NHS Leicester, Leicestershire and Rutland Integrated Care Board

Board meeting
Friday 1 July 2022

Supplementary documents:
PACK A

CONTENTS

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Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

NHS

APPENDIX 1

LLR CCGs' Board Assurance Framework 2022/23

(Version 2 as at 27 June 2022)

To be read in conjunction with the Risk Management Strategy and Policy

CONTENTS **PAGE**

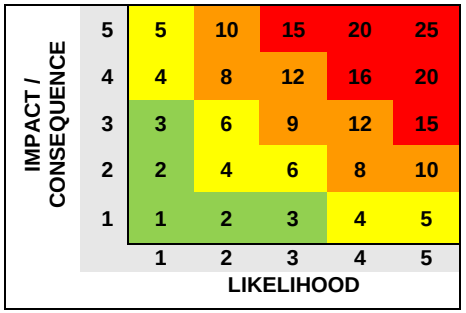
Definitions (as within the Risk Management Strategy and Policy, July 2020)

Areas	Definitions
Assurance	An evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework. The more measurable, verifiable and objectives an assurance is the stronger the declaration and source of evidence it is. The assurance must also be up to date. Effective assurance needs to be at two levels, internal and external
Board Assurance Framework	The Board Assurance Framework provides evidence that the Groups have systematically identified their objectives both strategically and operationally and manages its risks to achieving them. The framework systematically provides a vehicle for the identification of assurances and controls to risks and their effectiveness.
Cause	The reason for the risk to potentially occur.
Consequence	The results should the risk materialise.
Control	A measure put in place to mitigate a risk from occurring i.e. to prevent. Different types of control can be preventative, detective, directive and corrective.
Description	The way of explaining risk to allow consistent understanding across the Groups in a single sentence where possible i.e. think of the words preceding the risk 'There is a risk of' or There is a risk that' to put the risk in context.
Gaps in controls/ assurances	Where the residual risk does not meet the risk appetite, gaps in the controls and the assurances must be identified in order to reduce the residual risk as close as possible to the risk appetite.
Gross / Inherent Risk	Inherent risk is the effect of something that might happen before taking account of controls in place to manage or mitigate it. The higher the score, the more attention the risk will require and the more likely the LLR Governing Bodies would seek assurance as to how it was being managed whether directly or via a sub-committee.
Impact	A measurement of the effect the risk will have if it materialises.
Issue	Issue is something that has happened, as opposed to a risk which is something that could happen.
Likelihood	A measurement of the chance that a risk will materialise.
Mitigation Actions	These are the actions the risk owners take to reduce the risk or where this is not possible limit the impact of the risk.

Areas	Definitions
Net Risk	The measurement in terms of likelihood and impact on a risk after controls are considered to mitigate the risk. Used in the Groups on the Board Assurance Framework.
Objective	The context in which risks are assessed i.e. Groups Aims/Objectives
Operational risks	Operational risks are by-products of the day-to-day running of the CCGs and includes a broad spectrum of risks including clinical, fraud, security, financial and legal risks arising from employment law of health and safety.
Owner	Either the owner of the risk (risk owner i.e. Director) or owner of an action (action owner i.e. the completer on the assigned action by the risk owner).
Principal risk	Principal risks are defined as those that threaten the achievement of the CCG's principal objectives.
Register	A tool to capture and report on the risks identified at Department, Directorate or Corporate level.
Residual Risk	Another term for net risk.
Risk	ISO 31000:2009 defines risk as the "effect of uncertainty on objectives" and states that "risk is often expressed in terms of a combination of the consequences of an event and associated likelihood of occurrence"
Risk Appetite	An expression of the nature and quantum of risk or uncertainty which the organisation is willing to take or accept to achieve its strategic objectives. Risk appetite score may be a different for different objectives and / or different risk categories.
Risk Management	Risk Management is the process by which an organisation identifies risks, assesses their relative importance, determines the appropriate control mechanisms and ensures that the agreed action is taken. Risk management may involve judgement as well as data.
Risk Management Process	The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying and analysing, evaluating, treating, monitoring and communicating risk.
Risk Matrix	The tool used to as accurately as possible identify the appendix measurement of likelihood and impact of the risk identified.
Risk Tolerance	The threshold level of risk exposure which, when exceeded, will trigger an escalation.
Strategic risks	Strategic risks are those that represent major threats to achieving the CCG's strategic objectives or to its continued existence. Strategic risks will include key operational service failures, for example, failure to meet key targets or provision of poor-quality care would be very damaging to the CCG's reputation.

5 x 5 Risk Assessment Matrix (Risk Management Strategy and Policy)

IMPACT / CONSEQUENCE		LIKELIHOOD	
1	NEGLIGIBLE	1	RARE
2	MINOR	2	UNLIKELY
3	MODERATE	3	POSSIBLE
4	MAJOR	4	LIKELY
5	CATASTROPHIC	5	ALMOST CERTAIN



This will result in risks being rated in one of the following four categories

Risk score	Category
1 – 3	Low risk (green)
4 – 6	Moderate risk (yellow)
8 – 15	High risk (orange)
15 – 25	Extreme risk (red)

Key:

AW = Andy Williams, Chief Executive
NB = Nicci Briggs, Executive Director of Finance, Contracting and Corporate Governance
AM = Alice McGee, Executive Director of People and Innovation
SP = Sarah Prema, Executive Director of Strategy and Planning
CT = Caroline Trevithick, Executive Director – Nursing, Quality & Performance
RV = Rachna Vyas, Executive Director of Integration and Transformation

LLR CCGs' Strategic Objectives (as approved by the Governing Bodies in January 2021)

A. Increase the health outcomes of the Leicester, Leicestershire and Rutland population.
B. Reduce health inequalities across the Leicester, Leicestershire and Rutland population.
C. Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.
D. Deliver a sustainable system financial plan – ensuring funding is distributed to where services are delivered.
E. Deliver NHS Constitutional requirements
F. Develop and deliver services with providers that are evidenced based and offer value for money
G. Deliver integrated health and social care.

Summary of the LLR CCGs' Board Assurance Framework content (as at 27 June 2022)

Risk Ref (strategic objectives)	Risk theme	Exec Lead	Net /residual risk score (June 2022)	Page
LLR BAF 07 (A,B,C,F)	Emergency Preparedness, Resilience and Response (EPRR) arrangements	**RV**	6	8
LLR BAF 11 (A,B,C,E)	LLR CCGs will fail to meet core standards in relation to the delivery of the cancer targets	**RV**	20	12
LLR BAF 13 (D,E)	Failure to assure local health economy financial viability over the next 5 years	**NB**	12	15
LLR BAF 17 (A,B,C,D,E,F,G)	Cyber Security risk - the impact from new and previously unknown cyber threats is potentially significant across all LLR organisations.	**NB**	12	17
LLR BAF 18 (E)	Ambulance Handover delays **-** concerning ambulance handover delays and cancellation of elective activity	**RV**	16	20
LLR BAF 19	The 104 week wait standard not being met primarily due to Covid-19, increased pressures in the system relating to workforce capacity, sickness absence and theatre capacity across providers resulting in poor patient experience and a potential deterioration in health of patients.	**RV**	20	23
LLR BAF 20	There is high demand for GP appointments which continues to exceed availability of appointments due to variety of factors. This could result in the risk of patients being unable to access appointments and seeking alternatives placing pressure on other services.	**RV**	20	26
LLR BAF 21	CCGs' Workforce capacity and ability to retain staff to enable delivery of the strategic objectives and key services during the transitional phase and into the Integrated Care Board. **(archived on 27 June 2022, consideration is being given to workforce risk across the system).**	**AMc**	**Archived**	

Risk Ref: **LLR BAF 07**	**Risk Description: Emergency Preparedness, Resilience and Response (EPRR) arrangements** There is a lack of systematic and continuous processes in place for Emergency Preparedness, Resilience and Response (EPRR) and as a result the LLR CCGs are less resilient to respond to an emergency and to provide safe patient care. This may result in financial loss and legal consequences if the LLR CCGs are unable to comply with national NHS EPRR Core Standards.

Section A **A1. Strategic objective the risk is aligned to.**	**A3. Risk to be treated, confirm frequency of review by lead**		**Section B**		**Section C** **Risk rating (impact x likelihood = risk score)**						
Strategic Objectives E	*Monthly*	*Quarterly* ✓	**B1. Executive Lead (risk owner):**	**Rachna Vyas** **Risk Lead:** Amita Chudasama	**C1. Gross/inherent risk score**	**5**	**x**	**4**	**=**	**20**	**R**
A2. Date risk identified.	**A4. Risk Category**		**B2. Date last reviewed**	May 2022	**C2. Net/residual risk score**	**3**	**x**	**2**	**=**	**6**	**Y**
					C3. Risk appetite score	**2**	**x**	**2**	**=**	**4**	**G**
Carried forward from CCG specific BAFs 2020.	**Clinical**	✓	**B3. Committee/Group with oversight for risk?**	Executive Management Team (EMT)	**C4. Risk Treatment:** *(Terminate, Treat, Transfer, or Tolerate)*	Treat					
	Organisational	✓									
	Financial				**C5. Date current/residual score assessed**	June 2022					
	Information										

Section D: Key Controls

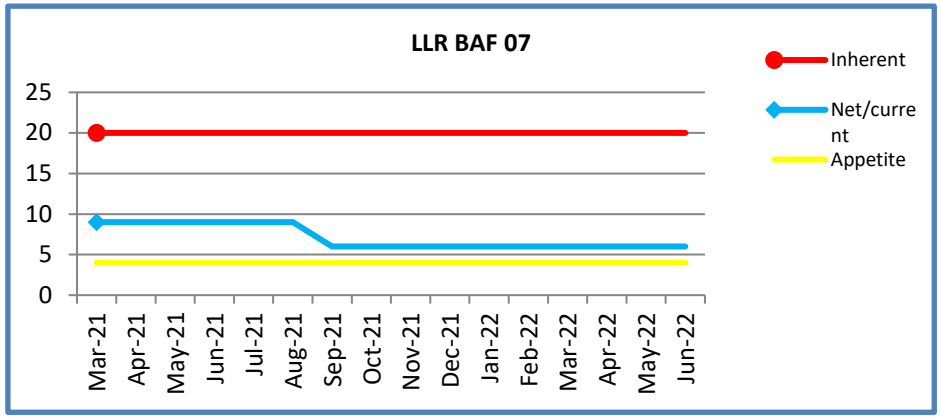
- LLR On Call Pack documents, plans and policies updated May 2022 including LLR Incident Response Plan.
- Reinstated the Local Health Resilience Partnership (LHRP) at executive and working group level.
- Creation of 2 new EPRR Groups – Health Emergency Planning Operational Group (HEPOG) to undertake and oversee actions from the LHRP meetings and a Health EPRR Risk Management Group to assess local health risks and priorities and establish a system risk register for EPRR.
- Testing of business continuity plans and emergency planning
- Final assessment of EPRR Core Standards received and CCGs were assessed as substantially compliance with a action plan in place to address issues as highlighted by NHSEI.

Section E: Rationale for current score

Given the key controls in place and the net/residual risk score remaining the same this risk would normally be de-escalated, however given the additional EPRR duties that will need to be met once the transition to an ICB has taken place there is a requirement for visibility at Governing Body level of EPRR level risks and hence this remains on the BAF.

- COVID Incident Command controls remain in place. Additional staffing requirements identified to enable the additional EPRR functions at ICB level to be met.
- Continue to review COVID Governance in line with government guidance. Arrangements. The HETCG meetings have been stepped down to a fortnightly basis to maintain oversight of COVID and case numbers as well as progression of the COVID vaccination and booster.
- Attendance at LHRP Executive continues with senior level staff in attendance at all meetings.
- Ongoing meetings with NHSE/I are in place with regards to how the EPRR Core Standards process will operate following a move to ICS status.
- 2021-22 Core Standards submitted. Confirm and Challenge exercise carried out with NHS England Regional EPRR Team. Update on Core Standards declaration will be presented to Governing Body in April 2022.
- ICB transitions meetings taken place and actions identified with the regional EPRR Team and progression being made to meet deadlines.
- EPRR ICB Transition checklist submitted to NHSE/I and follow up meeting held with Regional Head of EPRR - CCGs have been Rag rated green against readiness to operate as an ICB for EPRR.

Section F: Current risk score trend



Section G: Internal and/or external assurances

Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?

