pathway 1 discharges continues.	G	31/03/23

9/11/22	Roll out of criteria lead discharge to all wards has commenced.	A	31/03/23
9/11/22	Establish task and finish group to explore strengthening the role and contribution the VCSE sector can make to discharge.	A	31/03/23
10/01/23	ICB staff deployed as of 20th December 2022 to support discharge in acute trusts.	G	31/01/23
10/01/23	Funding secured from national £500m budget to support discharge. Business cases submitted and provisional plan agreed.	B	Complete
10/01/23	New 'four weeks of free care' funding (£250m national fund, of which £50m is capital) confirmed. Daily task and finish group established to agree implementation, week commencing 16/01/23.	G	31/01/23
10/01/23	28 Norse beds identified for pathway 2 beds at NCH&C. 9 beds used to date. Unable to fully utilise, due to criteria for admission and environment.	A	31/01/23

Visual Risk Score Tracker – 2022/23												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score								**15**	**15**	**15**	**15**	**15**
Change								**New**	→	→	→	→

Norfolk and Waveney ICB aim: To make sure that you only have to tell your story once

Principal risk: That people in Norfolk will have their time wasted due to lack of integration and poor data sharing between different providers of health and care. This could lead to frustration for patients and staff, and introduce errors due to multiple handovers of information

Summary of risks

Ref	Risk description	Risk owner / Operational Lead	Date risk identified	Target delivery date	Month risk rating											
					1	2	3	4	5	6	7	8	9	10	11	12
BAF12 **	Impact on Business Continuity in the event of a Successful Ransomware Cyber Attack	Ian Riley/ Anne Heath	01/07/22	31/03/23				15	15	15	15	15	8	8	Closed	
BAF12a	Impact on Business Continuity in the event of a Cyber Attack	Ian Riley/ Anne Heath													8	8
BAF12b	Impact on Business Continuity in the event of a specific Cyber Attack	Ian Riley/ Anne Heath													9	9
BAF13	Personal data	Ian Riley / Anne Heath	01/07/22	31/03/23				20	20	20	20	20	12	12	12	12

** In accordance with discussions at the ICB's Audit and Risk Committee, it was agreed that BAF12 would be split into two separate risks. Therefore, for the purposes of clarity BAF 12 has closed and BAF12a and BAF12b has been created.

BAF12 – Risk Closed (March 2023)

Risk Title	Impact on Business Continuity in the event of a Successful Ransomware Cyber Attack
Risk Description	Current heightened risk of hostile cyber-attack affecting the UK may, via a ransomware attack, impact on the ICB's ability to maintain business continuity, if access to data stored within Office 365 on the national NHS tenant, is compromised or prohibited (by data getting onto and corrupting the local network via Ransomware)
ICB priority	To make sure that people can live as healthy a life as possible

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Ian Riley	Board	Anne Heath	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**2**	**4**	**8**	**2**	**3**	**6**

Controls	Assurances on controls
• ICB, NCHC and CSU are already signed up to receive CareCERT alerts. Remedial action is implemented where necessary • Windows 10, Threat Protection and MDE are in place for ICB and Primary Care devices • Secure boundary protection is in place • Ivanti, SCCM patching process to prevent Ransomware getting on the network The process for accessing the out of hours support provided by NHS Digital to resolve major incidents will be established As of November 2022 NHSMail is protected by Microsoft Safe Links & Attachments	**Internal:** Cyber Security Assurance Manager, Head of Digital, IG Working Group, NWICB N365 Technical Workstream Delivery Group **External**: National Cyber Security Operations Centre, NHS Digital, AGEM CSU, MTI Technology Limited (technical partner to NHS Digital)

Gaps in controls or assurances

- An organisation's staff are the first line of defence in preventing a ransomware attack so can be a control and a risk. The threat posed by Ransom Cyber Attacks is greatly driven by user's behaviour. Greater Cyber Security awareness provides better prevention. A lack of awareness in users to recognize Phishing emails increases the risk of a successful Ransomware Attack happening. Good awareness can help prevent them. A new campaign will be launched for winter.
- Staff passwords may not follow best practice as the most recent advice has not been communicated – an awareness campaign has been run and will be part of a new campaign for winter.
- Staff may not be aware that their online presence on social media, whether work or personal, may reveal details that can be used to access their account – a digital footprint awareness campaign will be run in the autumn.
- A protocol informing staff of how to act in the event that they do become the victim of a phishing attack needs to be put together and made available to all staff in a prominent location, this should include details of "first aid" actions a user can take as well as how to notify the service desk and how to escalate the issue if they feel the response is not adequate.
- A source of resources and information for staff on how to prevent and report a phishing or ransomware attack has been put in place and is available on the intranet.
- Advice and guidance for staff on how to activate MFA is currently being developed. NHS Digital have provided specific advice that this is rolled out first to finance teams.
- Starter and leaver processes for NHS mail accounts are not standardized either within the ICB or Primary Care – users need to be made aware how important it is that all leavers have their NHS Mail accounts disabled – this guidance is currently being developed.
- The ICB is asked to provide NHS Mail accounts for non ICB or Primary Care staff – current cyber awareness training does not include these groups and they therefore pose a greater threat. NHS Digital advice is that organisations must meet DSPT standards.
- There is no out of hours cyber process for on-call managers to follow
- Out of hours cyber support from the commissioned IT provider is on a goodwill basis only
- There is no out of hours cyber support for Primary Care staff

- Microsoft 365 works on a system of retention rather than traditional backup. DSPT requires evidence of backup.
- Currently unable to test how support from the national Office 365 team will support the ICB to recover data in the event of a cyber attack.
- There is no regional Cyber Security Operations Centre (CSOC) available to provide expert technical resource to support business continuity, data recovery and cyber breach remediation – although there is evidence of NHS Digital providing this function to other organisations.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
16/05/22	Cyber security behaviour change support and awareness package with clear guidance being developed to include: • how to spot and report a phishing email • how to get help if you have fallen for a phishing email • campaign to improve password security • campaign to raise awareness of giving your data away on social media • campaign to encourage self-enrolment for MFA • provision of a channel dedicated to cyber awareness and information making MFA mandatory for non ICB or Primary Care staff provided with an NHS Mail address	**B**	Complete
10/01/23	Working with NCHC to ensure that MFA mandatory for non ICB or Primary Care Staff provided with an NHS Mail address.	**A**	31/03/23
16/05/22	Guidance has now been provided which includes a central Data Security helpline where all incidents can be reported and the nhs.net helpdesk should be contacted for the recovery of data.	**B**	Complete
16/05/22	Details of CSU point of contact for cyber security issues will be made available to silver and gold on-call directors via EPRR lead	**B**	Complete
16/05/22	Assurance has now been provided by NHS Digital both nationally and regionally to a level that meets DSPT requirements.	**B**	Complete
16/05/22	Digital Team currently testing implementation of InTune with mobile device management. Before scoping and agreeing rollout to staff using ICB issued and personal devices to access NHS Mail and MS Teams to be implemented as part of transfer to new IT provider	**B**	Complete
16/05/22 10/01/23	A feasibility including costed plan for the implementation of MFA for all staff across both the ICB and Primary Care is being developed and will be presented to the ICB's February IG Working Group. Work with NCHC Cyber and Infrastructure leads to plan the rollout of MFA across the ICB by NCHC ICT team. Outline plan to be presented to ICB IG Working group in February 2023.	**G**	03/02/23

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				15	15	15	15	15	8	8	8	8
Change				New	→	→	→	→	↓	→	→	→

BAF12a	
Risk Title	Impact on Business Continuity in the event of a Cyber Attack
Risk Description	Current heightened risk of hostile cyber-attack affecting the UK may, via a ransomware, brute force, DDOS (Distributed denial of service) or social engineering attack, impact on the ICB's ability to maintain business continuity, if access to data stored within Office 365 on the national NHS tenant, is compromised.
ICB priority	To make sure that people can live as healthy a life as possible

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Ian Riley	Board	Anne Heath	01/03/2023	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	2	4	8	2	3	6

Controls	Assurances on controls
• ICB, NCHC and CSU are already signed up to receive CareCERT alerts. Remedial action is implemented where necessary • Windows 10, Threat Protection and MDE are in place for ICB and Primary Care devices • Secure boundary protection is in place • Ivanti, SCCM patching process to prevent Ransomware getting on the network The process for accessing the out of hours support provided by NHS Digital to resolve major incidents will be established • As of November 2022, NHSMail is protected by Microsoft Safe Links & Attachments • The local Cyber Resilience group provides early access to Cyber intelligence allowing organisations in the local health community to be better prepared for cyber-attacks. • Annual IT Health checks (Penetration tests) undertaken to identify weaknesses in ICT/Cyber controls • SDWAN (Software Defined Wide Area Network) implemented across the ICB • The ICB's ICT provider are an exemplar in terms of Cyber Security and technical innovation. • Leaver processes for NHS mail accounts are now standardised for the ICB so all leavers have their NHS Mail accounts disabled	**Internal:** Cyber Security Assurance Manager, Head of Digital, IG Working Group, NWICB N365 Technical Workstream Delivery Group **External**: National Cyber Security Operations Centre, NHS Digital, AGEM CSU, NCHC, MTI Technology Limited (technical partner to NHS Digital)

Gaps in controls or assurances

- An organisation's staff are the first line of defence in preventing a ransomware attack so can be a control and a risk. The threat posed by Ransom Cyber Attacks is greatly driven by user's behaviour. Greater Cyber Security awareness provides better prevention. A lack of awareness in users to recognize Phishing emails increases the risk of a successful Ransomware Attack happening. Good awareness can help prevent them. A new campaign will be launched for winter.
- Staff passwords may not follow best practice as the most recent advice has not been communicated – an awareness campaign has been run and will be part of a new campaign from April.
- Staff may not be aware that their online presence on social media, whether work or personal, may reveal details that can be used to access their account – a digital footprint awareness campaign will be run from June 2023.
- A protocol informing staff of how to act in the event that they do become the victim of a phishing attack needs to be put together and made available to all staff in a prominent location, this should include

details of “first aid” actions a user can take as well as how to notify the service desk and how to escalate the issue if they feel the response is not adequate. This will be aviaible in April 2023