	Internal	External
External verification of level of compliance provided by NHS England on annual basis (June 2022) (positive assurance received).		✓
Guidance and checklist from National EPRR Team regarding transition to ICB received on 31st March 2022. Actions now being progressed as detailed below.		✓
LHRP work plan and meetings with NHS England in place.		✓
ICB Checklist and evidence	✓	✓
Updated showdown ICB plans and policies	✓	

Section H: Actions being taken to address gaps in controls and/or assurance

H1. Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the CCG failing to gain evidence that the controls/systems are effective?*	H2. Details the actions to be taken *(including brief note on updates/progress where appropriate and confirm when action completed) What actions are required to bridge the gaps in controls and/or assurance?*	H3. Action to be completed by (date)	H4. Will the action reduce impact of risk score or likelihood or both?		
			Impact	Likelihood	Both

Table-top exercise yet to be arranged to test the Business Continuity Plans across LLR CCGs	Exercise to be arranged by the EPRR Team along with the Corporate Governance Team. However, it is noted that the arrangements have been / continue to be tested through the pandemic. This has not taken place given the delay in the revised Business Continuity Plans	**Ongoing**			✓
Individual directorate and team business continuity plan to be developed that support home based and agile working arrangements.	Business Continuity template produced and supported by EPRR Team. The revised directorate BC plan templates circulated by the Corporate Governance Team. Directorates to complete and return templates by end of June 2022.	**June 2022**			✓
The regional NHSE/I EPRR Team is awaiting formal notification from the national team with regards to a refresh of the Civil Contingencies Act and whether the LLR CCGs will formally be upgraded to Cat 1 responders. We have now received the formal letter and ICB Readiness for EPRR checklist from the regional NHSEI EPRR Team. This states that ICBs will become Category 1 responder under Civil Contingencies Act 2004. The letter sets out the requirements for ICBs in fulfilling their legal duties from 1 July 2022.	Actions are already progressing to ensure readiness for 1 July 2022 and a formal update presented at the April Governing Body meeting. ICS Transition Action Plan is in place. The AEO EPRR identified staffing needs. On 31st March 2022 the Regional EPRR requested completion of a self-assessment assurance template to RAG rate ICB EPRR Readiness Assurance, the submission was made on 4th April 2022. Following this a meeting was held between the Regional Head of EPRR and the ICB AEO for EPRR and the EPRR and Operational Resilience Manager to discuss: • Governance arrangements, • Training and exercising • ICB Incident Response Plan • EPRR resourcing including staffing Following this meeting a further request has been received from the regional EPRR Team to provide an update and evidence against the ICB assurance template, the submission deadline is 27th May 2022.The EPRR Team is currently collating all the relevant evidence required and are on track to complete this within the timeframe. The RAG rating is split into 2 sections – Part A for the position as at 17 June 2022 - an overall RAG rating of green will be submitted for this. Part B focuses on longer-	**July 2022**			✓

	term steps for delivery between October-December 2022, these are on track however currently will be RAG rated Amber as several actions are required from NHSEI before the ICB can put in place final plans and actions. The Regional EPRR Team have also requested a copy of the Incident Response Plan to review by 31 May 2022. Once this document has been finalised a desktop exercise to walk through the plan will be carried out in conjunction with NHSEI, and system partners to ensure all process within the plan are operational and to capture any feedback before the Incident Response Plan is finalised.				
	Updated Major Incident Plan submitted to NHSE/I and sent for consultation to partners and providers and will be exercised on 24th June.	**June 2022**			

Risk Ref: LLR BAF 11	**Risk Description: Meeting the core standard relating to cancer targets** There is a risk that the CCG will fail to meet core standards in relation to the delivery of the cancer targets especially due to the COVID-19 pandemic where a wide range of activity ceased. This further exacerbated by insufficient capacity within UHL and inadequate systems and processes. This may result in potential risk to patients as a result of any delays in diagnosis, which could lead to patient harm, poor patient experience and reputational impact on the LLR CCG.

Section A **A1. Strategic objective the risk is aligned to.**	**A3. Risk to be treated, confirm frequency of review by lead**		**Section B**		**Section C** **Risk rating (impact x likelihood = risk score)**						
Strategic Objectives A, B, C, E	*Monthly* ✓	*Quarterly*	**B1. Executive Lead (risk owner):**	**Rachna Vyas** **Risk Leads:** Helen Mather Catherine Headley Kirsty Tite Laura Sharpe	**C1. Gross/inherent risk score**	**5**	**x**	**4**	**=**	**20**	**R**
A2. Date risk identified.	**A4. Risk Category**		**B2. Date last reviewed**	May 2022	**C2. Net/residual risk score**	**5**	**x**	**4**	**=**	**20**	**R**
					C3. Risk appetite score	**2**	**x**	**2**	**=**	**4**	**G**
Carried forward from CCG specific BAFs 2020.	**Clinical**	✓	**B3. Committee/Group with oversight for risk?**	System Operational Planning Group	**C4. Risk Treatment:** *(Terminate, Treat, Transfer, or Tolerate)*	Treat					
	Organisational				**C5. Date current/residual score asses**	June 2022					
	Financial										
	Information										

Section D: Key Controls

- COVID-19 Action Plan in place.
- Weekly cancer monitoring dashboard distributed across the system.
- Monthly cancer performance meeting with CCG Contracting Team and UHL.
- Action plan reviewed at Cancer Design Group on monthly basis. Quarterly review of actions at Systems Operational Group and EMT. Performance improvement trajectory in place.
- Harm review process in line with NHSE/I Backstop Policy.
- Quality Surveillance Group in place.
- Clinical Quality Review Group in place.
- Annual Cancer Patient Experience Survey undertaken.
- Regional post COVID-19 performance review.

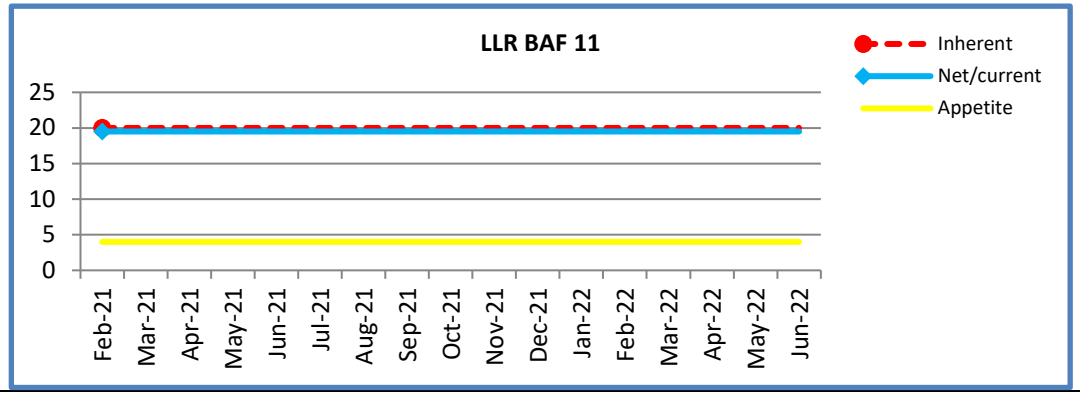
Section E: Rationale for current score

Cancer patients have been prioritised throughout the COVID-19 pandemic by the system, but the current acute pressures have created an even greater significant risk in this area. There is the highest likelihood of some performance targets not being met and with the delay in treatments there is a significant risk for patients. The impact and likelihood of this risk are both at the highest level currently.

Within the restoration and recovery phase, addressing the backlog will have an impact on our ability to achieve some of the targets specified. Given the capacity in the acute trust, our performance is likely to be negatively impacted as we action the backlogs and therefore the risk rating stands as it is. 2WW numbers are a concern due surge in referrals which is continuing, this is especially causing pressure in Breast, Head & Neck, ENT & Skin.
Interim reconfiguration is currently taking place which is providing additional estate for some services. Changes in IP are resulting in additional capacity and reduction in waiting times. RDP programme initiated with direct links to performance improvement.

- CCG staff have been supporting and working collaboratively with UHL to look at options and opportunities to support and improve capacity.
  - This has included working with the Pharmacy team to unblock barriers to increasing capacity within the provision of Chemotherapy at home and the utilisation of cancer funding to support additional diagnostic capacity.
- Focus on the high-volume tumour sites with the CCG supporting Urology (for example) in identifying short-medium and long-term transformational goals, together with monitoring of 2WW referrals and analysis of shortfalls in expected levels of activity.

Section F: Current risk score trend



Section G: Internal and/or external assurances

Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?

	Internal	External
• Individual cases are risk assessed prior to cancellation and prioritised for rescheduling to minimise the risk to patients.	✓	
• Weekly 104+ day wait patient review.	✓	
• Weekly monitoring of the backlog position for 62 day and both 31-day standards.	✓	
• 2WW targets are being met together with the Faster Diagnosis Standard. Patients who are being referred on 2WW pathways are being assessed and diagnosed or cancer excluded in a timely and efficient way. There has not been an impact in delay in diagnosis for patients who have presented with concerning symptoms AND been referred. UHL have undertaken significant work to ensure that this is achieved.	✓	✓

Section H: Actions being taken to address gaps in controls and/or assurance

H1. Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the CCG failing to gain evidence that the controls/systems are effective?*	**H2. Details the actions to be taken** *(including brief note on updates/progress where appropriate and confirm when action completed) What actions are required to bridge the gaps in controls and/or assurance?*	**H3. Action to be completed by (date)**	**H4. Will the action reduce impact of risk score or likelihood or both?**		
			Impact	**Likelihood**	**Both**
Capacity constraints allied to staffing vacancies across the Trust.	• UHL demand and capacity modelling exercise is being refocussed post COVID-19. • Theatre utilisation is being refocussed post COVID-19. • Review alternative skill mix/support to free up critical roles (Radiology, Oncology and Skin).	**Review Ongoing**			✓

	• Maximise efficiency – ongoing programme. • Review provision of robotic urology and general urology services. This is being supported by Specialised Commissioning as responsible commissioners for Robotic Prostatectomy surgery. • Next Steps – ensure patients on a 62-day pathway know what the next step is in their pathway is and when. • Working with Midlands Region to develop alternatives to Endoscopy e.g., CT Colon, FIT Testing and Capsular Endoscopy. • Independent sector and mutual aid activity plan has been developed to support restoration and recovery				
The capacity for the restoration of services is coming online. Patients previously referred to the hub have been retracted as capacity is in place internally.	As from the 1 April we should see 50% capacity returning and expect to see an improving position. Capacity back to pre-COVID levels but IPC constraints result in reduced levels of activity. Update in February stated that Capacity particularly breast, ENT, Urology is still a significant issue. Interim reconfiguration is currently taking place, which is providing additional estate for some services, including urology. Changes in IP are resulting in additional capacity and reduction in waiting times, this includes ENT.	**Review Ongoing**			✓
Cancer and urgent time critical surgery is a focus, although the number of cancelled procedures is significantly reducing. Thorough process of waiting list validation is in place: • Activity plans agreed with Independent Sector (IS) for 21/22 for Nuffield and the Spire and patients currently being booked, additional IS activity from Ramsay Grp, hospitals Fitzwilliam at Peterborough, Woodthorpe in Notts and Woodlands in Kettering to support recovery. In addition, it has been requested that Northants continue with support to take TURBT (trans urethral resection of bladder tumour), whilst UHL take complex tertiary referrals.	A LLR CCG team have developed communications for primary care to support patients waiting; discourage GPs trying to expedite patients and to encourage referrals and provide an up-to-date situation report on the latest cancer performance. PTL lists are being monitored consistently and all options are being considered and utilised where possible and appropriate to ensure patients are being treated in priority order. Regional meeting on mutual aid in Urology has taken place. All avenues are being explored with alternative providers. Additional estate provided for urology should have a positive impact on the pressure.	**Ongoing review of backlogs and performance on a monthly basis**			✓

Risk Ref: LLR BAF 13	**Risk Description: Financial viability over next 5 years** There is risk that due to a lack of robust information and tested schemes, the financial viability of the local health economy (over the next 5 years) cannot be assured. As a result, this could impact on the LLR CCGs' organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.

Section A **A1. Strategic objective the risk is aligned to.**	**A3. Risk to be treated, confirm frequency of review by lead**		**Section B**		**Section C** **Risk rating (impact x likelihood = risk score)**						
Strategic Objectives D, E	*Monthly* ✓	*Quarterly*	**B1. Executive Lead (risk owner):**	**Nicci Briggs** **Risk Lead:** Spencer Gay, Gill Killbery	**C1. Gross/inherent risk score**	**5**	**x**	**4**	**=**	**20**	**R**
A2. Date risk identified.	**A4. Risk Category**		**B2. Date last reviewed**	May 2022	**C2. Net/residual risk score**	**4**	**x**	**3**	**=**	**12**	**A**
					C3. Risk appetite score	**4**	**x**	**2**	**=**	**8**	**A**
Carried forward from CCG specific BAFs 2020.	**Clinical**		**B3. Committee/Group with oversight for risk?**	LLR Finance Committee – as part of the Integrated Care Board Governance	**C4. Risk Treatment:** *(Terminate, Treat, Transfer, or Tolerate)*	Treat					
	Organisational	✓									
	Financial	✓			**C4. Date current/residual score assessed**	June 2022					
	Information										

Section D: Key Controls

- Monthly triangulation meetings take place between contract teams which is followed by Commissioner update meetings.
- There is a 5 Year economy financial plan in place to address the identified LLR financial gap however this needs to be updated to reflect the current financial regime and allocations available to the system
- System Financial Strategy Produced for 2021/22 – 2023/24
- Balanced financial plan for 2022/23 submitted on 20 June 2022
- System Finance Team monitor the system position and provide monthly reports to LLR ICB Finance Committee. This includes review of the LLR CCG's financial plans to ensure consistency.
- Design Groups continually working with PMO to construct transformation plans which will support financial improvement

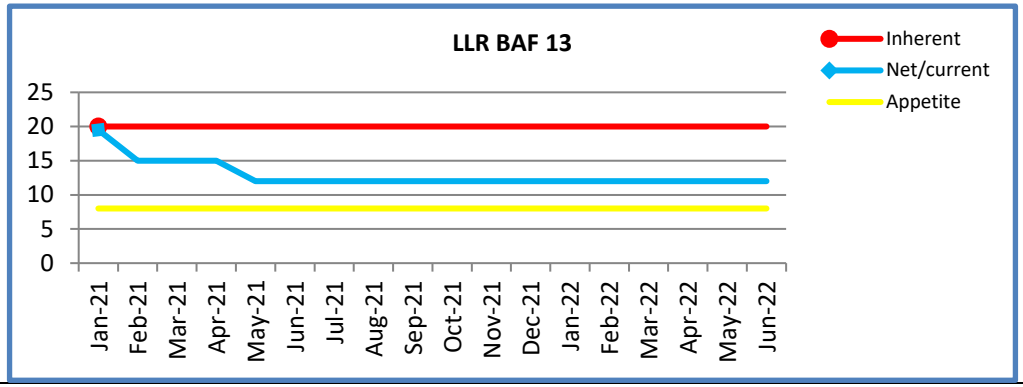
Section E: Rationale for current score

There are number of elements that contribute to the rationale for the current score. Due to the COVID-9 pandemic a historical position was adopted as a guide to the LLR CCGs' planning for the future position. This recognised the significant deficit for UHL and CCG deficits in 2019/20.

The future financial regime and levels of funding are now emerging, and long-term planning with be refreshed following final submission of the 21/22 plan.
The biggest challenge to delivery and reducing this risk further will be the level of cost efficiencies built in over the time-period. The LLR ICB will need to start delivering significant savings and continue throughout the period.

Current focus on the management of high levels of emergency activity and elective backlog are potentially impacting on the underlying position moving forward, while also delaying transformational projects. This is increasing the risk to the achievement of system breakeven in 4 years.

Section F: Current risk score trend



Section G: Internal and/or external assurances

Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?

	Internal	External
~~Auditors~~ External Financial performance reports are reviewed monthly as part of Board Reports		✓
Internal and External Auditor reports and findings are in place (integrity of the General Ledger and Financial Systems Report 2020/21 provided significant assurance).		✓
System operational group, NHS Strategic Executive and CFOs – overview of financial position and emerging plans	✓	

Section H: Actions being taken to address gaps in controls and/or assurance

H1. Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the CCG failing to gain evidence that the controls/systems are effective?*	**H2. Details the actions to be taken** *(including brief note on updates/progress where appropriate and confirm when action completed) What actions are required to bridge the gaps in controls and/or assurance?*	**H3. Action to be completed by (date)**	**H4. Will the action reduce impact of risk score or likelihood or both?**		
			Impact	**Likelihood**	**Both**
Review of medium term plan.	Position against medium term plan will be reviewed once 2022/23 plan is finalised.	~~**June 2022**~~ **August 2022**			✓

Risk Ref: LLR BAF 17	**Risk Description: Cyber Security** There is a risk that due to a significant rise in new and unknown cyber-attacks (locally or nationally) this could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.

Section A **A1. Strategic objective the risk is aligned to.**	**A3. Risk to be treated, confirm frequency of review by lead**		**Section B**		**Section C** **Risk rating (impact x likelihood = risk score)**							
Strategic Objectives A,B,C,D,E,F,G	*Monthly* ✓	*Quarterly*	**B1. Executive Lead (risk owner):**	**Nicci Briggs (as SIRO)** **Risk Lead:** Chris Biddle (LHIS)	**C1. Gross/inherent risk score**	**4**	**x**	**4**	**=**	**20**	**R**
A2. Date risk identified.	**A4. Risk Category**		**B2. Date last reviewed**	May 2022	**C2. Net/residual risk score**	**3**	**x**	**4**	**=**	**12**	**A**
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October 2020	**Clinical**		**B3. Committee/Group with oversight for risk?**	Executive Management Team (EMT)	**C4. Risk Treatment:** *(Terminate, Treat, Transfer, or Tolerate)*	Treat					
	Organisational	✓									
	Financial	✓			**C5. Date current/residual score assessed**	June 2022					
	Information	✓									

Section D: Key Controls

- Network boundary protection (firewalls) using multi-tiered approach.
- Internal counter measures such as Advanced Threat Protection (ATP), Sophos Anti-Virus, Intercept-X anti-ransomware, 'honeypot' alerting system, etc.
- Change controls and policy/procedure framework for operation of security platforms.
- Alerting and intrusion detection systems in place.
- Routine and cyclical technical security testing of network boundaries.
- Independent assessment of security posture (e.g. Bitsight = top 10% of healthcare organisations).
- Assurances through cyber security governance frameworks (e.g. ISO27001, Data Security Protection Toolkit, SPT, etc).
- Established and tested incident response procedures
- Continuity and disaster recovery plans in place.
- Monitoring of security alerts and information published through credible routes (e.g. NHSDigital CareCERT, SANS).

Section E: Rationale for current score

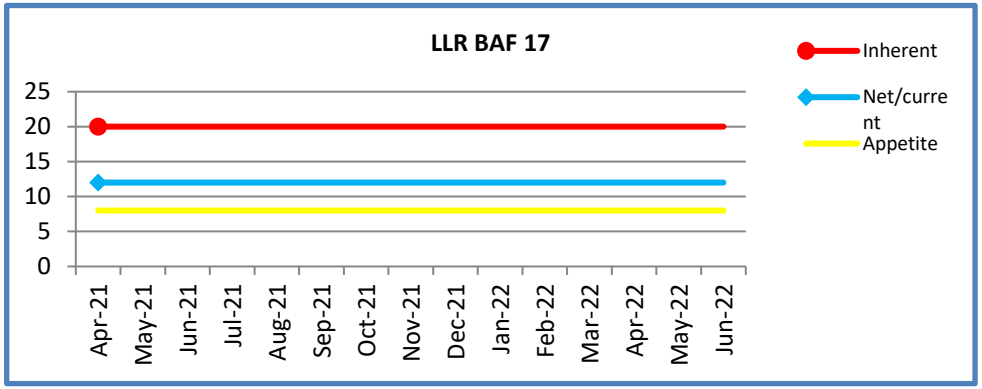
There are no changes to the risk scoring and monitoring of the risk continues as this reflects the current pandemic response and an increased reliance on remote working technologies. A major national NHS systems outage in January 2021 highlighted the need for robust and tested local continuity plans to provide assurance that clinical services can continue to operate, especially in 'out of hours' scenarios.

Geopolitical situation in Ukraine has heightened the threat profile of attack on UK's IT infrastructure. Although it is unlikely that healthcare will be directly targeted, adverse events affecting national infrastructure could have a collateral effect on NHS national systems.

An established process is in operation for addressing and remediating vulnerability alerts from NHS Digital. No outstanding issues are present and feedback reporting through the NHS Digital portal provides assurance that all notified alerts have been considered.

- LHIS has subscribed to the Police Cyber Alarm platform which provides alerts to potentially malicious activity on our network boundary.
- LHIS continues to conduct security testing of various estate-wide services.
- Moved to NHS Mail
- Subscribed to the NCSC Early Warning System which adds an additional layer of monitoring to our external network boundary.
- Active directory audit being planned
- Ransomware simulation being planned
- NCSC desktop simulations underway

Section F: Current risk score trend



Section G: Internal and/or external assurances

Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?

	Internal	External
Routine technical security testing	✓	
External evaluation of security posture (e.g. Bitsight)		✓
Audit reviews of security and governance frameworks (e.g. ISO27001, DSPT) (Internal Audit Review on DSPT 2020/21 provided significant assurance).		✓
Incident response to threats/attacks (i.e. was the attack successful) (assurance provided indicates controls are effective).	✓	
External security testing of LLR networks		✓
LHIS has attained a Tiger scheme penetration testing accreditation (positive assurance).	✓	✓

Section H: Actions being taken to address gaps in controls and/or assurance

H1. Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the CCG failing to gain evidence that the controls/systems are effective?*	**H2. Details the actions to be taken** *(including brief note on updates/progress where appropriate and confirm when action completed) What actions are required to bridge the gaps in controls and/or assurance?*	**H3. Action to be completed by (date)**	**H4. Will the action reduce impact of risk score or likelihood or both?**		
			Impact	**Likelihood**	**Both**
Efficacy of local continuity plans for service provision in the event of a successful cyber-attack, preventing access to IT systems (including VPN) for an extended period (e.g., days).	Acquire assurance, through testing, that local service continuity plans are established and are operating as expected (i.e., service provision is not affected by outage).	**End September 2022**			✓

Ability of LHIS to respond effectively to 'zero-day' and new threats that have not been previously identified.	Test incident response and disaster recovery procedures. This work has started but further work is being planned during Q2. Output to be reported.	**End September 2022**			✓
Log4J vulnerability which was published in December 2021. This is a major issue as this piece of code is present in many computer systems and a very serious vulnerability has been found which could allow an attacker to remotely exploit the computer/network running the software.	Remediation is ongoing and many patches and compensating controls have been deployed as part of the response. Risk profile is currently considered low, as a result of the actions taken.	**June 2022 COMPLETE**			✓
New technical vulnerabilities and risks are identified without adequate remediation plans.	Additional external technical security testing has been commissioned which includes external attack surface review, ransomware simulation, registration with NCSC Web Check and Active Directory review.	**Review December 2022**			✓
Geopolitical situation in eastern Europe - The current conflict in Ukraine has heightened the likelihood of attack by Russian state actors. Although it is unlikely that UK healthcare will be specifically targeted, there is a significantly increased likelihood of attack on UK government infrastructure which could have a collateral impact on the NHS, specifically in relation to nationally hosted services	Additional controls have been deployed to strengthen our local security posture. Increased frequency of external security testing Reduction in timescales for inactive user accounts Backup/restore testing conducted Additional 'honeypot' platforms deployed Geo-blocking under review	**August 2022**			✓

Risk Ref: LLR BAF 18	**Ambulance Handover Delays:** Ambulance handover times not being met due to increased pressure across the system, resulting in risks to assessing patients in the community, risks to patients that are delayed on the back of ambulances and risks to patients that require an elective procedure due to cancellations as a result of capacity.

Section A **A1. Strategic objective the risk is aligned to.**	**A3. Risk to be treated, confirm frequency of review by lead**		**Section B**		**Section C** **Risk rating (impact x likelihood = risk score)**						
Strategic Objectives E	*Monthly*	*Quarterly* ✓	**B1. Executive Lead (risk owner):**	**Rachna Vyas** **Risk Leads**: Sarah Lavin, Leena Tailor	**C1. Gross/inherent risk score**	**5**	**x**	**5**	**=**	**25**	**R**
A2. Date risk identified.	**A4. Risk Category**		**B2. Date last reviewed**	May 2022	**C2. Net/residual risk score**	**4**	**x**	**4**	**=**	**16**	**R**
					C3. Risk appetite score	**2**	**x**	**3**	**=**	**6**	**Y**
Carried forward from CCG specific BAFs 2020.	**Clinical**	✓	**B3. Committee/Group with oversight for risk?**	Executive Management Team (EMT)	**C4. Risk Treatment:** *(Terminate, Treat, Transfer, or Tolerate)*	Treat					
	Organisational	✓			**C5. Date current/residual score assessed**	June 2022					
	Financial										
	Information										

Section D: Key Controls

- Improvement at the point of handover including rapid handover and potential development of a pre-transfer area to allow flow through ED and minimise patents awaiting on back of ambulances.
- Monitor and maintain conveyance rates to ensure appropriate pathways are being utilised rather than ED as a default.
- LLR CCG signed up to the ambulance improvement collaborative focused on opening transfer of EMAS calls into urgent community response.