- A source of resources and information for staff on how to prevent and report a phishing or ransomware attack has been put in place and is available on the intranet.
- Advice and guidance for staff on how to activate MFA is currently being developed. NHS Digital have provided specific advice that this is rolled out first to finance teams. MFA will become mandatory on NHS Mail in June 2023
- The ICB is asked to provide NHS Mail accounts for non ICB or Primary Care staff – current cyber awareness training does not include these groups and they therefore pose a greater threat. NHS Digital advice is that organisations must meet DSPT standards.
- Out of hours cyber support from the commissioned IT provider is on a goodwill basis only
- There is no out of hours cyber support for Primary Care staff
- Currently unable to test how support from the national Office 365 team will support the ICB to recover data in the event of a cyber attack .
- There is no regional Cyber Security Operations Centre (CSOC) available to provide expert technical resource to support business continuity, data recovery and cyber breach remediation – although there is evidence of NHS Digital providing this function to other organisations.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
16/05/22	Cyber security behaviour change support and awareness package with clear guidance being developed to include: • how to spot and report a phishing email • how to get help if you have fallen for a phishing email • campaign to improve password security • campaign to raise awareness of giving your data away on social media • campaign to encourage self-enrolment for MFA • provision of a channel dedicated to cyber awareness and information • making MFA mandatory for ICB or Primary Care staff provided with an NHS Mail address		Complete
10/01/23	Working with NCHC to ensure that MFA mandatory for non ICB or Primary Care Staff provided with an ICB NHS Mail address.		Complete
16/05/22	Guidance has now been provided which includes a central Data Security helpline where all incidents can be reported and the nhs.net helpdesk should be contacted for the recovery of data.		Complete
16/05/22	Details of CSU point of contact for cyber security issues will be made available to silver and gold on-call directors via EPRR lead		Complete
16/05/22	Assurance has now been provided by NHS Digital both nationally and regionally to a level that meets DSPT requirements.		Complete
09/03/23	Deploy Zscaler (Could based AI Firewall and security platform) on the three office networks.		Complete

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score											8	8
change											*New*	➔

BAF12b	
Risk Title	Impact on Business Continuity in the event of a specific Cyber Attack
Risk Description	Current heightened risk of hostile cyber-attack affecting the UK may, via a Phishing attack resulting in data exfiltration and/or ransomware attack resulting in a data breach of patient/personal information and/or financial extortion, impact on the ICB's ability to maintain business continuity, if access to data stored within Office 365 on the national NHS tenant takes place, by gaining access to and/or corrupting data held within the ICB's section of the national tenant. Through one of the following top three risks identified by the IG Working Group: - 1. Ransomware attack 2. Lack of user awareness 3. Phishing/social engineering
ICB priority	To make sure that people can live as healthy a life as possible

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Ian Riley	Board	Anne Heath	01/03/2023	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	3	3	9	2	3	6

Controls	Assurances on controls
• From June 2023 MFA on NHS Mail will deployed as part of national policy from NHSE • ICB, NCHC and AGEM CSU are already signed up to receive CareCERT alerts. Remedial action is implemented where necessary • Windows 10, Threat Protection and MDE are in place for ICB and Primary Care devices • Secure boundary protection is in place • Ivanti, SCCM patching process to prevent Ransomware getting on the network The process for accessing the out of hours support provided by NHS Digital to resolve major incidents will be established • Since November 2022, NHSMail is protected by Microsoft Safe Links & Attachments	**Internal:** Cyber Security Assurance Manager, Head of Digital, IG Working Group, NWICB Technical Workstream Delivery Group **External**: National Cyber Security Operations Centre, NHS Digital, AGEM CSU, MTI Technology Limited (technical partner to NHS Digital)

Gaps in controls or assurances

- MFA on NHS Mail will become mandatory with NHSE Policy from June 2023. In advance this will be piloted with the Digital Team and deployed to Finance and BI as priority areas. In addition in advance advice and guidance for staff on how to activate MFA will be developed and shared widely with staff.
- An organisation's staff are the first line of defence in preventing a ransomware attack so can be a control and a risk. The threat posed by Ransom Cyber Attacks is greatly driven by user's behaviour. Greater Cyber Security awareness provides better prevention. A lack of awareness in users to recognize Phishing emails increases the risk of a successful Ransomware Attack happening. Good awareness can help prevent them. A new campaign will be launched for winter.
- Staff passwords may not follow best practice as the most recent advice has not been communicated – an awareness campaign has been run and will be part of a new refresh campaign in April.
- Staff may not be aware that their online presence on social media, whether work or personal, may reveal details that can be used to access their account – a digital footprint awareness campaign will be run in June.
- A protocol informing staff of how to act in the event that they do become the victim of a phishing attack needs to be put together and made available to all staff in a prominent location, this should include

details of “first aid” actions a user can take as well as how to notify the service desk and how to escalate the issue if they feel the response is not adequate. This will be provided in April.

- A source of resources and information for staff on how to prevent and report a phishing or ransomware attack has been put in place and is available on the intranet.
- The ICB is asked to provide NHS Mail accounts for non ICB or Primary Care staff – current cyber awareness training does not include these groups and they therefore pose a greater threat. NHS Digital advice is that organisations must meet DSPT standards.
- Out of hours cyber support from the commissioned IT provider is on a goodwill basis only
- There is no out of hours cyber support for Primary Care staff
- Currently unable to test how support from the national Office 365 team will support the ICB to recover data in the event of a cyber-attack.
- There is no regional Cyber Security Operations Centre (CSOC) available to provide expert technical resource to support business continuity, data recovery and cyber breach remediation – although there is evidence of NHS Digital providing this function to other organisations.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
16/05/22	Digital Team currently testing implementation of InTune with mobile device management. Before scoping and agreeing rollout to staff using ICB issued and personal devices to access NHS Mail and MS Teams to be implemented as part of transfer to new IT provider		Complete
16/05/22 10/01/23	A feasibility including costed plan for the implementation of MFA for all staff across both the ICB and Primary Care is being developed and will be presented to the ICB’s February IG Working Group. Work with NCHC Cyber and Infrastructure leads to plan the rollout of MFA across the ICB by NCHC ICT team. Outline plan to be presented to ICB IG Working group in February 2023.		Complete
09/02/23	Ahead of mandatory MFA on NHS Mail from NSHE implement MFA across the entire ICB as per the plan submitted to the Feb 23 IGWG		29/05/23
03/02/23	Conduct Phishing Simulation to test user awareness of Phishing, providing specific Phishing Awareness training to those members of staff who click links and/or enter their credentials		30/06/23
09/03/23	Refresh Cyber Awareness following the campaign in October/November to ensure existing staff are reminded of the protocols in place and new staff who missed the campaign are made aware. Inclusion in ICB Newsletter and Staff Briefing.		Complete
09/02/23	Develop process for managing compromised NHSmail accounts with NCHC for ICB staff, including remediation of the user account and review of the potential for data exfiltration.		Complete
09/03/23	Pilot deployment of Zscaler (Cloud based AI Firewall and security platform) on selected end user devices within the ICB prior to deployment across the ICB.		Complete

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score											*9*	*9*
change											*New*	➔

BAF13

Risk Title	**Personal data**			
Risk Description	There is a risk that the ICB's constitution and statutory / delegated functions will not permit it to process personal data without consent, once the protection of the current COPI Notice ceases on 30 June 2022; particularly functions that have been stood up during the pandemic. This also includes the risk to the CEfF (the access to controlled financial data pertaining Patient Identifiable Data). The ICB has not as yet been given legal right to access personal confidential data			
ICB priority	To make sure that people can live as healthy a life as possible			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Ian Riley	Audit and Risk	Anne Heath	01/07/2022	31/03/2023

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**5**	**20**	**3**	**4**	**12**	**3**	**3**	**9**

Controls	**Assurances on controls**
• Guidance from the ICS Establishment CoP suggests that all functions currently conducted by a CCG can transition to an ICB Constitution for NHS Norfolk and Waveney ICB allows for the transition of all functions delivered by the CCG	**External:** ICS Establishment COP and EOE IG ICB Transition Group **External**: IG Working Group and Population Health and Care Operational Delivery Group

Gaps in controls or assurances

- Functions established under the COPI Notice, which the ICB wishes to continue will need to move to BAU with supporting Data Sharing or Data Processing Agreements.
- Buy in from GP Practices to enable the ICB to continue to use primary care data for functions such as the Virtual Support Team, after the COPI Notice has expired.

Updates on actions and progress

Date	**Action**	**RAG**	**Target completion**
10/06/22	A review of services has been conducted using COPI registers and the outcome has identified the areas that require to continue to process data.	**B**	complete
10/06/22	A data processing contract was agreed with Kafico and has been disseminated to General Practice to support areas which have been identified as BAU for the ICB and would need to continue. PHM team collating update of signed agreement.	**B**	complete
10/06/22	Letter from director of Data and Information Management systems of NHSE provided on 28th June 2022 detailing the CAG approval of the amendment from CCG to ICB for the existing section 251 agreements in place for invoice validation and risk stratification.	**B**	complete
23/08/22	PHM team are engaged with practices for signatures of agreements. IG team are seeking regular updates for assurance that agreements are being signed and continue to chase up for these.	**A**	Awaiting latest list of practices signed up from PHM team
11/01/23	Procuring software to monitor and manage data controllers IG agreements across the ICS. This will enable reporting to be done more easily on which agreements have been signed and a full audit trail.	**G**	31/03/2023
10/01/23	NHSE Section 251 agreement has been extended to September 2023. Invoice validation to be in-housed and ICB has requested a change to ensure the ICB team are covered to continue this processing. The PHM team have an up to date list of practices that have signed up to the data processing contract (awaiting latest list to be sent to IG) which allows the ICB to process data on their behalf. The ICB will not process	**G**	

	data for practices that have not signed up. The ICB has initiated and have all acute providers signed up to a PHM data sharing framework which allows for the primary care and acute data to be combined and the ICB and risk stratification supplier to support PHM projects.		