Section E: Rationale for current score

Due to current ambulance handover delays significant risk is being held in unsighted patients in the community. Patients are also spending significant time remaining on ambulances for 2+hours which increases the likelihood of deterioration for a patient who will be at greater risk of clinical conditions such as pressure sores. This may have further consequences for a patient such as a potential increased length of stay. An inherent/ gross score of 25 is assigned to this risk to reflect the cumulative impact a patient.

Work is underway to ensure patients are seen at the correct place and alternative locations where patients can be seen efficiently to avoid ED so that ambulance handover times are met to avoid delays. Additional services such as SDEC for Ambulances and transfer of EMAS calls into urgent community response will reduce the risk. Greater focus around daily discharges by midday will assist with patient flow to help treat the risk.

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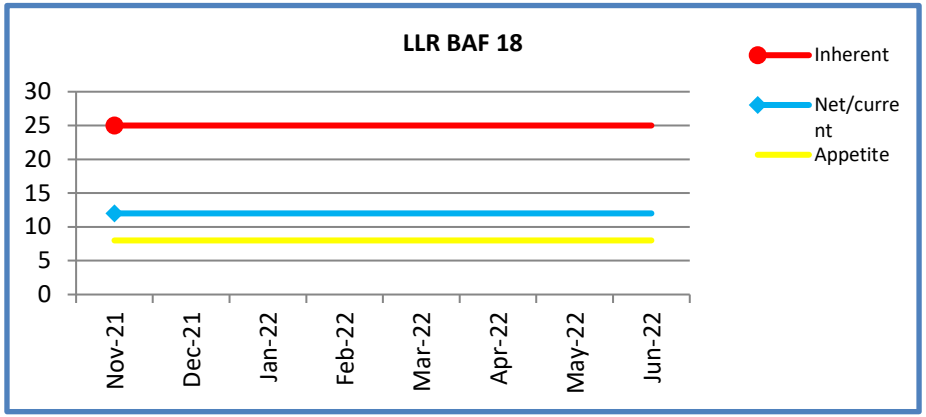
- Work has progressed to improve access to 'same day emergency care' (SDEC) from ~~to~~ EMAS, to also include 111 patients to medical and cardiorespiratory and PE SDEC's.
- The system focus is on flow and discharge of which if delivered consistently should assist with ambulance handover delays.
- Daily Flow Escalation Call – to ensure figures and actions are completed and on track.
- System Quality Team working closely with the UHL EMAS Quality Leads to complete harm reviews.
- LLR system is part of the Emergency Care Improvement Support Team (ECIST) designed to assist with urgent community response case access to EMAS stack management.
- CCG EMAS quality leads reviewing access to primary care for EMAS to improve waiting times for crews on scene calling practices, currently a process is in place with GP back door numbers provided, however concerns have been raised that advice from GPs is inconsistent and not in line with admission avoidance. Primary Care are updating backdoor numbers to be shared with UHL and EMAS.
- UEC Dashboard will be provided by NSHEI to see data on UEC standards achieved at Trust level -LRI including 12hr waits, handover times, ambulance conversion to admit rates, which will provide focus areas and evidence for approval to support ongoing improvement work or to identify gaps in current areas.
- Programme of work to explore improvement opportunities for 111 cat 3&4 call back times in 111 to reduce EMAS auto dispatches.
- Unscheduled Care Hub project currently in pilot phase to reduce number of hospital admissions and improve EMAS use of alternative care pathways.

Section F: Current risk score trend



Section G: Internal and/or external assurances

Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?

	Internal	External
Daily Flow (10:30) Escalation calls	✓	✓
~~UEC Cell meetings~~ now call 'Acute Care Collaborative meeting	✓	✓
System Flow Board meetings	✓	✓
Quality Performance Assurance Group (QPAG)	✓	

Section H: Actions being taken to address gaps in controls and/or assurance					
H1. Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the CCG failing to gain evidence that the controls/systems are effective?*	**H2. Details the actions to be taken** *(including brief note on updates/progress where appropriate and confirm when action completed) What actions are required to bridge the gaps in controls and/or assurance?*	**H3. Action to be completed by (date)**	**H4. Will the action reduce impact of risk score or likelihood or both?**		
			Impact	**Likelihood**	**Both**
Post midday discharges (gap).	Working with the Discharge Team to focus on discharges before midday. Daily discharge meetings (10:30) – Operational support provided by UEC team member.	**This is on-going and progress updates would be provided**			✓
Domiciliary care market stretched in LLR causing complexity with patient flow.	Adult social care contracting teams are reviewing current contracts and growing capacity	**October 2022**			✓
Due to the significant level of ambulance handover delays and system pressure difficult decisions have to be made on a daily basis to cancel elective activity to release available capacity for non-elective care. This increases pressure on achieving standards 104 week wait and ultimately increases the risk for the patient.	The system is focused on improving UEC patient flow to ensure elective activity can continue.	**Being reviewed on a regular basis.**			✓

Risk Ref: LLR BAF 19	**Risk Description:** The 104 weeks wait standard not being met primarily due to Covid-19, increased pressures in the system relating to workforce capacity, sickness absence and theatre capacity across providers resulting in poor patient experience and a potential deterioration in health of patients.

Section A **A1. Strategic objective the risk is aligned to.**	**A3. Risk to be treated, confirm frequency of review by lead**		**Section B**		**Section C** **Risk rating (impact x likelihood = risk score)**						
Strategic Objectives A, B, C, E	*Monthly* ✓	*Quarterly*	**B1. Executive Lead (risk owner):**	**Rachna Vyas** **Risk Leads:** Helen Mather/ Helen Hendley	**C1. Gross/inherent risk score**	**5**	**x**	**4**	**=**	**20**	**R**
A2. Date risk identified.	**A4. Risk Category**		**B2. Date last reviewed**		**C2. Net/residual risk score**	**5**	**x**	**4**	**=**	**20**	**R**
					C3. Risk appetite score	**2**	**x**	**2**	**=**	**4**	**G**
April 2022	**Clinical**	✓	**B3. Committee/Group with oversight for risk?**	System Operational Planning Group	**C4. Risk Treatment:** *(Terminate, Treat, Transfer, or Tolerate)*	Treat					
	Organisational				**C5. Date current/residual score assessed**	June 2022					
	Financial										
	Information										

Section D: Key Controls

- COVID 19 action plan in place
- Continuous waiting list validation both clinical and administrative
- Weekly waiting list meeting with each Speciality reviewing all 104+WW
- Weekly Regional reporting and meetings
- Monthly Trust and System performance meetings
- Action plan reviewed at Systems Ops Group and System Executive
- Harm review process in place in line with NHSE/I Backstop Policy
- Quality Surveillance Group in place
- Speciality transformation plan in place
- Mutual Aid – Senior Responsible Officer driving Mutual Aid in clinical areas under pressure

Section E: Rationale for current score

104+WW patients are balanced with the P2 group to ensure they get access to available facilities during this period of acute pressure due to staffing, sickness, emergency pressures currently being experienced. The impact and likelihood of this risk remains at a high level.

The 104+WW is one of the highest priorities in our Restoration and Recover phase with an endeavour to achieve 0 104+WW as soon as possible whilst delivering P2 services. Given the capacity constraints in the Acute Trust our performance is negatively impacted as we action the backlog, including the use of Mutual Aid and Independent Sector therefor the risk rating stands as is.

The volume of 104+WW remains one of our highest concerns. It is reducing but is still significant in volume especially in Orthopaedics, General Surgery, ENT, Urology and Gynaecology.

Changes in IPC rules have supported increasing clinic templates and number of patients per list providing some additional capacity as well as increasing the use of Mutual Aid and Independent Sector where possible.

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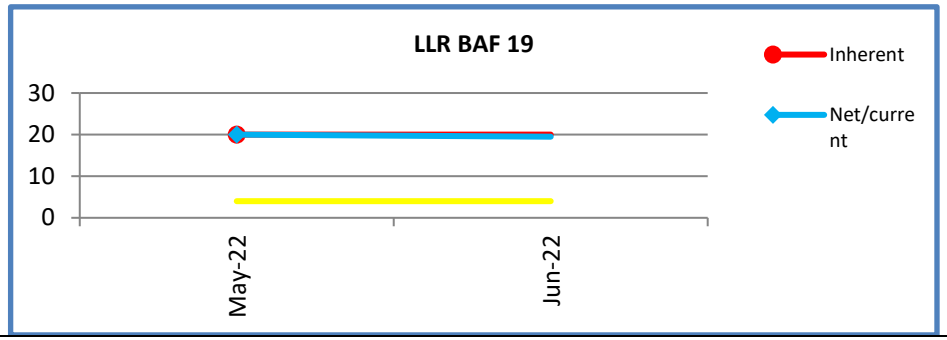
• Use of Independent Sector both local and Regional to support Specialities with significant problems • Trust and System focus of GIRFT to improve productivity. • Use of Primary Care providers to undertake outpatients and minor procedures • Speciality pathway re-design	**Section F: Current risk score trend** 

Section G: Internal and/or external assurances

Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?

	Internal	External
Weekly 104+WW patient reviews	✓	✓
Individual cases are risk assessed prior to cancellation and prioritised for re-scheduling to minimise the risk to patients	✓	
Regular review of patients suitable for Mutual Aid and Independent Sector led by a senior manager	✓	
Diagnostics targets are monitored weekly to assess impact on 104+WW	✓	

Section H: Actions being taken to address gaps in controls and/or assurance

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			Impact	Likelihood	Both
Capacity Constraints allied to staff vacancies and sickness across the Trust	• Demand and Capacity review being undertaken across the Trust. • Outpatient Transformation Plan, introducing PIFU, A&G and Virtual Clinics. • Theatre Utilisation Plan in place linked to GIRFT work. • Increasing access to Mutual Aid moving the patients to other providers. • Reviewing the use of technology eg use of robots in both general surgery, urology and gynaecology.	**Currently it is an ongoing process therefore unable to determine timelines**			✓

	• Use of Independent Sector being maximised to offer patients alternative location. • Waiting list validation to remove any patient who has already had surgery or no longer requiring it. • LLR has a Workforce sub-group, and we are working with them to develop roles and training to develop our workforce from a multi-disciplinary perspective				
Impact of Emergency pressures on Elective capacity	• Reviewing IPC rules to increase the clinic templates and number of patients per theatre list. • The development of an Elective Care Hub and the LGH. • Identification of protected beds for surgical capacity at GGH, LGH and LRI • The use of Mutual Aid and Independent Sector • Use of Primary Care facilities to undertake both outpatients and minor procedures • Improved use of the Community Hospital facilities to provide outpatients and day case • Work with GIRFT data to improve productivity in all facilities	**As above**			✓

Risk Ref: LLR BAF 20	**Risk Description:** There is a risk that the demand for general practice appointments continues to exceed availability of appointments. This is due to a variety of factors including increasing demand driven and exacerbated by late acute presentations, increased mental health presentations, tackling the backlog in long term condition / routine face to face appointments and continuing workforce challenges. This may result in the risk of patients being unable to access appointments and seeking alternatives placing pressure on other services.

Section A **A1. Strategic objective the risk is aligned to.**	**A3. Risk to be treated, confirm frequency of review by lead**		**Section B**		**Section C** **Risk rating (impact x likelihood = risk score)**						
Strategic Objectives A, B, C, D, F & G	*Monthly* ✓	*Quarterly*	**B1. Executive Lead (risk owner):**	**Rachna Vyas** **Risk Leads:** Yasmin Sidyot/Ian Potter/Sarah Smith	**C1. Gross/inherent risk score**	**4**	**x**	**5**	**=**	**20**	**R**
A2. Date risk identified.	**A4. Risk Category**		**B2. Date last reviewed**		**C2. Net/residual risk score**	**4**	**X**	**5**	**=**	**20**	**R**
					C3. Risk appetite score	**3**	**X**	**3**	**=**	**9**	**A**
April 2022	**Clinical**	✓	**B3. Committee/Group with oversight for risk?**	Primary Care Transformation Board	**C4. Risk Treatment:** *(Terminate, Treat, Transfer, or Tolerate)*	Treat					
	Organisational				**C5. Date current/residual score assessed**	June 2022					
	Financial										
	Information										

Section D: Key Controls

- Monthly review at Primary Care Transformation Board
- Monthly metrics discussed at Acute Care Collaborative
- Fortnightly review at PC/UEC Access Programme meetings
- Triangulation with the RCGP, OPEL and Accelerated Access Improvement Programme initiatives
- Quality Dashboard
- Additional workforce via ARRS to support service delivery

Section E: Rationale for current score

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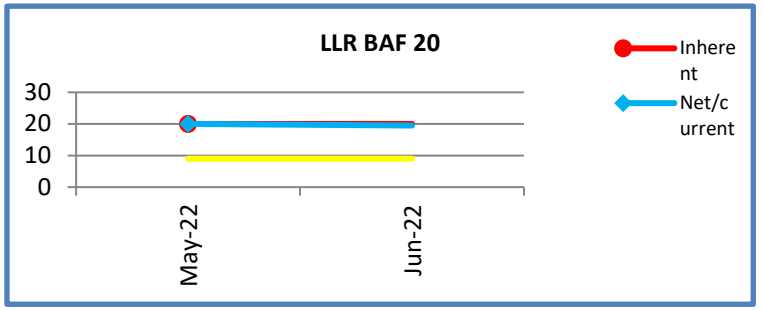
General Practice continues to experience significant challenges owing to increasing demand driven by a range of factors including and exacerbated by late acute presentations, increased mental health presentations, tackling the backlog in long term condition / routine face to face appointments and continuing workforce challenges.

Demand continues to exceed capacity, compounded by the desire to be seen by GPs rather than accepting signposting to lower acuity services such as community pharmacies.

Risk is sustained as the number of practices needing support is not diminishing and we are seeing an increasing number of general practices on the risk log with significant and serious patient safety and quality issues.

	Section F: Current risk score trend 

Section G: Internal and/or external assurances

Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?

	Internal	External
Daily escalation calls	✓	✓
Fortnightly PC/UEC Access Programme meetings	✓	✓
Fortnightly Acute Care Collaborative	✓	✓
Monthly Primary Care Transformation Board	✓	✓

Section H: Actions being taken to address gaps in controls and/or assurance

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			Impact	**Likelihood**	**Both**
Ability to articulate the variety in service delivery across the 134 GP practices We have an operational plan that will be overseen via Primary Care Transformation Board	Primary Care Transformation Board Dashboard which will articulate a range of performance metrics, reportable by GP practice, PCN or Place	Phased from June 2022 onwards	✓		

2

Leicester, Leicestershire and Rutland Integrated Care Board

Conflicts of Interest, Gifts and Hospitality and Sponsorship Policy

(including standards of business conduct)

Reference number:	LLR Corporate XXX
Title:	Conflicts of Interest, Gifts and Hospitality and Sponsorship Policy (including standards of business conduct)
Version number:	Version 1 (July 2022)
Policy Approved by:	
Date of Approval:	
Date Issued:	
Review Date:	
Document Author:	Daljit K. Bains Head of Corporate Governance
Executive Lead:	Nicci Briggs, Executive Director of Finance, Contracting and Corporate Governance

Version Control

Version number	Approval / Amendments made	Date
Version 1	▪ Policy for the Integrated Care Board based on NHS England's guidance on conflicts of interest as published in June 2017. This Policy also describes the standards of business conduct.	June 2022

DOCUMENT STATUS:
This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of the document are not controlled.

RELATED DOCUMENTS:
This document will reference additional policies and procedures which will provide additional information.

All ICB policies can be provided in large print or Braille formats upon request. An interpreting service, including sign language, is also available.

Contents

Introduction

1. NHS Leicester, Leicestershire and Rutland Integrated Care Board (hereafter "the ICB") in this policy seeks to describe the public service values, which underpin the work of the NHS.

2. The ICB aspires to the highest standards of business conduct and corporate behaviour and responsibility. It recognises that managing conflicts of interest is essential as part of its day-to-day activities. Effective handling of conflicts of interest is crucial to give confidence to patients, tax payers, healthcare providers and Parliament that ICB commissioning decisions are robust, fair and transparent and offer value for money. Failure to manage conflicts of interest could lead to legal challenge and even criminal action in the event of fraud, bribery and corruption.

Policy Statement

3. This policy has been developed in line with guidance on conflicts of interest published by NHS England in June 2017.

4. This Policy sets out the approach for the ICB to identify, manage and record any conflicts of interest that may arise as part of the commissioning of healthcare for the residents of Leicester, Leicestershire and Rutland. Reference to supporting material, guidance and legislation detailed within the "Useful Documents and References" section should be read in conjunction with this Policy where appropriate.

5. The aim of this policy is to support the ICB, its committees and staff to manage conflicts of interest risks effectively. It:

    - Introduces common principles and rules for managing conflicts of interest, gifts and hospitality and sponsorship.
    - Provides simple advice about what to do in common situations.
    - Supports good judgement about how interests should be approached and managed.
    - Enables collaboration and innovation with our partners by managing conflicts as appropriate and in line with the principles and guidance.
    - Supports standards of business conduct.

6. Adhering to this policy will help ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

Principles

7. The members of the Board of the ICB, committees or individuals who take decisions, where they are acting on behalf of the public or spending public money, are expected to observe the principles of good governance in the way they do their business. The Nolan principles underpin this Policy:

- **Selflessness** – holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends;
- **Integrity** – holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;
- **Objectivity** – in carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit;
- **Accountability** – holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office;
- **Openness** – holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands;
- **Honesty** – holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest;
- **Leadership** – holder of public office should promote and support these principles by leadership and example.

8. General safeguards will be in place, which will be particularly important in relation to the key commissioning decision-making points leading up to, during, and after the actual procurement of services, and in deciding whether to go out to procurement. The general safeguards that will be needed to manage conflicts of interest will vary to some extent, depending on at what stage in the commissioning cycle decisions are being made. The following principles will need to be integral to the commissioning of all services, including decisions on whether to continue to commission a service, such as by contract extension. The principles and general safeguards are as follows, conflicts of interest can be managed by:

   a) Doing business appropriately: if commissioners get their needs assessments, consultation mechanisms, commissioning strategies and procurement procedures right from the outset, then conflicts of interest become much easier to identify, avoid and/or manage, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny.

   b) Being proactive, not reactive: commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possible opportunity, for instance by:
   - considering potential conflicts of interest when electing or selecting individuals to join the Board or other decision-making bodies;

- ensuring individuals receive proper induction and training so that they understand their obligations to declare conflicts of interest. They should establish and maintain registers of interests, and agree in advance how a range of possible situations and scenarios will be handled, rather than waiting until they arise.

c) Assuming that individuals will seek to act ethically and professionally, but may not always be sensitive to all conflicts of interest: rules should assume people will volunteer information about conflicts and, where necessary, exclude themselves from decision-making, but there should also be prompts and checks to reinforce this.

d) Being balanced and proportionate: rules should be clear and robust but not overly prescriptive or restrictive. They should ensure that decision-making is transparent and fair, but not constrain people by making it overly complex or cumbersome.

e) Openness: ensuring early engagement with patients, the public, clinicians and other stakeholders, including local Healthwatch and Health and Wellbeing Boards, in relation to proposed commissioning plans.

f) Responsiveness and best practice: ensuring that commissioning intentions are based on local health needs and reflect evidence of best practice – securing 'buy in' from local stakeholders to the clinical case for change.

g) Transparency: documenting clearly the approach taken at every stage in the commissioning cycle so that a clear audit trail is evident.

h) Securing expert advice: ensuring that plans take into account advice from appropriate health and social care professionals, e.g. through clinical senates and networks, and draw on commissioning support, for instance around formal consultations and for procurement processes.

i) Engaging with providers: early engagement with both incumbent and potential new providers over potential changes to the services commissioned for a local population.

j) Creating clear and transparent commissioning specifications that reflect the depth of engagement and set out the basis on which any contract will be awarded.

k) Following proper procurement processes and legal arrangements, including even-handed approaches to providers.

l) Ensuring sound record-keeping, including up to date registers of interests; and

m) A clear, recognised and easily enacted system for dispute resolution.

9. ICB's constitutional arrangements set out how the ICB will comply with these requirements.

10. If applicable, individuals should also refer to their respective professional codes of conduct relating to conflicts of interest.

11. ICB recognises that a perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring. If in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it; and that for a conflict of interest to exist, financial gain is not necessary.

12. The ICB also aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and advances equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.

Scope of the Policy

13. This policy applies to members of the Board, all staff including:
    a. All salaried employees.
    b. All prospective employees, who are part-way through recruitment.
    c. Contractors and sub-contractors.
    d. Agency and interim staff.
    e. Board, Committee and sub-committee members (some of who may not be directly employed or engaged by the organisation).

14. It is particularly relevant to anyone who may be placed in a conflict of interest position including representatives from provider organisations, all groups involved in commissioning, contracting and procurement processes and where decision making is required by those individuals.

15. The ICB will also require that the commissioning support unit (CSU) and other contractors are aware of the contents of this policy.

Definition of an Interest

16. For the purposes of this guidance 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".

17. A conflict of interest may be:
    a. *Actual:* there is a material conflict between one or more interests; or

    b. *Potential:* there is the possibility of a material conflict between one or more interests in the future.

18. Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently. It will be important to exercise judgement and to declare such interests where there is otherwise a risk of imputation of improper conduct.

19. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise. A potential for competing interests and/or a perception of impaired judgement or undue influence can also be a conflict of interest and can be as damaging as an actual conflict of interest.

20. Conflicts of interest can arise in many situations, environments and forms of commissioning. Conflicts of interest can arise throughout the whole commissioning cycle from needs assessment, to procurement exercises, to contract monitoring.

21. A conflict of interest occurs where an individual's ability to exercise judgement or act in one role is, or could be, impaired or otherwise influenced by his or her involvement in another role or relationship. A benefit may arise from the making of a gain or the avoidance of a loss.

22. Interests fall into four categories outlined below:

    i. **Financial interests:** where an individual may get direct financial benefits from the consequences of a commissioning decision they are involved in making. 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 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).

ii. **Non-financial professional interests:** where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, 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 and Secondary Care Clinician with special interests e.g., in dermatology, acupuncture etc.
- An active member of a particular specialist professional body (although routine GP membership of the RCGP, British Medical Association (BMA) 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 findings 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

iii. **Non-financial personal interests:** 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 and care.

iv. **Indirect interests:** 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 and could stand to benefit from a decision they are involved in making. 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.

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.

23. The above categories and examples are not exhaustive and discretion will be

exercised on a case by case basis, having regard to the principles set out in this Policy, in deciding whether any other role, relationship or interest which would impair or otherwise influence the individual's judgement or actions in their role within the ICB. If so, this should be declared and appropriately managed.

Statutory requirements and guidance

24. The Health and Care Act 2022 sets out clear requirements of NHS organisations to make arrangements for managing conflicts of interest and potential conflicts of interest, to ensure they do not affect or appear to affect the integrity of the ICB's decision making process.

25. In line with legal requirements, NHS England published guidance on conflicts of interest to support ICBs; and this Policy is to be read in conjunction with NHS England's guidance.

26. The ICB is required to:

    a. Maintain one or more registers of interest of: members of the Board, members of its committees or sub-committees of its Board, and its employees;

    b. Publish or make arrangements to ensure that members of the public have access to these registers on request;

    c. Make arrangements to ensure individuals declare any conflict or potential conflict in relation to a decisions to be made, and record them in the registers as soon as they become aware of it, and within 28 days;

    d. Make arrangement, set out in their constitution, for managing conflicts of interest, and potential conflicts of interest in such a way as to ensure that they do not and do not appear to, affect the integrity of the group's decision-making processes; and

    e. Have regard to guidance published by NHS England in relation to conflicts of interest.

    f. Appoint a conflicts of interest guardian, the expectation is that the role will be assumed by the audit chairs, who will be an important point of contact for any conflicts of interest queries or issues.

    g. Establish a robust process for managing any breaches of the Policy and for anonymised details of the breach to be published on the ICB's website for the purpose of learning and development.

    h. Adhere to more strengthened provisions around decision-making when a member of the Board, or committee or sub-committee is conflicted.

    i. Adhere to strengthened provisions around the management of gifts and hospitality, including the need for prompt declarations and a publicly accessible register of gifts and hospitality.

j. Include an annual audit of conflicts of interest management within their internal audit plans and to include the findings of this audit within their annual end-of-year governance statement.

k. Ensure completion of a mandatory online conflicts of interest training by all ICB employees, Board and committee members.

l. Ensure that it does not award a contract for the provision of NHS health care services where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract.

m. Keep a record of how it managed any such conflict in relation to NHS commissioning contracts it enters into.

27. The ICB has adopted some of the model templates from NHS England's guidance to support this Policy.

Roles and Responsibilities

49. Everyone in ICB has responsibility to appropriately manage conflicts of interest.

50. The **Board of the ICB** is responsible for ensuring that:

- The ICB's policies and procedures reflect statutory requirements and good practice particularly in relation to the procurement of services;

- Arrangements are in place to ensure decision-making can be audited, reviewed and scrutinised to ensure transparency, openness and effectiveness; and

- Adherence to the expectations set out in the standards of business conduct in the Constitution.

- On appointing Board, committee or sub-committee members and senior staff, the appointing panel will need to consider whether conflicts of interest should exclude individuals from being appointed to the relevant role. This will need to be considered on a case-by-case basis but the ICB's constitution and processes will reflect the ICB's general principles.