Visual Risk Score Tracker – 2022/23												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score				**20**	**20**	**20**	**20**	**20**	**12**	**12**	**12**	**12**
Change				**New**	→	→	→	→	↓	→	→	→

Norfolk and Waveney ICB aim: To make Norfolk and Waveney the best place to work in health and care

Principal risk: That people will not want to work in health and care in Norfolk and Waveney leading to difficulties recruiting and retaining staff. This could lead to difficulties in providing our services

Summary of risks

Ref	Risk description	Risk owner / Operational lead	Date risk identified	Target completion date	Month risk rating											
					1	2	3	4	5	6	7	8	9	10	11	12
BAF14	#WeCareTogether People Plan	Ema Ojiako / Emma Wakelin	01/07/22	01/04/24				12	12	12	12	12	12	12	12	12
BAF15	Staff Burnout	Ema Ojiako / Jo Catlin	01/07/22	31/03/23				12	12	12	12	12	12	12	12	12
BAF16	The resilience of general practice	Mark Burgis / Sadie Parker	01/07/22	31/03/23				12	12	16	16	16	16	16	16	16
BAF17	Financial Wellbeing	Ema Ojiako / Emma Wakelin	01/08/22	ongoing					12	12	12	12	12	12	12	12
BAF18	Transition and delegation of primary care services	Andrew Palmer / Sadie Parker	31/10/22	31/10/23								16	16	16	16	12
BAF20	Industrial action	Ema Ojiako / Karen Watts / Emma Wakelin	14/11/22	31/03/23								12	12	12	12	12

BAF14

Risk Title	**#WeCareTogether People Plan**			
Risk Description	There is a risk that there is failure in the implementation of our *#WeCareTogether* People Plan in respect to improving health and wellbeing, creating new opportunities, maximising skills of our staff and creating a positive and inclusive culture at work. If this happens then we will not achieve our goal to be the 'best place to work'. This may lead to increased sickness and turnover, high vacancies and poor patient care, and our people may experience bullying and discrimination.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Ema Ojiako	People and Culture	Emma Wakelin	01/07/2022	01/04/24

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**3**	**4**	**12**	**1**	**3**	**3**

Controls	**Assurances on controls**
ICB controls • Staff Involvement group in place provides forum for reps from the ICB to discuss internal topics relating to our people • SMT – review of ToR for this group to ensure the role and remit aligns to requirements of ICB, this will include oversight and management of some people functions • OD plan implementation – Plan has been running for 24 months but would benefit from enhanced resource to address all elements of people within an effective organisation • Director of People has commenced in post and will continue to progress work with ICB DoN and MD to collaborate on workforce transformation • Director of people to Chair ICB People Board and Remuneration, people & Culture Committee for oversight and assurance System Alignment • Monthly Health and Wellbeing Board Systems Leads meeting to respond to the emerging needs and issues in place. • Bi-weekly Workforce Workshops commenced which showcase workforce transformation activity and allow our staff across ICB and ICS to attend to hear more, ask questions, and collaborate on the #WCT programme • Monthly Workforce Governance meetings in place to steer discussions on: growing our own; up skilling staff. *#WeCareTogether* People Plan has over40 key projects to help us achieve our goal. • Inclusive Culture: Monthly EDI Systems Inclusions meeting to; develop a system plan to shape and support an inclusive and just culture; respond to any emerging needs and issues; support focus groups to enable staff to have a voice in shaping this work. *#WeCareTogether* system wide People Plan in place since August 2020.	**Internal:** EMT, SMT, SIG

Gaps in controls or assurances
• Lack of clarity for People Function within ICB – People Director or Director of Governance portfolios to be agreed. Insufficient internal people resource to deliver requirements of people function to ensure the ICB is a healthy and effective organisation. Review of statutory people functions and those required to transform the ICB is underway which will include key risks and mitigations for EMT to review. • Greater focus on internal staff communication and engagement is required • Change in roles for Health and Wellbeing, EDI, and Freedom to Speak up Guardians represents a risk until we identify replacements • Lack of dedicated resource to effectively analyse our 'people data'; a 'people dashboard; that is reviewed and considered with the same scrutiny as operational and financial performance • Lack of significant and consistent progress/focus on WRES standards. • Lack of sight on impact of retention, wellbeing as a result of Covid retirement flight risk, burnout, might undermine our grow, attract and retain strategy. Increasing sickness levels against historic picture. High vacancies and sickness levels.

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
26/12/21	• We now have 4 workstreams (system recruitment, reducing sickness, bank & agency, e-rostering) mapped to our SOF 4 plan for workforce. These workstreams will be monitored at the monthly system finance meetings and the WDG. These themes will reduce workforce risks on implementation. **November 22 update** • System pressures and conflicting priorities for organisations have impacted on the delivery of these programmes resulting in delays and a lack of decision making on core elements of the programmes. • Newton Europe diagnostic work will support plans for a review of HR process and practice with strategic input from Director of People. **Director of People has commenced in post and is working with Director of Governance to realign portfolio's**	**A**	31/3/23
30/03/22	Workforce Dashboard to monitor high level milestones and assess progress in place.	**B**	Complete
01/04/22	EDI lead commenced in role to support focus on WRES and Inclusion across the system.	**B**	Complete
19/08/22	ICS people plan #WeCareTogether will be refreshed (national mandate) – resource secured to lead this work which will ensure ICB staff are included	**G**	Ongoing
14/11/22	Refresh continues with c250 people engaged since August to review progress since 2020 and consider where updates are required for the #WCT People Plan. Refresh launch planned for early 2023 alongside updated #WCT platform which will develop over time to be a single point of access for people seeking support to join N&W ICS and to reach their potential working with us	**G**	March 2023

Visual Risk Score Tracker												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score				**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**
Change				**New**	→	→	→	→	→	→	→	→

BAF15

Risk Title	**Staff burnout**
Risk Description	Burnout is measured by three elements. • Exhaustion - an imbalance between work demands and individual resources. • Individual strain - an emotional response of exhaustion and anxiety, which is heightened by not feeling effective • Defensive coping - changes in attitudes and behaviour, such as greater cynicism System pressures (increasing activity, workforce vacancies, sickness, and resilience) have increased the risk of fatigue and exhaustion. We are seeing increases in poor physical and mental wellbeing, low morale and motivation. The transition from CCG to ICB also presents a risk of staff feeling unsettling and anxious in line with a change process which will require focussed support to lead people. The narrative that we are failing to meet targets (clinical and financial) is constant. Individuals need to feel they are making a difference. This could lead to an increase in staff absence rates (short and longer term), retention and most worryingly significant mental and physical issues. If this happens this could have a significant impact on the services that they deliver.
ICB priority	To make Norfolk and Waveney the best place to work in health and care

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Ema Ojiako	People and Culture	Jo Catlin	01/07/2022	31/03/23

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**3**	**4**	**12**	**1**	**4**	**4**

Controls	**Assurances on controls**
• We are seeing an increase in ICB staff requesting support from System Workforce Team – in particular line management culture change, new ways of working, developing teams. • The Staff Involvement Group and Senior Management Team continue to flag issues regarding economic and cost of living rises – agreement to add as a new risk to ICB corporate risk register as the impact of lifestyle pressures will impact on peoples resilience and increase likelihood of burnout • Discussion at future EMT regarding the Internal People function is tabled, the incoming People Director is a HR professional and we will seek their guidance on future form and function Despite the 2022 pay increase, with the pension contribution changes some of our staff will be worse off. Add this to the cost-of-living pressures (see BAF17) this could further demotivate	**Internal:** SMT, EMT, ICB Board, Staff Involvement Group, Wellbeing Guardian **External**: ICS Boards, NHSE/I

Gaps in controls or assurances

- Changes in NHS legislation, increased/additional workload and pressures post pandemic
- Issues are not new, they have been enhanced by the pandemic – longer term culture change required to support staff (especially in our approach to Flexible Working to support our people to obtain a better work/life balance)
- Currently no dedicated budget or resource to support health and wellbeing initiatives
- Change in roles for Health and Wellbeing, EDI, and Freedom to Speak up Guardians represents a risk until we identify replacements

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
October 2021	Established H&WB Champions and Steering Group, utilising NHS H&WB Diagnostic and resources to shape actions and approach **November update** • H&WB summit held in September to commence ICS H&WB strategy • Continued support at organisation and system level to support staff wellbeing, this includes a focus on financial wellbeing, and our CV19 Resilience hub for health and social care staff • Presentation at Clinical Director and through Medical Director briefings highlighted H&WB offers in place for Primary Care Workforce, this will also be captured in medical Director Blog in November for a wider audience Business case for ICB to implement Vivup, Employee benefit scheme to be proposed to ICB SMT on 17/11. Other Trusts in ICS already use or are implementing the use of Vivup so this will enable ICB to level up and offer equitable support for our staff	G	31/01/23
May 2022	In response to NSS results, pilot new approach to wellbeing conversations, incorporating available resources and support. Fully implement in July 2022	B	Complete
May 2022	Communications and engagement review has now completed with findings to be presented to EMT in August/September	B	Complete
May 2022	Refocussed Extended Senior Leadership agenda to focus on the People Promise values and to include regular updates and opportunities to receive updates, share information, and collaborate on the change process for the ICB. Meetings now held face to face to encourage collaboration and enhance relationships **November 22 update** ICB Leadership Summit to be held 16/11 with EMT and Senior members of the ICB as a starting point in a redesign and development of how EMT and Snr leads work together in the ICB	G	September 2022

Visual Risk Score Tracker – 2022/23												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score				**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**
Change				**New**	→	→	→	→	→	→	→	→

BAF16

Risk Title	**The resilience of general practice**
Risk Description	There is a risk to the resilience of general practice due to several factors including the ongoing Covid-19 pandemic, workforce pressures and increasing workload (including workload associated with secondary care interface issues). There is also evidence of increasing poor behaviour from patients towards practice staff. Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. This will have a wider impact as neighbouring practices and other health services take on additional workload which in turn affects their resilience. This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services.