- The appointing panel will assess the materiality of the interest, in particular whether the individual (or any person with whom they have a close association) could benefit (whether financially or otherwise) from any decision the ICB might make. This will be particularly relevant for Board, committee and sub-committee appointments, but should also be considered for all employees and especially those operating at senior level.

- The appointing panel will also need to 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.

- Any individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to a ICB (whether as a provider of healthcare, including 'new care model' providers or healthcare commissioning support services, or otherwise) should recognise the inherent conflict of interest risk that may arise and should not be a member of the Board or of a committee or sub-committee of the ICB, in particular if the nature and extent of their interest and the nature of their proposed role is such that they are likely to need to exclude themselves from decision-making on so regular a basis that it significantly limits their ability to effectively perform that role. Specific considerations in relation to delegated primary care are set in this Policy.

28. The **Chief Executive (Accountable Officer)** has overall accountability for the ICB's management of conflicts of interest. The Head of Corporate Governance has responsibility for:

    a. The day-to-day management of conflicts of interest matters and queries;
    b. Maintaining the ICB's register(s) of interest and the other registers referred to this Policy;
    c. Supporting the Conflicts of Interest Guardian to enable him / her to carry out the role effectively;
    d. Providing advice, support, and guidance on how conflicts of interest should be managed; and
    e. Ensuring that appropriate administrative processes are put in place.

51. **ICB non-executive directors -** the ICB's non-executive directors play a critical role in:

- providing scrutiny, challenge and an independent voice in support of robust and transparent decision-making and management of conflicts of interest; and
- Chairing some of the ICB's committees.

52. **Conflicts of Interest Guardian** - this role is undertaken by the ICB's audit chair, as he has no provider interests. The conflicts of interest guardian will be supported by the ICB's Head of Corporate Governance.

53. The conflicts of interest guardian will liaise with the Head of Corporate Governance on a regular basis ensuring he / she is well briefed on conflicts of interest matters and issues arising.

54. The Conflicts of Interest Guardian will, in collaboration with the ICB's Head of Corporate Governance:

    a. Act as a conduit for members of the public with any concerns with regards to conflicts of interest.

b. Be a safe point of contact for employees or workers of the ICB to raise any concerns in relation to this policy.

c. Support the rigorous application of conflicts of interest principles and policies.

d. Provide independent advice and judgment 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.

55. Whilst the Conflicts of Interest Guardian has an important role within the management of conflicts of interest, executive members of the ICB have an on-going responsibility for ensuring the robust management of conflicts of interest, and all employees, Board and committee members will continue to have individual responsibility in playing their part on an ongoing and daily basis.

56. **Clinical Leads** – any clinician with a responsibility for or involvement in, commissioning services must:

- satisfy themselves that all decisions made are fair, transparent and comply with the law;
- keep up to date with and follow the guidance and codes of practice that govern the commissioning of services where they work;
- formally declare any financial interest that they, or someone close to them, or their employer has in a provider company, in accordance with the governance arrangements in the jurisdiction where they work;
- take steps to manage any conflict between their duties as a clinician and their commissioning responsibilities, for example by excluding themselves from the decision making process and any subsequent monitoring arrangements.

57. **Head of Corporate Governance** will:

- Oversee the arrangements for the management of conflicts of interest ensuring the day-to-day management of conflicts of interest matters and queries.
- Maintain the ICB's register(s) of interest and the other registers referred to in this Policy.
- Support the Conflicts of Interest Guardian to enable them to carry out the role effectively.
- Provide advice, support, and guidance to the Board, Committees, officers on how conflicts of interest should be managed.
- Ensure that appropriate administrative processes are put in place.
- Review this policy on regular intervals as agreed and make recommendations to the Audit Committee for any required changes.
- Ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential

conflict of interests, to ensure the integrity of the ICB's decision making processes
- Ensure any declarations of interest and appropriate registers are published on the ICB website.

58. **Decision-making staff** – some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff'.

59. Decision-making staff in this organisation are:
    a. Executive Directors and Non-Executive Directors.
    b. Those at Agenda for Change Band 8c and above.
    c. Those directly involved in recruitment decisions,
    d. Other may be included as decision making evolves.

60. **All Members of Staff** - it is the responsibility of each member of staff to:

- Ensure that he/she reads and understands this Policy, and reads the Policy in conjunction with the ICB's Constitution, Standing Orders, Scheme of Reservation and Delegation, Standing Financial Instructions (SFIs) and operational scheme of delegation and other governance documents as relevant and how they apply to him/her.

- Carry out their duties in accordance with the governance documents listed above.

- Be aware of their duties and responsibilities arising from the Bribery Act 2020.

- Ensure that he/she does not place him/herself in a position where private interests and NHS duties might conflict;

- Ensure that they do not undertake duties, remunerated or otherwise, outside his/her employment with the ICB if there is any actual or potential conflict with, or prejudice of, the standards set out in this document.

- Refuse to accept any casual gifts or inducement by declining politely. Articles of low intrinsic value such as diaries or calendars, or small tokens of gratitude to the value of up to £25 from patients or their relatives, need not necessarily be refused. If in doubt, the line manager or Head of Corporate Governance should be consulted. If small gifts are accepted a record of this should be made in the gift and hospitality register which is maintained by the Head of Corporate Governance (see further guidance and form at Appendix B).

- acceptance of reasonable levels of hospitality by staff is permissible but should not lead to undue favourable treatment being given to the party providing the hospitality. Any hospitality accepted (or offered and then declined) must be declared by the receiving party.

- offer only modest hospitality such as a working lunch in the course of working meetings. Alcoholic beverages must not be provided.

- maintain appropriate confidentiality at all times in respect of information to which he/she has access in the course of his/her duties. In particular, he/she will observe the strict rules relating to patient confidentiality, and will not misuse commercial information, nor will he/she make it available to other people without consulting the line manager.

- ensure that he/she always conducts him/herself and provides services in such a way as to up-hold the good name of the NHS and the ICB

- adhere to the ICB's disciplinary rules as set out in its disciplinary policy

- be aware and comply with the provisions of the Bribery Act 2010 as amended from time to time

- understand that failure to follow this policy may damage the ICB and its work and so may be viewed as a disciplinary matter, to be dealt with under normal disciplinary procedures, and the penalty could include dismissal.

- **Members of staff <u>must not</u>:**

    - use a current or past official position to obtain preferential rates for private transactions, other than organised schemes for NHS employees, such as Health Service Discounts; and

    - attempt to influence the awarding of contracts by any factors other than those set out in Standing Orders and Prime Financial Policies or otherwise designed to ensure that value for money is obtained.

61. **Outside employment** – means employment and other engagements outside of formal employment arrangements. The ICB will take all reasonable steps to ensure that employees, committee members, contractors and others engaged under a contract with the ICB are aware of the requirement to inform the ICB if they are employed or engaged in, or wish to be employed or engage in, any employment or consultancy work in addition to their work with the ICB. The purpose of 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 including paid advisory positions and paid honorariums which relate to bodies likely to do business with the ICB.

    - Directorships of other organisations.

    - Self-employment, including private practice charitable trustee roles, political roles and consultancy work, 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.

62. **Individuals will need to obtain prior permission to engage in outside employment, and ICB reserves the right to refuse permission where it believes a conflict will arise which cannot be effectively managed.** ICB is responsible for ensuring that clear and robust organisational policies are in place to manage issues arising from outside employment Staff are required to declare any existing outside employment on appointment; and any new outside employment when it arises. In particular, it is unacceptable for pharmacy advisers or other advisers, employees or consultants to the ICB on matters of procurement to themselves be in receipt of payments from the pharmaceutical or devices sector.

63. Furthermore the ICB may also have a legitimate reason(s) within employment law for knowing about outside employment of staff; even if this does not give rise to risk of a conflict.

Identification and management of conflicts of interest (including gifts and hospitality)

64. Conflicts of interest are a common and sometimes unavoidable part of the commissioning and delivery of healthcare. As such, it may not be possible or desirable to completely eliminate the risk of conflicts. Instead, it may be preferable to recognise the associated risks and put measures in place to manage the conflicts appropriately when they do arise.

65. ICB will establish robust systems to identify and manage conflicts of interest. This will involve creating an environment in which ICB staff, Board and committee members feel encouraged and obliged to be open, honest and upfront about actual or potential conflicts. Transparency in this regard will lead to effective identification and management of conflicts.

66. There will be occasions where an individual declares an interest in good faith but, upon closer consideration, it is clear that this does not constitute a genuine conflict of interest. Advice can be sought from the Head of Corporate Governance to assist in reviewing the interest and whether it needs to be declared.

67. There will be other occasions where the conflict of interest is profound and acute. In such scenarios (such as where an individual has a direct financial interest which gives rise to a conflict, e.g., employment outside the ICB or involvement with an organisation which benefits financially from contracts for the supply of goods and services it is likely that the ICB will want to consider whether, practically, such an interest is manageable at all. If it is not, the appropriate course of action may be to refuse to allow the circumstances which gave rise to the conflict to persist. This may require an individual to step down from a particular role and/or move to another role within the ICB. The ICB's HR policies, Board and committee terms of reference, and standing orders will be reviewed regularly to ensure the ICB is able to take appropriate action to manage conflicts of interest robustly and effectively in such circumstances.

Gifts and Hospitality

Gifts

68. A 'gift' is defined as 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.

69. All gifts of any nature offered to ICB staff, Board and committee members by suppliers or contractors linked (currently or prospectively) to the ICB's business should be declined, whatever their value. The person to whom the gifts were offered should also declare the offer to the Head of Corporate Governance so the offer, which has been declined, can be recorded on the register.

70. Overarching principles:

a. ICB staff should not accept gifts that may effect, or be seen to affect, their professional judgement. This overarching principle should apply in all circumstances;
b. Any personal gift of cash equivalents (e.g. vouchers, tokens, offers of remuneration to attend meeting s whilst in a capacity working for a 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 Head of Corporate Governance, who has designated authority to maintain the register of gifts and hospitality and recorded on the register.

71. Gifts from suppliers and contractors:

a. 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 as described in the ABPI Code of Practice for the Parliamentary Industry. The person to who, the gifts were offered should also declare the offer to the Head of Corporate Governance.

72. **Gifts from other sources** (e.g. patients, families, service users):

a. ICB staff should not ask for any gifts;
b. modest gifts under the value of £50.00 may be accepted and do not need to be declared.

Hospitality

73. Hospitality means offers of meals, refreshment, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events etc.

74. 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.

75. A blanket ban on accepting or providing hospitality is neither practical nor desirable from a business point of view. However, individuals should be able to demonstrate that the acceptance or provision of hospitality would benefit the NHS or ICB.

76. **Overarching principles:**
    a. ICB staff should not ask for or accept hospitality that may affect, or be see to affect their professional judgement;
    b. Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event,
    c. 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.

77. Meals and refreshment:
    a. Under a value of £25 may be accepted and need not to be declared;
    b. of a value between £25 and £75 may be accepted and must be declared (see also the ABPI Code of Practice for the Pharmaceutical Industry);
    c. over a value of £75 should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be records on an organisation's register(s) of interest as to why it was permissible to accept.

78. Travel and accommodation:
    a. Modest offers to pay some or all of the travel and accommodation cost related to attendance at events may be accepted and must be declared.

    b. Offers which go beyond modest, or are of a type that the ICB itself might not usually offer, need approval by the Head of Corporate Governance or the Chief Finance Officer, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the ICB's register(s) of interest as to why it was permissible to accept travel and accommodation of this type

    c. A non-exhaustive list of examples include:
        i. Offers of business class or first-class travel and accommodation (including domestic travel); and
        ii. Offers of foreign travel and accommodation.

79. In addition, particular caution should be exercised where hospitality is offered by suppliers or contractors linked (currently or prospectively) to the ICB's business. Offers of this nature can be accepted if they are modest and reasonable but advice should always be sought from a senior member of the ICB (e.g. the Head of Corporate Governance) as there may be particular sensitivities, for example if a contract re-tender is imminent. All offers of hospitality from actual or prospective suppliers or contractors (whether or not accepted) should be declared and recorded.

Commercial sponsorship / sponsored events

80. For the purpose of this policy, commercial sponsorship is defined as including: 'NHS funding from an external source, including funding of all, or part of, the costs of a member of staff, NHS research, staff training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (including guest speakers), buildings or premises'. Joint working is defined as including: 'situations where for the benefit of patients, the NHS and industry organisations pool skills, experience and resources for the joint development and implementation of patient centred projects and share a commitment to successful delivery'.

81. Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs or 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.

82. When sponsorships are offered to ICB staff, Board and committee members, the following principles must be adhered to:

    a. Sponsorship of ICB events by appropriate external bodies (e.g. pharmaceutical companies) should only be approved if a reasonable person would conclude that the event will result in clear benefit for the ICB and the NHS;
    b. During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and regulations;
    c. 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;
    d. 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 of the main purpose of the event;
    e. The involvement of a sponsor in an event should always be clearly identified in the interest of transparency;
    f. The ICB will 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;
    g. Staff will be required to declare their involvement with arranging sponsored events.

83. **Other forms of sponsorship** – organisations external to the ICB or NHS may also sponsor posts or research. However, there is a potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to 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 managed well. A discussion with the Head of Corporate Governance and / or the Conflicts of Interest Guardian should take place prior to approval for acceptance of such sponsorship.

84. In all these cases, the ICB and its employees must publicly declare sponsorship or any commercial relationship linked to the supply of goods or services and be held to account for it.

85. Where such collaborative partnerships involve a pharmaceutical company, the arrangements must comply fully with the Medicines (Advertising) Regulations 1994 (regulation 21 'Inducements and hospitality') see also The ABPI Code of Practice for the Pharmaceutical Industry.

86. Whatever type of agreement is entered into, a clinician's judgement must always be based upon clinical evidence that the product is the best for their patients.

Declaring interests and gifts and hospitality

87. It is a statutory requirement that the ICB make arrangements to ensure individuals declare any conflict or potential conflict in relation to a decision to be made by the group as soon as they become aware of it, and in any event within 28 days. A record of the interest must be made in the register as soon as individuals become aware of it.

88. Periodic reminders for staff, Board and committee members to declare any interests will be sent to staff by the Head of Corporate Governance. The Register will be updated regularly (on at least a six monthly basis).

89. As a matter of course, declarations of interest will be made and regularly confirmed or updated.

90. All persons referred to within the scope of this Policy must declare any interests. Declarations of interest should be made as soon as reasonably practicable and by law within 28 days after the interest arises (this could include an interest an individual is pursuing). Declaration of interest forms are available at Appendices A and B.

91. Further opportunities to make declarations include:

- **On appointment:**
  Applicants for any appointment to the ICB or its Board or any committees will be asked to declare any relevant interests. When an appointment is made, a formal declaration of interests will again be made and recorded.

- **Six-monthly:**
  the Head of Corporate Governance will ensure that on a six-monthly basis the register of interests is accurate and up-to-date. Declarations of interest should be obtained from all relevant individuals every six months and where there are no interests or changes to declare, a "nil return" will be recorded.

- **At meetings:**
  All attendees are required to declare their interests as a standing agenda item for every Board, committee, sub-committee or working group meeting, before the item is discussed. Even if an interest has been recorded in the register

of interests, it should still be declared in meetings where matters relating to that interest are discussed. Declarations of interest will be recorded in minutes of meetings.

- **On changing role, responsibility or circumstances:**
  Whenever an individual's role, responsibility or circumstances change in a way that affects the individual's interests (e.g., where an individual takes on a new role outside the ICB or enters into a new business or relationship starts a new project / piece of work or may be affected by a procurement decision for example 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*. This could involve a conflict of interest ceasing to exist or a new one materialising. It should be made clear to all individuals who are required to make a declaration of interests that if their circumstances change, it is their responsibility to make a further declaration as soon as possible and in any event within 28 days, rather than waiting to be asked. It should also be clear who such individuals should formally notify, and how that team or person can be contacted. ICB may also wish to consider including this requirement in employees' contracts.

92. Whenever interests are declared they should be promptly reported to the Head of Corporate Governance who has designated responsibility for maintaining the register of interests and the registers of gifts and hospitality.

Register(s) of interests and gifts and hospitality

93. The ICB has a statutory requirement to maintain one or more registers of interest of: the members of the group, members of its Board, members of its committees or sub-committees of its Board, and its employees. The ICB will publish, and make arrangements to ensure that members of the public have access to, these registers on request; and will also maintain one or more registers of gifts and hospitality. The ICB should maintain one or more register of interest and one or more register of gifts and hospitality.

94. Declarations of interest and gifts and hospitality should be made by 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; and
  - Seconded staff

  In addition, any self-employed consultants or other individuals working for the ICB under a contract for services should make a declaration of interest in accordance with this guidance, as if they were ICB employees.

- **Members of the Board:** All members of the ICB's committees, sub-committees/sub-groups, including:

  - Co-opted members;

- Appointed deputies who deputise for Executive Directors during periods of absence; and
- Any members of committees/groups from other organisations.

Where the ICB is participating in a joint committee alongside other ICBs, any interests which are declared by the committee members should be recorded on the register(s) of interest of each participating ICB.

95. All interests declared must be promptly transferred to the relevant ICB register(s) by the Head of Corporate Governance for maintaining registers of interest. An interest should remain on the public register for a minimum of 6 months after the interest has expired. In addition, the ICB will retain a private record of historic interests for a minimum of 6 years after the date on which it expired. The ICB's published register of interests will state that historic interests are retained by the ICB for the specified timeframe, with details of whom to contact to submit a request for this information.

Register(s) of Interest

96. The declaration of interest(s) form and guidance for use by ICB Board members, and ICB employees is as at Appendix A. Appendix A contains the following information as a minimum:

- Name of the person declaring the interest;
- Position within, or relationship with, the ICB (or NHS England in the event of joint committee);
- Type of interest e.g., financial interests, non-financial professional interests;
- Description of interest, including for indirect interests details of the relationship with the person who has the interest;
- The dates from which the interest relates; and
- The actions to be taken to mitigate risk - these should be agreed with the individual's line manager or a senior manager within the ICB.

Register of Gifts and Hospitality

97. ICB needs to maintain one or more registers of gifts and hospitality for the individuals listed above (i.e. ICB employees, members of the Board, and members of the ICB). Individuals are reminded not to accept gifts or hospitality or other benefits, which might reasonably be seen to compromise their professional judgement or integrity.

98. All individuals need to consider the risks associated with accepting offers of gifts, hospitality and entertainment when undertaking activities for or on behalf of the ICB. 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.

Declaration of offers and receipt of gifts and hospitality

99. The guidance and form for declaring gifts and hospitality is at Appendix B. All hospitality or gifts declared must be promptly transferred to a register of gifts and hospitality that all ICBs should maintain. This should include any gifts and hospitality declared in meetings. As a minimum, the register contains the following information:

    a. Recipient's name;

    b. Current position(s) held by the individual (within the ICB);

    c. Date of offer and/or receipt;

    d. Details of the gifts of hospitality

    e. The estimated value of the gifts or hospitality

    f. Details of the supplier/offeror (e.g. their name and the nature of their business);

    g. Details of previous gifts and hospitality offered or accepted by this offeror/ supplier;

    h. Details of the officer reviewing/approving the declaration made and date;

    i. Whether the offer was accepted or not; and

    j. Reasons for accepting or declining the offer.

Publication of registers

100. All ICB employees, members of the Board and all members of the ICB should declare interests and offers / receipt of gifts and hospitality, however some staff, Board and committee members are more likely than others to have decision making influence on the use of taxpayers' money because of the requirements of their role. For the purposes of this policy these people are referred to as "decision making staff". Decision making staff, Board and committee members are those that have a material influence on how taxpayers' money is spent. Decision making staff may also include management, administrative and clinical staff who have the power to enter into contracts on behalf of the ICB; and / or are involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions.

101. As a minimum, the ICB is required to publish the register(s) of interest, and register(s) of gifts and hospitality of decision making staff, Board and committee members at least annually in a prominent place on the ICB website, and will be made available at the ICB office upon request.

102. 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).

Where an individual believes that substantial damage or distress may be caused, to him/herself 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, who should seek appropriate legal advice where required, and the ICB should retain a confidential un-redacted version of the register(s).

103. All decision making staff, Board and committee members will be made aware, in advance of publication, that the register(s) will be kept, how the information on the registers may be used or shared and that the register(s) will be published. Individuals are made aware of this via the ICB's fair processing notice that details the identity of the data controller, the purposes for which the registers are held and published, and contact details for the data protection officer. This information will be published and made available to individuals identified in the registers.

104. All staff who are not decision making staff but who are still required to make a declaration of interest(s) or a declaration of gifts or hospitality will also be informed in advance of the publication of the register(s) and how the information on the register(s) will be kept and shared. In the main this will be via the ICB's fair processing notice.

105. Interests (including offers of gifts and hospitality) of decision making staff will remain on the public register for a minimum of 6 months. In addition, the ICB is required to retain a private record of historic interests and offers / receipt of gifts and hospitality for a minimum of 6 years after the date on which it expired. The ICB's published register of interests will state that historic interests are retained by the ICB for the specified timeframe, with details of the Head of Corporate Governance who can be contacted should a request of this information be made.

106. The register(s) of interests (including the register of gifts and hospitality) will also be published as part of the ICB's Annual Report and Annual Governance Statement. A web link to the ICB's registers is acceptable.

Managing conflicts of interest at meetings

107. ICBs must make arrangements for managing conflicts of interest, and potential conflicts of interest, in such a way as to ensure that they do not, and do not appear to, affect the integrity of the group's decision-making.

108. ICB will review its governance structures and policies for managing conflicts of interest, at agreed intervals, to ensure that they reflect the guidance and are appropriate. This should include consideration of the following:

    a. The **make-up of the Board and committee structures** and processes for decision-making;

    b. Whether there are sufficient management and internal controls to detect **breaches** of the ICB's conflicts of interest policy, including appropriate external oversight and adequate provision for **raising concerns under this policy**;

c. How **non-compliance** with policies and procedures relating to conflicts of interest will be managed (including how this will be addressed when it relates to contracts already entered into); and

d. Identifying and implementing **training** or other programmes to assist with compliance, including participation in the training offered by NHS England.

Chairing arrangements and decision-making processes

109. The chair of a meeting of the ICB's Board or any of its committees, sub-committees or groups has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action in order to manage the conflict of interest.

110. In the event that the chair of a meeting has a conflict of interest, the vice chair is responsible for deciding the appropriate course of action in order to manage the conflict of interest. If the vice chair is also conflicted then the remaining non-conflicted voting members of the meeting should agree between themselves how to manage the conflict(s).

111. In making such decisions, the chair (or vice chair or remaining non-conflicted members as above) may wish to consult with the Conflicts of Interest Guardian or another member of the Board.

112. It is good practice for the chair, with support of the ICB's Head of Corporate Governance and, if required, the Conflicts of Interest Guardian, to proactively consider ahead of meetings what conflicts are likely to arise and how they should be managed, including taking steps to ensure that supporting papers for particular agenda items of private sessions/meetings are not sent to conflicted individuals in advance of the meeting where relevant.

113. To support chairs in their role, they have access to a declaration of interest checklist for consideration prior to meetings (see Appendix C), which should include details of any declarations of conflicts which have already been made by members of the group.

114. The chair should ask at the beginning of each meeting if anyone has any conflicts of interest to declare in relation to the business to be transacted at the meeting. Each member of the group should declare any interests which are relevant to the business of the meeting whether or not those interests have previously been declared. Any new interests which are declared at a meeting must be included on the ICB's relevant register of interests to ensure it is up- to-date.

115. Similarly, any new offers of gifts or hospitality (whether accepted or not) which are declared at a meeting must be included on the ICB's register of gifts and hospitality to ensure it is up-to-date.

116. It is the responsibility of each individual member of the meeting to declare any

relevant interests which they may have. However, should the chair or any other member of the meeting be aware of facts or circumstances which may give rise to a conflict of interests but which have not been declared then they should bring this to the attention of the chair who will decide whether there is a conflict of interest and the appropriate course of action to take in order to manage the conflict of interest.

117. When a member of the meeting (including the chair or vice chair) has a conflict of interest in relation to one or more items of business to be transacted at the meeting, the chair (or vice chair or remaining non-conflicted members where relevant as described above) 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:

    a. Where the chair has a conflict of interest, deciding that the vice chair (or another non-conflicted member of the meeting if the vice chair is also conflicted) should chair all or part of the meeting;

    b. Requiring the individual who has a conflict of interest (including the chair or vice chair if necessary) not to attend the meeting;

    c. Ensuring that the individual concerned does not receive the supporting papers or minutes of the meeting which relate to the matter(s) which give rise to the conflict: requiring the individual to leave the discussion when the relevant matter(s) are being discussed and when any decisions are being taken in relation to those matter(s). In private meetings, this could include requiring the individual to leave the room and in public meetings to either leave the room or join the audience in the public gallery;

    d. Allowing the individual to participate in some or all of the discussion when the relevant matter(s) are being discussed but requiring them to leave the meeting when any decisions are being taken in relation to those matter(s). This may be appropriate where, for example, the conflicted individual has important relevant knowledge and experience of the matter(s) under discussion, which it would be of benefit for the meeting to hear, but this will depend on the nature and extent of the interest which has been declared;

    e. Noting the interest and ensuring that all attendees 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. The conflicts of interest case studies (provided by NHS England) include examples of material and immaterial conflicts of interest.