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Mark Burgis	Primary Care	Sadie Parker	01/07/2022	31/03/2024

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**3**	**4**	**12**

Controls	**Assurances on controls**
• Locality teams and strategic primary care teams prioritised around supporting the resilience of general practice, dedicated resource to support the Covid vaccination programme. All practices have previously been supported to review business continuity plans • PCN ARRS (additional roles reimbursement scheme) funding has increased again in 2022/23 • Primary care workforce and training team working closely with locality teams to identify clinical and volunteer workforce and to ensure training available to support practices and PCNs in setting up and maintaining services • Resilience funding process has been completed earlier this year (Q2) to provide practices with more opportunity to bid and respond • Interface group with representation from primary, community and secondary care system partners Standard contract requirements on interface – gap analysis and action plans, including monitoring being reviewed by contracts team	**Internal:** EMT, Strategic Command, SMT, workforce steering group, primary care cell **External**: Primary Care Commissioning Committee, NHS England via delegation agreement, Health Education England, Norfolk and Waveney Local Medical Committee

Gaps in controls or assurances

- Practice visit programme, CQC inspections focused on where there is a significant risk or concern
- Unplanned risk associated with Covid and flu outbreaks or positive cases, as well as higher levels of sickness absence in general
- Impact of ambulance delays diverting practice teams from routine and urgent care to respond to emergencies
- Continued reports of poor patient behaviour across practices, decrease in patient satisfaction with general practice through GP patient survey, consistent with national position
- Progress on interface action planning process across Trusts impacted by ongoing winter pressures
- Reporting process for inappropriate transfers of workload from community and secondary care providers to general practice not yet fully worked through
- Workforce and capacity shortages across community pharmacy and dental practices, and ongoing drug shortages, are having an impact on general practice and the rest of the system

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
29/12/22	No change in risk score. Practices reporting increasing pressures, compounded by sickness and workforce challenges in the context of the system being in a level 2 critical incident. Rising costs for practices also impacting ability to increase capacity. Comms campaign underway with further planning to raise awareness and understanding of clinical triage and the varied roles in general practice. Agreement with LMC for local discretionary support for practices to enable clinicians in practices to clinically prioritise services for patients on the balance of risk – this will focus on QOF and IIF. Further measures being considered for discussion with the LMC in the New Year.	**B**	31/01/2023
16.02.23	Nationally, routine CQC inspections have been suspended. Practice plans submitted to access local discretionary support contained a number of resilience themes: • Recruitment and retention issues, mainly for GPs, nursing staff, receptionists and clinical pharmacists • High levels of staff sickness • Pressures on estates capacity as a result of increasing PCN ARRS roles • Increased and unsustainable winter demand, eg suspected and actual Strep A cases, flu and Covid • Impact on their ability to manage patients in the community and continue to provide services due to ambulance delays • Inability to undertaken phlebotomy on Saturdays as part of enhanced access Colleagues from workforce, digital and estates have been linking in with individual practices accordingly. Additional £150k funding for each locality is now in place until end of March and ARI hubs have all been established to provide additional capacity. Resilience 'handbook' under development to signpost practices to support available. Additional interim capacity from within the ICB has been identified to support the PID inbox process to enable practices to report interface issues. The LMC office is also lending support to analysing themes reported.	**A**	31/03/2023

Visual Risk Score Tracker												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score						**16**	**16**	**16**	**16**	**16**	**16**	**16**
Change				→	→	↑	→	→	→	→	→	→

BAF17

Risk Title	**Financial wellbeing**
Risk Description	There is a risk that in the current climate staff will become increasingly under pressure to maintain cost of living. As well as financial wellbeing, this will also impact on peoples physical, mental and social wellbeing – which is likely to impact on resilience and productivity at work. People may also consider alternative employment which offers more flexibility or increased income, take on secondary jobs, or access other avenues outside of workspace to increase financial wellbeing. We also anticipate this will affect working arrangements – for example, reluctance to attend f2f meetings because of fuel or parking costs, or an increase in requests for office working in the winter to reduce personal heating bills which will affect the space available at our sites (e.g. NCC).
ICB priority	To make Norfolk and Waveney the best place to work in health and care

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Ema Ojiako	People and Culture	Emma Wakelin	01/08/2022	ongoing

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**4**	**3**	**12**	**4**	**4**	**12**

Controls	Assurances on controls
• Monthly Staff Involvement Group Meetings in place with representation from all Directorates provides a safe space to highlight risks and issues for staff wellbeing that can be responded to • Weekly staff briefings will have regular inputs from SIG members with information and guidance for support and to demonstrate that we hear and are doing what we can to support staff needs • Recognition that financial wellbeing can affect any member of staff regardless of salary – SMT and EMT to recognise this to ensure compassionate and mindfulness to all staff • Identification of an Employee Reward and Benefit Programme. Many other organisations in our system offer this but the ICB does not have anything in place. They also offer an integrated Employee Assistance Programme (EAP) to support wellbeing and advice on financial management. We do have an EAP which we currently pay for, but sits in isolation under HR. Perhaps not utilised as much as it could be. Plans will include potential alignment to ICS Partner organisations to maximise offer for our system workforce. • Close working with ICS partner organisations coordinated through the ICB System Associate Director of Workforce Transformation and HRD network. This includes a T&F group for financial wellbeing with reps from NHS Providers, LA, and ICB.	**Internal:** SMT, EMT, ICB Board, Staff Involvement Group, Remuneration People & Culture Chair **External**: HRDs, N&W People Board

EoE Regional Teams (HEE/NHSEI) also provide support, resources and regular updates on national responses.	

Gaps in controls or assurances

- This is a macro issue, relatively outside of our control. The country's economic climate shows no sign of easing
- Currently no dedicated budget or resource to support health and wellbeing initiatives nor a dedicated Health and Wellbeing Co-ordinator with expertise in all elements of wellbeing. This would be beneficial as we currently rely on volunteer HWB champion roles.
- Change in roles for Health and Wellbeing, EDI, and Freedom to Speak up Guardians represents a risk until we identify replacements

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
14/11/22	Review of financial support offers underway – requested by EoE regional workforce team and DoF Network	G	18/11/22
Sept 2022	Following a period of engagement and discussions within ICB, business case to implement Vivup – the Employee Benefit Scheme for ICB staff will be presented ICB SMT on 17/11. Other Trusts in ICS already use or are implementing the use of Vivup so this will enable ICB to level up and offer equitable support for our staff. Aim to have this in place for staff to access before 25/12	G	24/12/22

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score					12	12	12	12	12	12	12	12
Change					New	→	→	→	→	→	→	→

BAF18

Risk Title	Transition and delegation of Primary Care Services (Dentistry, Optometry and Community Pharmacy) including complaints service and potential transition of Contact Centre for these areas.
Risk Description	Primary Care Services will become the responsibility of the Integrated Care Board from 1st April 2023, the risk is there will be a lack of additional capacity, resources and finance to effectively commission these services within existing ICB teams (Finance, Complaints, Quality, Workforce, Contracts and Delegated Commissioning) during and following the transition process, leading to a poor patient experience for our local population.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Andrew Palmer	Primary Care	Sadie Parker	31/10/22	31/10/2023

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	3	4	12	3	2	6

Controls	Assurances on controls
• Dental staff to be aligned to ICB's • Single ICB host agreed for the region for community pharmacy and optometry contracting • Pre-delegation assurance framework (PDAF) and safe delegation checklist (SDC) published in draft to support transition work. • Weekly regional task and finish group in place to support the transition and share workload • Regular regional primary care directors and finance directors meetings in place • CSU Medicines Optimisation Team already have working relationships with Community Pharmacies around quality. Proposal for complaints/Contact Centre transition to be delayed to April 2024.	**Internal:** ICB Task and Finish Group, ICB Finance and Primary Care Directors meetings, EMT, Primary Care Commissioning Committee **External:** NHS England, Norfolk and Waveney LDC

Gaps in controls or assurances

- Visibility, decision and agreement on transfer of budget from regional team to ICB.
- Alignment of staff members from region to ICB to be agreed, with focus on contracting only.
- Pharmacy and Optometry services to be aligned to ICB's hosted by HWE ICB
- Lack of resource to support management of finance.
- The level of the unmet need for Dentistry and the associated financial consequence of this once addressed (if possible) given the transfer for funds are to be based on 2022-23 current expenditure which per NHSEI forecasts are also below budget (suggesting a growing unmet need). Non-clinical financial pressures are also likely to arise in relation to resourcing costs given the loss of the economies of scale held in the current model for which the ICB are not funded adding pressure to their Running Costs control target.
- Concern around the financial consequences due to Dental contracts currently being returned or removed from providers, resulting in temporary and more expensive contracts with reduced activity and higher UDA (Unit of Dental Activity).
- Lack of resource to support management of clinical quality, safety and patient experience for these services and for the governance of these functions i.e. managing complaints quality visits and specialist advice and support for providers.
- Access to NHS dentistry services has consistently been an area of quality concern that the local system has escalated to NHSE. This impacts on some of our most vulnerable patient groups.
- Significant workforce shortfalls across dentistry, optometry and community pharmacy.
- Hosting arrangements for pharmacy and optometry services are not yet confirmed, drafting of memorandum of understanding is underway.
- Final versions of PDAF and SDC not yet available.
- The ICB has not been provided with sufficient information to fully complete the PDAF and SDC prior to submission of initial draft in September.

- No confirmation yet as to whether NHSE Contact Centre work/staff to be transferred to ICBs and no data as to staff numbers/workload this would bring. Concern break-up of regional/national team will lead to inefficiencies, remove economies of working to scale and concern there will not be team resilience due to small numbers of staff transferred.

- No data on the complaints service such as numbers of staff and activity levels for complaints work leaving little time to ensure an effective transition of services.

- Unclear decision-making process for transition of complaints with infrequent regional meetings and currently no access to the project group who will be making the recommendation for transfer of complaints service to December Board for approval.

Updates on actions and progress

Date opened	Action / Update	BRAG	Target completion
Jan 2023	Internal governance established Board paper November 2022. Further submission to Board in February 2023 PDAF submitted to NHSE Sept 2023. Safe Delegation checklist updated and submitted to NHSE in Sept and Dec. Final submission due 8/2/23 Terms of Reference for Primary Care Commissioning Committee and proposal for a Scheme of Delegation and establishment of two Operational Delivery Groups for medical and dental services to PCCC Jan 2023 for agreement. To Board in February for approval Complaints model – decision made to delegate to ICBs from April 2023, staff to transfer July 2023. Complaints data has been shared. NHSE ContactUs will be delegated from July 2023, with risk of unknown activity and workload. Memorandum of Understanding with HWE for hosting Pharmacy & Optometry services final draft available for ICB EMT agreement Jan 2023 Understanding of financial risk has improved through information sharing and assurance has improved Regional oversight & decision making provided by ICB PC Directors (fortnightly meetings) Multiple task and finish groups (NHSE and ICBs in region) in place re Finance, Quality, IG & Digital; also weekly General mtg for ICB leads, to discuss concerns and issues, share learning and information NHSE has arranged multiple masterclasses to share learning with ICB teams and will continue	G	28/02/23
Mar 2023	Final submission of Safe Delegation Checklist on 8 Feb with a deep dive meeting with NHSE on 21 Feb to discuss progress and concerns. Task and Finish Group with NHSE and ICBs has facilitated shared learning and discussion about concerns and agree resolution or escalation as appropriate, has been beneficial. Audit Committee and Board have received detailed reports in February on progress, risks and mitigations being taken. Governance arrangements through Primary Care Commissioning Committee approved by the Board Finance team continue to work with NHSE team to understand financial controls and budgets. Access to payment and contracting systems to be enabled for ICB staff from 1 April 2023 TUPE process for staff transfer to ICB confirmed. Vacancies being recruited where no staff being transferred including Finance, Quality, Complaints and Primary Care Commissioning teams. The ICB has	G	30/06/2023

	secured a contract with Primary Care Contracting to provide expert advice, guidance and training during 2023/24. Delays to national data migration process is resulting in interim arrangements being agreed for continued access to NHSE data with a Data Protection Impact Assessment and updated Data Sharing Agreement to be completed. Complaints model to be completed by July 2023, discussions underway to agree how this will happen. Staff will be aligned from April 2023. Engagement with key stakeholders in each of the professions (pharmacy, optometry and dental) has commenced with regular meetings in place.		

Visual Risk Score Tracker – 2022/23												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score								**16**	**16**	**16**	**16**	**12**
Change								**New**	→	→	→	↓

BAF20

Risk Title	**Industrial Action (IA)**
Risk Description	The Royal College of Nursing (RCN) have announced the outcome of their strike ballot on 09/11/2022 for their members. The NMC recognises that 'nurses, midwives and nursing associates have the right to take part in lawful industrial action, including strike action, Trade Unions representing NHS staff have advised the Secretary of State for health and Social Care that they are in dispute over the 2022/23 pay award. The RCN ballot outcome for Norfolk and Waveney (N&W) is in favour of strike action affecting the following organisations. • NHS N &W Integrated Care Board (ICB) • Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUHFT) • Norfolk and Suffolk NHS Foundation Trust (NSFT) • Norfolk Community Health and Care (NCH&C) The strike action in England must take place within six months of the close of industrial strike action strike ballot. Action could be either continuous strike action, which is when two or more strike days occur consecutively, with no working days in between or discontinuous strike action which is when strike days are not consecutive.

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Ema Ojiako	Quality and Safety	Karen Watts & Emma Wakelin	14/11/2022	31/03/2023

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**3**	**12**	**2**	**3**	**6**

Controls	**Assurances on controls**
• Ballot and any strike action that follows must comply with specific legal requirements. There are structured thresholds that need to be met before industrial action can be taken, at least 50% of all members eligible to vote needs to be met before industrial action can be taken. • Only members of a union who have balloted members and received support for strike action in accordance with legal requirements can strike, those who are employed on Agenda for Change terms by an NHS employer. • Only members of a union who are on duty for an employer on strike can strike, employees who are on long-term sick or maternity leave cannot strike. • Employee protection, any employee who takes part in lawful industrial action is protected against unfair dismissal. • NHSE have started negotiations at a national and local level, with established lines of communication with Trade Unions (TU) to manage the impact of any action. • N&W Task and Finish Group for coordination has been set up with strategic oversight of Directors of Nursing (DoNs) and HRD. • Multi-agency exercise planned for ICB and system partners to test emergency preparedness, week beginning 14/11/22. • Communication plan through the national team to ICB Comms Lead in progress. • ICB have reviewed clinical staff for potential redeployment.	**Internal:** N&W Task and Finish Group, ICB Executive Management Team (EMT), System EMT, Quality & Safety Committee, ICB Board. Emergency Planning and Preparedness meetings. **External**: NHSE regional and national oversight. Directors of Nursing (DoNs) and HRD networks

Gaps in controls or assurances

- Full impact on work force and business continuity difficult to ascertain as unknown how many staff will take up the option to strike.
- Loss of ICB staff to support providers to manage BAU.
- Duration of strike period and implementation dates.

Updates on actions and progress

Date Opened	Action / Update	BRAG	Target Completion
14/11/22	NHS England has provided the ICB with advice and guidance on preparations to plan for minimal disruption to patient care, emergency services can operate as normal.	G	31/03/23
14/11/22	Negotiations have commenced at a national and local level to gain a clearer picture on how services will operate on days of strike action to ensure patient safety is not compromised	G	31/03/23
14/11/22	ICB will support Trusts to be prepared by, • Consolidating completion of Trust's self-assessment templates for return in the event of IA. • Set up a N&W Task and Finish Group for coordination with a rhythm of meetings. Strategic oversight by Directors of Nursing (DoNs) and HRD	G	30/11/22
14/11/22	ICB will share information on confirmed industrial action, including information on derogations across the system. • ICB will work with system comms teams and our HRD and DoN networks to ensure information and system planning is consistent across the system including with TUs to manage impact of any action.	G	31/03/23
14/11/22	Testing system preparedness will be coordinated with wider winter planning. Exercise Artic Willow planned for week commencing 14/11/22.	A	21/11/22
14/11/22	Communications will be through ICB Comms Lead content provided by National team including messaging for the public commenced. Guidance and support for decision making around operational delivery and engagement with staff taking industrial action will be shared by the Comms Team.	G	30/11/22
14/11/22	ICB have reviewed clinical staff for potential deployment. Face to face clinical skills training commenced for ICB staff	G	31.12.22

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score								12	12	12	12	12
Change								New	→	→	→	→

Agenda item: 14

NHS
Norfolk and Waveney
Integrated Care Board

Subject:	**Quality and Safety Committee Report**
Presented by:	Aliona Derrett, Quality and Safety Committee Chair Tricia D'Orsi, Executive Director of Nursing
Prepared by:	Evelyn Kelly, Quality Governance & Delivery Manager
Submitted to:	Integrated Care Board Meeting
Date:	28 March 2023

Purpose of Paper

To provide the Board with an update on the work of the Quality and Safety Committee for the period of 24 January 2023 to 28 March 2023.

Committee:	Quality and Safety
Committee Chair:	Aliona Derrett
Meetings since the previous update on 24 January 2023:	02 February 2023,15:00 – 17:00 02 March 2023, 15:00 – 17:00
Overall objectives of the committee:	• To seek assurance that the Norfolk and Waveney system has a unified approach to quality governance and internal controls that support it to effectively deliver its strategic objectives and provide sustainable, high-quality care and to have oversight of local implementation of the NHS National Patient Safety Strategy. • To be assured that these structures operate effectively, that timely action is taken to address areas of concern, and to respond to lessons learned from all relevant sources including national standards, regulatory changes, and best practice. • To oversee and monitor delivery of the ICB key statutory requirements, including scrutiny of the robustness and effectiveness of its arrangements for safeguarding adults and children, infection prevention and control, medicines optimisation and safety, and equality and diversity. To ensure that patient outcomes from care are collected and

	measured, to inform outcomes-based commissioning for quality. • To review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to quality, and the delivery of safe, timely, effective, and equitable care. To consider the effectiveness of proposed mitigations and to escalate concerns to risk owners and operational leads/forums as agreed by Committee Members. • To approve ICB arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and secure continuous improvement in quality. To seek assurance that commissioning functions act with a view to supporting quality improvement; developing local services that promote wellbeing and prevent adverse health outcomes, equitably, across all patients and communities in Norfolk and Waveney.
Main purpose of meeting:	**02 February 2023:** regular meeting of the Committee covering all standing items plus the following focus areas: • Terms of Reference and System Quality Strategy • Risk focus on Ambulance Response Times and Neuro-Developmental Disorder Provision • System Serious Incident Report • Updates on the Local Maternity and Neonatal System (LMNS) and Adult Mental Health and Out of Area Placements • Approval of the updated ICB Adult Safeguarding Policy and System Quality Group Terms of Reference **02 March 2023:** regular meeting of the Committee covering all standing items plus the following focus areas: • Risk focus on Ambulance Response Times, NHS Continuing Health Care and Care Capacity, and Ophthalmology • Update on the NNUH Rapid Assessment and Treatment Service • Quarterly Research and Evaluation Report

BAF and any significant risks relevant / aligned to this Committee:	**Quality and Safety Committee BAF risks:** BAF01: Living with COVID-19 BAF02: System Urgent & Emergency Care BAF03: Providers in CQC 'Inadequate' Special Measures BAF04: Cancer Diagnosis and Treatment BAF05a: Mental Health Transformation Programme BAF05b: CYP Mental Health Transformation Programme BAF06: Health Inequalities BAF08: Elective Recovery BAF09: NHS Continuing Healthcare BAF10: EEAST Response Time and Patient Harms BAF19: Discharge from Inpatient Settings BAF20: Industrial Action Other risks aligned to the Committee have been reviewed against the new ICB Risk Management Matrix. All of these are aligned to the overarching BAF as noted above, except for the additional risks noted below: • Variation in BCG Immunisation Provision (**New**) • Eye Care (Ophthalmology) Waiting List • Deprivation of Liberty Safeguard Applications • LD & Autism Residential and Transition Provision • 12hr Mental Health Emergency Department Breaches • Neurodevelopmental Disorder Pathway • LD CAMHS Psychiatry Provision • Children's Speech and Language Therapies • Children's Podiatry • Digital infrastructure for Maternity Services • Local commissioning variations, including Adult Speech and Language Therapies, Community Neurology and Epilepsy Services and Post-Discharge Feeding Tube Support Committee noted the commitment across the system to formalise the sharing and alignment of risk registers across commissioners and providers.
Key items for assurance/noting:	**<u>February 2023</u>** **Terms of Reference and System Quality Strategy** Committee ratified the System Quality Group Terms of Reference and approved amendments made to Committee Terms of Reference ready for ratification at Board in March 2023. The draft 2022-2025 quality priorities will align with the strategic priorities of the ICB and shape the system's approach to quality by developing a system that has a culture of compassionate leadership, with a focus on improving care quality and outcomes and ensuring services are safe and

	sustainable, for now and for future generations, using insights around health inequalities and population to achieve fair outcomes. The strategy is due for Board discussion in March 2023, after which an operational implementation and resource plan set out governance, progress and success metrics and a rolling schedule of evaluation and continuous engagement. Listening to our public, patients, carers, and staff will be central to the development, delivery and evaluation of the strategy and they will be included in our further developments. **Ambulance Response Times** Committee received an overview of Serious Incidents relating to delayed ambulance conveyance, handover to Acute Care or transfer between facilities. The report described actions undertaken by the system to mitigate further harm and provided an update on systemwide workstreams and proposals to support safety in the Norfolk & Waveney area, as the system de-escalates from Critical Incident (26 January 2023), following an improvement in mean time for the most urgent ambulance conveyancing dispositions. Committee heard that delays continue to occur due to multiple factors, including patient flow and discharge challenges and this continues to be one of the highest risks to patient safety and staff wellbeing within the system, with a programme of mitigations in place to strengthen and promote pre-hospital pathways, improve patient flow, and standardise hospital emergency department handover processes. **Neuro-Developmental Disorder (NDD) Provision** Committee received an update that highlighted inequities in provision across the Norfolk and Waveney footprint, and the implications of service provision gaps on service quality, patient experience, and escalation of health and educational support needs. Procurement for additional waiting list initiatives has concluded, with feedback from young people and families informing how support will be offered. It is anticipated that approximately 500 young people will move off the waiting lists over the next 3-6 months. The ICB continues to support the development and dissemination of NDD resources for professionals and stakeholders and raise the profile of improvements and changes to service delivery. **System Serious Incident Report** Committee received an overview of all Serious Incidents reported by Norfolk and Waveney providers from 15/09/2022 to 31/12/2022, including a trend analysis, and mitigating actions. The most reported themes were treatment delay, outbreaks of infectious illness, slips, trips and falls and maternity and obstetric incidents.

	Local Maternity and Neonatal System (LMNS) The LMNS has a continued commitment to maintaining safe and personalised maternity care, supporting the service transformation required to take forward learning from the nationally commissioned reviews, including the Ockenden Review and is aligned to the Better Births vision for NHS Maternity Services. The update focused on local transformation work, the East Kent Kirkup Report and system-level safety and quality assurance. **Adult Mental Health and Out of Area Placements** Committee were briefed on proposed projects plans to extend existing provision at ACT Wellbeing Hubs to 24/7 and requested some assurance that a review of building accessibility is factored into the proposal, in response to some soft intelligence around challenges for some service users. Committee responded to the Recovery Action Plan for Out of Area Placements and noted a delay in progress based on the figures within the slides. Committee requested assurance that the action plan is being revisited and scheduled further discussion at a future meeting. Members noted that improvements in dementia diagnosis rates appear to vary over the Norfolk and Waveney localities and were provided with assurance from the ICB Mental Health Transformation Team that the new local provider collaborative is enabling joined up work across the system. **<u>March 2023</u>** **Ambulance Response Times** Committee were briefed on increased prevalence of reported incidents within the Great Yarmouth and Waveney area. The ICB Nursing & Quality Team is working with the Ambulance Trust to review reviewed a broader data set to understand if this is a coding or reporting issue or if it is a true variation that needs to be explored further. Learning from recent adverse incidents has highlighted failures of 'rapid release' implementation to enable Ambulance crew to deploy out to critical patients waiting in the community. The UEC Serious Incident Tactical Group has recommended that the EEAST 'delayed handover protocol' be recirculated across the three Acute Hospitals and Members requested assurance from system partners that this has been actioned. Committee reflected on the importance of ReSPECT documentation to empower people to make advanced plans in relation to emergency care at the end of their life, was highlighted. Committee noted that a system workstream is required to lead and drive this work forward.

	NHS Continuing Health Care and Care Capacity Committee were updated on the challenges around care provider capacity across Norfolk and Waveney and the impact on the ICB CHC Team's ability to plan and manage appropriate packages of care for eligible patients; particularly those with more complex needs. This impacts on patient experience as well as financial cost of care. Committee noted actions taken to help mitigate this risk, including collaboration with the local authorities to provide stability and joint decision making and development of a joint commissioning approach with NCC. Joint oversight of care cost pressures by the ICB Finance, Contracts and CHC Teams and recruitment to vacant posts within the ICB CHC Team are also expected to improve the position. It was noted how important this piece of work is as it links closely to the challenges with discharge. **Ophthalmology** An update was provided by the ICB Planned Care Team on the programme of work undertaken to address waiting list backlogs and delayed eye care clinic appointments, which have particularly impacted on cataract, medical retina, and glaucoma pathways. Committee were briefed on actions taken to improve access, including a risk-based focus on development of the most impacted pathways, risk stratification of backlog patients and delivery of additional appointment capacity. Failsafe measures have been put in place for high-risk glaucoma patients. Pathway redesign is commencing with cataracts, and the first draft of a new system-wide cataract service specification is underway, to standardise the conditioning of post-operative reviews and improve referral management across the whole system. **NNUH Rapid Assessment and Treatment Service** Committee received a briefing on the service put in place as an intervention to enable timelier handover of patients from ambulances into the NNUH Emergency Department. Committee recognised the value of commencing clinical review and work up more quickly and collaborative work between NNUH and EEAST has enabled this to improve patient experience and make a marked improvement in their performance against the national 4hr target. **Quarterly Research and Evaluation Report** The quarterly report captured progress within the design, development and management of research grants and primary care support around research participant recruitment. It highlighted the following additional systemwide activity taking place to develop the 5-year ICS Research and Innovation Strategy and funding grants won to support patient and public involvement in primary care research.

Items for escalation to Board:	No additional escalations were requested. See risks and issues noted above.
Items requiring approval:	Ratification of updated Committee Terms of Reference and approval of System Quality Strategy. Both items are scheduled for the March 2023 Board Agenda.
Confirmation that the meeting was quorate:	***Quoracy (as per Governance Handbook):*** *there will be a minimum of one Non-Executive Board Member, plus at least the Director of Nursing or Medical Director.* The February and March 2023 meetings were quorate, as defined above.

Key Risks	
Clinical and Quality:	This report highlights clinical quality and patient safety risks and mitigating actions.
Finance and Performance:	Finance and performance are intrinsically linked to quality, in relation to safe, effective, and sustainable commissioned services.
Impact Assessment (environmental and equalities):	N/A
Reputation:	See above.
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	The report supports the clinical quality and patient safety elements of the NHS Constitution.
Conflicts of Interest:	Committee member's interests are documented and managed according to ICB policy.

Norfolk and Waveney
Integrated Care Board

Agenda item: 15

Subject:	**Finance Committee Report**
Presented by:	**Hein van den Wildenberg, Non-executive Member, Finance Committee Chair**
Prepared by:	**Russell Pearson Associated Director of System Finance**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**28th March 2023**

Purpose of paper:

To provide the Board with an update on the work of the Finance Committee up to the 15th March 2023

Committee:	Finance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update	Last update provided: 24.01.2023 Subsequent Meetings: 31.01.2023 and 21.02.2023
Overall objectives of the committee:	The objective of the committee is to contribute to the overall delivery of the ICS objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan and strategy, consistent with the ICS Strategic Plan and its operational deliverables.
Main purpose of meeting:	To gain assurance on the financial position of the ICS and ICB.
BAF and any significant risks relevant / aligned to this Committee:	BAF 11 – Achieve the 2022/23 financial plan BAF 11A – Underlying deficit position
Key items for assurance/noting:	The points below follow from the February 2023 Finance Committee. The March Finance Committee falls on the same day as submission of board papers. Any relevant update from that meeting, will be provided verbally. **Part 1 (System overview)**

	• Per Month 10 (January 2023) NHS organisations in the ICS report an aggregate £ 15.7m deficit, £ 13.3m adverse against plan • As concluded in the report to the January ICB Board, the Finance Committee was not assured that the system would achieve an overall break-even position, and considered a financial deficit a realistic prospect. The current confirmed Forecast OutTurn (FOT) for the year now points to a £ 20m system deficit, the majority of which sits within James Paget University Hospital (JPUH). Main drivers for the deficit are operational pressures impacting the achievement of additional ERF (Elective Recovery Fund), and the staffing of additional capacity. It should be noted that (nearly) all NHS organisations in the ICS require significant use of so-called non-recurrent measures, which show the underlying strain on the finances. • The CFO of JPUH took the committee through its financial recovery plan, highlighting the underlying drivers of the deficit and productivity challenge from investments in recent years. • The Committee heard an update on capital expenditure (CDEL). The CDEL position per the end of January 2023 was an actual spend of £58.4m, £20.2m less than the year to date plan, largely a result of slippage/delays. The forecast outturn for the year suggests a CDEL position of £ 102.1m, some 3% more than the plan. • The Committee discussed the emerging financial plan for 23/24, which had already undergone challenge internally and by NHS England. The foreseen deficit at system level for 23/24 at that point in time was £55.7m. It also assumes significant risks are absorbed by each organisation. The committee will closely monitor these risks during next financial year. A triangulation between the finances, workforce and activity levels was not available at the time of the meeting. • The foreseen deficit will also necessitate financial recovery plans to be drawn up by more organisations in the system, and likely other governance arrangements. As this report to the Board is the last one of the financial year, please find a summary of spotlight topics covered this year:

	Spotlight on organisations: In its meetings since July 2022, the committee has engaged with the CFOs of the ICB, and each of the 5 providers: Queen Elizabeth Hospital King's Lynn, Norfolk and Norwich University Hospital, James Paget University Hospital, Norfolk Community Health and Care Trust, Norfolk & Suffolk Foundation Trust. The committee therefore receives a rolling financial update through the year from NHS providers and the ICB. Spotlight on topics: In its meetings since July 2022, the committee has engaged with stakeholders through spotlights on Mental Health Investment Standard, Discharge to Assess, Continuing Health Care, and Elective Recovery Fund and its financial implications. **Part 2 (ICB specific)** Per Month 10 (January) the ICB was reporting a break even year to date position. The Forecast OutTurn (FOT) position at the end of month 10 was also break even with a reported net risk to that position of £1.4m. The forecast efficiency delivery for the ICB was £10.0m, £0.3m better than the plan. The ICB makes significant use of non-recurrent benefits to achieve a break-even FOT. The ICB will leave the 22/23 financial year with a forecast underlying deficit of £59m. A paper explained the reasons for that. The current 23/24 plan is a break even position but £72m of mitigations have been used to achieve that position.
Items for escalation to Board:	The key elements for escalation to the Board are: - Forecast OutTurn for 22/23 at system level is a deficit of £20m - Emerging financial plan for 23/24 as presented to the February committee points to a significant deficit of some £56m
Items requiring approval:	
Confirmation that the meeting was quorate:	Confirmed the meeting was quorate.

Key Risks	
Clinical and Quality:	Not applicable

Finance and Performance:	It is important that there is scrutiny of financial management of the ICB and this function is performed by the Finance Committee.
Impact Assessment (environmental and equalities):	Not applicable
Reputation:	Ensuring effective committees and order of business essential for maintaining the reputation of the ICB
Legal:	Finance Committee is a statutory committee of the ICB.
Information Governance:	Not applicable.
Resource Required:	None.
Reference document(s):	Not applicable.
NHS Constitution:	Not applicable.
Conflicts of Interest:	Not applicable.

Norfolk and Waveney
Integrated Care Board

Agenda item: 16

Subject:	**Primary Care Commissioning Committee Report**
Presented by:	**James Bullion, Local Authority Member**
Prepared by:	**Sadie Parker, Director of Primary Care**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**28 March 2023**

Purpose of paper:

To provide the Board with an update on the work of the Primary Care Commissioning Committee for the February and March 2023 meetings.

Committee:	Primary Care Commissioning Committee
Committee Chair:	James Bullion, Local Authority Member
Meetings since the previous update on 24 January 2023	7 February 14 March
Overall objectives of the committee:	The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.
Main purpose of meeting:	To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care.
BAF and any significant risks relevant / aligned to this Committee:	BAF16 – the resilience of general practice Current mitigated score – 4x4=16 There is a risk to the resilience of general practice due to several factors including the ongoing Covid-19

	pandemic, workforce pressures and increasing workload (including workload associated with secondary care interface issues). There is also evidence of increasing poor behaviour from patients towards practice staff. Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. This will have a wider impact as neighbouring practices and other health services take on additional workload which in turn affects their resilience. This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services. BAF18– the transition and delegation of primary care services Current mitigated score – 3x4=12 Primary Care Services will become the responsibility of the Integrated Care Board from 1st April 2023, the risk is there will be a lack of additional capacity, resources and finance to effectively commission these services within existing ICB teams (Finance, Complaints, Quality, Workforce, Contracts and Delegated Commissioning) during and following the transition process, leading to a poor patient experience for our local population.
Key items for assurance/noting:	<u>February</u> • Providing General Practice Services in Norwich – Public Consultation • Learning Disability Health Checks • Severe Mental Illness Health Checks • Estates Quarterly Report • Care Quality Commission Reports on: ○ Heacham Medical Practice • Primary Care Commissioning Committee Self-Assessment Report • Prescribing Report • Finance Report <u>March</u> • Risk Register • Learning Disability Health Checks • Severe Mental Illness Health Checks • CQC report on High Street Surgery in Lowestoft • General Practice Contract Re-issue Project

	• Prescribing report • Finance report
Items for escalation to Board:	The resilience of general practice, summarised in BAF16 continues to be of concern in the system, despite the significant activity being undertaken (605,000 appointments in January, 47% same or next day and 76.4% face to face compared to 69.4% nationally). This is nearly 38,000 more appointments than delivered in January 2020 (pre-pandemic).
Items requiring approval:	<u>February</u> • Committee Self-Assessment <u>March</u> • None
Confirmation that the meeting was quorate:	Yes

Key Risks	
Clinical and Quality:	Care Quality Commission inspection reports are brought to committee meetings
Finance and Performance:	Finance reports are noted monthly
Impact Assessment (environmental and equalities):	N/A
Reputation:	The committee meeting is held monthly in public and includes membership from the Local Medical Committee, Healthwatch Norfolk and Suffolk and the Health and Wellbeing Boards in Norfolk and Suffolk
Legal:	Terms of reference, primary medical services contracts, premises directions and policy guidance manual
Information Governance:	Any confidential or sensitive information is heard in private
Resource Required:	Primary care commissioning team
Reference document(s):	Primary medical services regulations, statement of financial entitlements, premises directions and policy guidance manual, delegation agreement with NHS England
NHS Constitution:	N/A
Conflicts of Interest:	Arrangements are in place to manage conflicts of interest

Norfolk and Waveney
Integrated Care Board

Agenda item: 17

Subject:	**Performance Committee Report**
Presented by:	**Hilary Byrne**
Prepared by:	**Tessa Litherland**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**28 March 2023**

Purpose of paper:

To provide the Board with an update on the work of the Performance Committee for the period 19 January 2023 to 28 March 2023.

Committee:	Performance Committee
Committee Chair:	Hilary Byrne
Meetings since the previous update on 24 January 2023:	• 16 March 2023
Overall objectives of the committee:	1. Oversee the implementation of the IPR system as the primary source of performance metrics for the ICB Board, Performance Committee, Tier 3 and 4 Boards and Groups. 2. Assure NHSE/I of progress against SOF4 measures and improvement of SOF segmentation. 3. Assure the system and programme areas use benchmarking and best practice to improve areas of concern and drive ambition. 4. The Committee will require assurance from the Programme Boards in relation to delivery and highlighting any appropriate risks. Receive robust improvement/recovery plans from the Programme Boards for measures as set out in the 2023/24 priorities and operational planning guidance, including UEC, General Practice and Maternity national improvement plans and other key performance indicators.

Main purpose of meeting:	The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that ensures a high performing system. The Committee exists to scrutinise the robustness of and gain and provide assurance to the ICB regarding the delivery of key performance standards by commissioned providers, performance of the system against the NHS Outcomes Framework and progress with improving wider population health outcome measures.
BAF and any significant risks relevant / aligned to this Committee:	No BAF items currently aligned to this committee.
Key items for assurance/noting:	• Committee Objectives and forward workplan for 2023/24 agreed and signed off. • Progress on developing meaningful, useful metrics for each programme board continues, with escalation highlights through to Performance Committee. • Performance against SOF4 metrics reviewed. • Updates from SRO's for Elective Recovery, Urgent and Emergency Care, Cancer and Mental Health received.
Items for escalation to Board:	Items to note continuing pressures on: • 78 week wait year end position • Discharge pressures in UEC • 12hr mental health breaches remain challenged • Ambulance handover times remain challenged
Items requiring approval:	Nothing requiring approval.
Confirmation that the meeting was quorate:	Yes, meeting was quorate.

Key Risks	
Clinical and Quality:	Not applicable.
Finance and Performance:	It is important that there is scrutiny of performance and its management across the ICB and this function is performed by the Performance Committee.
Impact Assessment (environmental and equalities):	Not applicable.
Reputation:	Ensuring effective committees and order of business essential for maintaining the reputation of the ICB
Legal:	Performance Committee is a committee of the ICB.
Information Governance:	Not applicable.

Resource Required:	None.
Reference document(s):	Not applicable.
NHS Constitution:	Not applicable.
Conflicts of Interest:	Not applicable.

Norfolk and Waveney
Integrated Care Board

Agenda item: 19

Subject:	**Audit and Risk Committee Report**
Presented by:	**David Holt**
Prepared by:	**Amanda Brown, Head of Corporate Governance**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**28 March 2023**

Purpose of paper:

To provide the Board with an update on the work of the Audit and Risk Committee for the period 6 December 2022 to 9 February 2023.

Committee:	Audit and Risk Committee
Committee Chair:	David Holt, Non-executive Member
Meetings since the previous update on 24 January 2023	• 9 February 2023
Overall objectives of the committee:	This Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.
Main purpose of meeting:	The main purpose of the meeting: • **Deep dive discussion – ICB's readiness to delegate for assurances around controls and project management on Pharmacy, Optometry and Dentistry in-housing** The Head of Primary Care Commissioning and the programme lead for the transition of Pharmacy, Optometry and Dental (POD) Services presented to the meeting. The meeting discussed the key risks on the transition of these services. The risks include having sufficient staff with the

	requisite knowledge and experience to support the work that is transferring, the financial risk around management of services delegated to the ICB, and a risk that there will not be sufficient resources to manage performance and quality concerns. The ICB is also waiting to receive details about the information that is being transferred and noted that responsibility for primary care complaints will also transfer. These risks feed into the challenges around provision and patient expectations. The meeting also discussed how the Primary Care Commissioning Committee's role will be expanded to include all four primary care services. The committee will be supported by two delivery groups that will focus on primary medical services and dental services. The ICB will continue to work closely with NHS England colleagues in the region to ensure a safe transfer of responsibilities and staff from April 2023 and as far as possible work with other ICBs post April to share learning and mitigate risks. The meeting also noted that whilst there are challenges to be faced there are also opportunities to commission services differently which will take time to develop. • **Annual Report and Accounts (ARA)** The Associate Director for Communications and Engagement presented to the meeting to give an update on key messages for the ICB Annual Report and Accounts 2022-23. There will be two sets of ARAs this year as one will be for the final 3-month period of the former Norfolk and Waveney CCG and the ICB ARA will be for 1 July 2022 to 31 March 2023. The CCG report been drafted and is ready for final submission. The ICB report is being prepared and service leads being asked to provide narrative to go into the report. There will also be an engagement section linked to the performance report which will focus on the people and communities approach and include feedback from various parties. There will be high-level messages in the paper and also more specific information from service lines. The draft annual report will be shared with the executive management team and Board prior to submission to NHS England on 27 April. • **Internal audit**

	Since the last meeting the Conflicts of Interest audit has been completed and received reasonable assurance. There are several audits in progress and are due to be issued shortly. The ICB internal auditors confirmed that the draft Head of Internal Audit Opinion will be available in time for submission to NHS England on 10 March and that there are no areas of significant issue to raise. The situation with respect to outstanding audit recommendations is that there are currently only two overdue recommendations. • **Draft indicative audit strategy 2023/26 and annual plan** The draft plan was presented by internal audit to the meeting and discussed. It was agreed that the plan needs to reflect key issues the ICB might face and challenges in delivery and to have a more system focus. It was agreed that the draft plan would be presented at the committee's next meeting after there has been discussion with the executive management team. • **Anti-Crime Service Progress Report** A report summarising all counter fraud activity undertaken since the last meeting was presented. Work included ensuring that robust policies and procedures are in place and that conflict of interest matters are being addressed. A discussion also considered the issues posed by hybrid working and overlapping employment. • **External Audit Interim Plan – CCG audit** External audit presented this report to provide the committee with a basis to review the proposed audit approach and scope for audit. The plan summarised external audit's initial assessment of key risks and outlined planned audit strategy in response to those risks. There were no issues of materiality for the CCG report. The meeting was advised that materiality is ¼ for the CCG accounts and ¾ for ICB accounts. The ICB audit plan is to be presented to the next meeting. • **Losses and Special Payments – no new items for write off**

	There were no additional losses and special payments to raise at the meeting. Current losses and payments for the year equate to just under £36.5k. • **Conflicts of Interest Committee** The Conflicts of Interest Committee is a sub-committee of the Audit and Risk Committee which has responsibility to ensure that ICB policy and processes are in place and effective. The committee received a copy of the Conflicts of Interest committee's minutes and there was a discussion on conflicts of interest on-line training which has been withdrawn by NHS England. It is expected that training modules will be made available again by NHS England date to be confirmed. • **Board Assurance Framework (BAF)** The Director of Corporate Affairs and ICS development updated the meeting on work taking place on the BAF. The executive management team have reviewed all risks on the register and Board members have reviewed tolerated risks and risk appetite. A system audit chairs meeting took place in February at which the BAF was presented with a view to include wider system risks within the risk work. There is also work taking place to produce a system risk statement. • **Items for information** The Committee also received updates on the following matters: o Completed audit and risk committee self-assessment o Information Governance Work Group o Procurement update o Register of TIAA Client Briefings o Policy Status Report o Audit Committee Annual Plan o Report on any urgent Board decisions and non-compliance with the Standing Orders o Items from other committees
BAF and any significant risks relevant / aligned to this Committee:	The Committee has responsibility for oversight of the ICB risk management process and the whole Board Assurance Framework.
Key items for assurance/noting:	Deep dive review POD transition
Items for escalation to Board:	None

Items requiring approval:	No items for approval.
Confirmation that the meeting was quorate:	Yes

Key Risks	
Clinical and Quality:	Internal audit reports provide assurance on internal control processes
Finance and Performance:	The Committee monitors the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.
Impact Assessment (environmental and equalities):	None
Reputation:	The Committee supports the ICB reputation by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.
Legal:	It is a statutory requirement for the ICB to have an audit and risk committee.
Information Governance:	This Committee provides assurance to the Board that there is an effective framework in place for the management of risks associated with IG.
Resource Required:	None
Reference document(s):	None
NHS Constitution:	N/A
Conflicts of Interest:	The Committee is responsible for satisfying itself that the ICB's policy, systems and processes for the management of conflicts (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

Norfolk and Waveney
Integrated Care Board

Agenda item: 20

Subject:	**Conflicts of Interest Committee Report**
Presented by:	**David Holt**
Prepared by:	**Martyn Fitt, Corporate Affairs Manager**
Submitted to:	**Board**
Date:	**28 March 2023**

Purpose of paper:

To provide the Board with an update on the work of the Conflicts of Interest Sub Committee for the period 1 July 2022 to 17 January 2023

Committee:	Conflicts of Interest Committee
Committee Chair:	David Holt, Non-executive Member
Meetings since the previous update	• 17 January 2023
Overall objectives of the committee:	This Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.
Main purpose of meeting:	In addition to the standing items, the main purpose of the meeting was to brief and assure and the committee on the following items: **1.Conflicts of Interest general update for Qs 2 and 3** A detailed report was submitted to the Committee for assurance and scrutiny. The report covered the high priority areas noted within the ICB's Work Programme in respect of conflicts of interest compliance and updates on the delivery of these key milestones. The Committee was made aware of a risk that has emerged in relation to mandatory training following HEE's decision to remove training for COI nationally. • **2.Conflicts of Interest Policy breach consideration and decision**

	The Committee was presented with details and evidence in respect of a potential breach of the ICB's Conflicts of Interest Policy arising from an internal programme and contract award. An investigation was carried out drawing on the known facts of the case and pulling together a timeline and statements from those involved to enable members of the committee the opportunity to review all available information and evidence. The Committee was asked to consider and make a decision on whether the matter was such that it should be treated and recorded formally as a breach of the ICBs policy. Members had a full and rich debate regarding the matter and provided meaningful challenge to the investigating team. The Committee concluded the matter was a 'near-miss' and agreed with the learning and recommendations noted within the report. • **3. Observations in respect of the changes to primary care commissioning and impact on conflicts of interest** An item was raised under AOB by one of the Committees NEM's who also attends the ICB's Primary Care Commissioning Committee relating to concerns around the organisations ability to respond to the upcoming changes with the delegation of primary care and conflicts of interest considerations this presents.
	The Committee has responsibility for oversight of the ICB risk management process and the full Board Assurance Framework.
Key items for assurance/noting:	• Conflicts of Interest general update for Qs 2 and 3 • Conflicts of Interest Policy breach consideration and decision • Observations in respect of the changes to primary care commissioning and impact on conflicts of interest
Items for escalation to the Audit and Risk Committee:	The Conflicts of Interest Committee noted two matters for the Audit and Risk Committees attention: • The risk associated with Health Education England's decision to withdraw Conflicts of Interest Mandatory Training • The potential impact on the expansion of primary care commissioning to include P.O.D would likely have on how the ICB manages conflicts of interest
Items requiring approval:	No items for approval
Confirmation that the meeting was quorate:	Yes

Key Risks	
Clinical and Quality:	Internal audit reports provide assurance on internal control processes
Finance and Performance:	The Committee monitors the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.
Impact Assessment (environmental and equalities):	None
Reputation:	The Committee supports the ICB's reputation by providing oversight and assurance to the Committee and Board on the adequacy of governance and internal control processes within the ICB.
Legal:	It is a statutory requirement for the ICB to have an audit and risk committee.
Information Governance:	This Committee provides assurance to the Board that there is an effective framework in place for the management of risks associated with IG.
Resource Required:	None
Reference document(s):	None
NHS Constitution:	N/A
Conflicts of Interest:	The Committee is responsible for satisfying itself that the ICB's policy, systems and processes for the management of conflicts (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.