118. Where the conflict of interest relates to outside employment and an individual continues to participate in meetings pursuant to the preceding two bullet points, he or she should ensure that the capacity in which they continue to participate in the discussions is made clear and correctly recorded in the meeting minutes. Where it is appropriate for them to participate in decisions they must only do so if they are acting in their ICB role.

Delegated Commissioning arrangements

119. **Delegated commissioning** enables ICB to assume responsibility for commissioning in relation to primary care and other such services as required by NHS England.

120. As a general rule, any joint committee meetings, including the decision-making and deliberations leading up to the decision, should be held in public unless the ICB has concluded it is appropriate to exclude the public where it would be prejudicial to the public interest to hold that part of the meeting in public. Examples of where it may be appropriate to exclude the public include:

    a. Information about individual patients or other individuals which includes sensitive personal data is to be discussed.

    b. Commercially confidential information is to be discussed, for example the detailed contents of a provider's tender submission.

    c. Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings is to be discussed.

    d. To allow the meeting to proceed without interruption and disruption.

Minute-taking

121. It is imperative that the ICB ensures complete transparency in its decision-making processes through robust record-keeping. If any conflicts of interest are declared or otherwise arise in a meeting, the chair must ensure the following information is recorded in the minutes:

- **who has the interest**;
- **the nature of the interest and why it gives rise to a conflict**, including the magnitude of any interest;
- the **items on the agenda** to **which the interest relates**;
- **how the conflict was agreed to be managed**; and
- **evidence that the conflict was managed as intended** (for example recording the points during the meeting when particular individuals left or returned to the meeting).

Managing conflicts of interest throughout the commissioning cycle

122. Conflicts of interest need to be managed appropriately throughout the whole commissioning cycle. At the outset of a commissioning process, the relevant interests of all individuals involved should be identified and clear arrangements

put in place to manage any conflicts of interest. 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 conflicts of interest case studies provided by NHS England include examples of this. The ICB will identify and appropriately manage any conflicts of interest that may arise where staff are involved in both the management of existing contracts and the procurement of related / replacement contracts.

123. The ICB will also identify as soon as possible where staff may transfer to a provider (or their role may materially change) following the award of a contract. This should be treated as a relevant interest, and the ICB will ensure it manages the potential conflict.

Designing service requirements

124. The way in which services are designed can either increase or decrease the extent of perceived or actual conflicts of interest. Particular attention will be given to public and patient involvement in service development.

125. Public involvement supports transparent and credible commissioning decisions. It should happen at every stage of the commissioning cycle from needs assessment, planning and prioritisation to service design, procurement and monitoring. ICBs have legal duties under the Act to properly involve patients and the public in their respective commissioning processes and decisions.

Provider engagement

126. It is good practice to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient needs. This may include providers from the acute, primary, community, and mental health sectors, and may include NHS, third sector and private sector providers. Such engagement, done transparently and fairly, is entirely legal. However, 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 (be they incumbent or potential new providers) in developing a service specification for a contract for which they may later bid. The ICB will be particularly mindful of these issues when engaging with existing / potential providers in relation to the development of new care models.

127. Provider engagement should follow the three main principles of procurement law, namely equal treatment, non-discrimination and transparency. This includes ensuring that the same information is given to all at the same time and procedures are transparent. This mitigates the risk of potential legal challenge.

128. As the service design develops, it is good practice to engage with a range of providers on an on-going basis to seek comments on the proposed design e.g., via the commissioners website and/or via workshops with interested parties (ensuring a record is kept of all interaction). NHS Improvement has issued guidance on the use of provider boards in service design.

129. Engagement should help to shape the requirement to meet patient need, 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.

130. The ICB will ensure that it meets any obligation to document its decisions including, but not limited to, any obligations under the National Health Services (Procurement, Patient Choice and Competition) (No 2) regulations 2013 and the Public Contracts Regulations 2015.

Specifications

131. The ICB, as a Commissioner should seek, as far as possible, to specify the outcomes it wishes to see delivered through a new service, rather than the process by which these outcomes are to be achieved. As well as supporting innovation, this helps prevent bias towards particular providers in the specification of services. However, we will also need to ensure careful consideration is given to the appropriate degree of financial risk transfer in any new contractual model.

132. Specifications should be clear and transparent, reflecting the depth of engagement, and set out the basis on which any contract will be awarded.

Procurement and awarding grants

133. The ICB will need to be able to recognise and manage any conflicts or potential conflicts of interest that may arise in relation to the procurement of any services or the administration of grants. “Procurement” relates to any purchase of goods, services or works and the term “procurement decision” should be understood in a wide sense to ensure transparency of decision making on spending public funds. The decision to use a single tender action, for instance, is a procurement decision and if it results in the commissioner entering into a new contract, extending an existing contract, or materially altering the terms of an existing contract, then it is a decision that should be recorded.

134. The ICB must comply with two different regimes of procurement law and regulation when commissioning healthcare services: the NHS procurement regime, and the European procurement regime:

    a. The NHS procurement regime – the NHS (Procurement, Patient Choice and Competition (No.2)) Regulations 2013: made under S75 of the 2012 Act; apply only to NHS England and ICBs; enforced by NHS Improvement; and

    b. The European procurement regime – Public Contracts Regulations 2015 (PCR 2015): incorporate the European Public Contracts Directive into national law; apply to all public contracts over the threshold value (€750,000, currently £589,148); enforced through the Courts. The general principles arising under the Treaty on the Functioning of the European Union of equal treatment, transparency, mutual recognition, non-discrimination and proportionality may apply even to public contracts for healthcare services falling below the threshold value if there is likely to be

interest from providers in other member states.

135. Whilst the two regimes overlap in terms of some of their requirements, they are not the same – so compliance with one regime does not automatically mean compliance with the other.

136. The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 201323 states:

> *ICBs must not award a contract for the provision of NHS health care services where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract; and*
>
> *ICBs must keep a record of how it managed any such conflict in relation to NHS commissioning contracts it has entered into. [As set out in paragraph 113 below, details of this should also be published by the ICB.]*
>
> *The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013*

137. Paragraph 24 of PCR 2015 states: "Contracting authorities shall take appropriate measures to effectively prevent, identify and remedy conflicts of interest arising in the conduct of procurement procedures so as to avoid any distortion of competition and to ensure equal treatment of all economic operators". Conflicts of interest are described as "any situation where relevant staff members have, directly or indirectly, a financial, economic or other personal interest which might be perceived to compromise their impartiality and independence in the context of the procurement procedure".

138. The Procurement, Patient Choice and Competition Regulations (PPCCR) place requirements on commissioners to ensure that they adhere to good practice in relation to procurement, run a fair, transparent process that does not discriminate against any provider, 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. Furthermore the PPCCR places requirements on commissioners to secure high quality, efficient NHS healthcare services that meet the needs of the people who use those services. The PCR 2015 are focused on ensuring a fair and open selection process for providers.

139. An obvious area in which conflicts could arise is where the ICB commissions (or continues to commission by contract extension) healthcare services, including GP services, in which a member of the ICB has a financial or other interest. This may most often arise in the context of the delegated primary care function.

140. A procurement checklist, provided in Appendix D, sets out factors that the ICB should address when drawing up plans to commission general practice services. This will assist in providing evidence of deliberations on conflicts of interest. In addition, Appendix E is the form to be completed documenting the conflicts of interest for bidders and contractors.

141. ICB will be required to make the evidence of their management of conflicts publicly available, and the relevant information from the procurement template should be used to complete the register of procurement decisions. Complete transparency around procurement will provide:

    a. Evidence that the ICB is seeking and encouraging scrutiny of its decision- making process;

    b. A record of the public involvement throughout the commissioning of the service;

    c. A record of how the proposed service meets local needs and priorities for partners such as the Health and Wellbeing Boards, local Healthwatch and local communities;

    d. Evidence to the audit committee and internal and external auditors that a robust process has been followed in deciding to commission the service, in selecting the appropriate procurement route, and in addressing potential conflicts.

142. External services such as commissioning support units (CSUs) can play an important role in helping ICBs decide the most appropriate procurement route, undertake procurements and manage contracts in ways that manage conflicts of interest and preserve the integrity of decision-making. When using a CSU, the ICB will have systems to assure itself that a CSU's business processes are robust and enable the ICB to meet its duties in relation to procurement (including those relating to the management of conflicts of interest). This would require the CSU to declare any conflicts of interest it may have in relation to the work commissioned by the ICB.

143. The ICB cannot, however, lawfully delegate commissioning decisions to an external provider of commissioning support. Although CSUs are likely to play a key role in helping to develop specifications, preparing tender documentation, inviting expressions of interest and inviting tenders, the ICB itself will need to:

    a. Determine and sign off the specification and evaluation criteria;

    b. Decide and sign off decisions on which providers to invite to tender; and

    c. Make final decisions on the selection of the provider.

Register of procurement decisions

144. ICB needs to 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 must include:
    a. The details of the decision;

    b. 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);

c. A summary of any conflicts of interest in relation to the decision and how this was managed by the ICB retaining the anonymity of bidders; and

d. The award decision taken.

145. The register of procurement decisions must be updated whenever a procurement decision is taken. A draft register is included at Appendix F. The Procurement, Patient Choice and Competition Regulations 9(1) place a requirement on commissioners to maintain and publish on their website a record of each contract it awards. The register of procurement decisions will be made publicly available and easily accessible to patients and the public.

146. Although it is not a requirement to keep a register of services that may be procured in the future, it would be considered good practice to ensure planned service developments and possible procurements are transparent and available for the public to see.

Declarations of interests for bidders / contractors

147. As part of a procurement process, it is good practice to ask bidders to declare any conflicts of interest. This allows commissioners to ensure that they comply with the principles of equal treatment and transparency. When a bidder declares a conflict, the commissioners must decide how best to deal with it to ensure that no bidder is treated differently to any other. Please see Appendix E for a declaration of interests for bidders/ contractors template.

148. It will not usually be appropriate to declare such a conflict on the register of procurement decisions, as it may compromise the anonymity of bidders during the procurement process. However, commissioners should retain an internal audit trail of how the conflict or perceived conflict was dealt with to allow them to provide information at a later date if required. Commissioners are required under regulation 84 of the Public Contract Regulations 2015 to make and retain records of contract award decisions and key decisions that are made during the procurement process (there is no obligation to publish them). Such records must include “communications with economic operators and internal deliberations” which should include decisions made in relation to actual or perceived conflicts of interest declared by bidders. These records must be retained for a period of at least three years from the date of award of the contract.

Contract Monitoring

149. The management of conflicts of interest applies to all aspects of the commissioning cycle, including contract management.

150. Any contract monitoring meeting needs to consider conflicts of interest as part of the process i.e., the chair of a contract management meeting should invite

declarations of interests; record any declared interests in the minutes of the meeting; and manage any conflicts appropriately and in line with this guidance. This equally applies where a contract is held jointly with another organisation such as the Local Authority or with other ICBs under lead commissioner arrangements.

151. The individuals involved in the monitoring of a contract should not have any direct or indirect financial, professional or personal interest in the incumbent provider or in any other provider that could prevent them, or be perceived to prevent them, from carrying out their role in an impartial, fair and transparent manner.

152. The ICB will be mindful of any potential conflicts of interest when they disseminate any contract or performance information/reports on providers, and manage the risks appropriately.

Raising concerns and breaches

153. There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidently, or because of the deliberate actions of staff or organisations. For the purposes of this policy these situations are referred to as “breaches”.

154. It is the duty of every ICB employee, Board member, committee or sub-committee 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. These individuals should not ignore their suspicions or investigate themselves, but rather speak to the designated ICB point of contact for these matters (the point of contact may vary in accordance with the ICB’s conflicts of interest and whistleblowing policies).

155. Any non-compliance with the ICB’s conflicts of interest policy should be reported in accordance with the terms of the policy, and ICB’s whistleblowing policy (where the breach is being reported by an employee or worker of the ICB) or with the whistleblowing policy of the relevant employer organisation (where the breach is being reported by an employee or worker of another organisation).

156. Effective management of conflicts of interest requires an environment and culture where individuals feel supported and confident in declaring relevant information, including notifying any actual or suspected breaches of the rules. In particular, Head of Corporate Governance will work with lead officers to ensure that organisational policies are clear about the support available for individuals who wish to come forward to notify an actual or suspected breach of the rules, and of the sanctions and consequences for any failure to declare an interest or to notify an actual or suspected breach at the earliest possible opportunity.

157. Anonymised details of breaches will be published on the ICB’s website for the purpose of learning and development.

Reporting breaches

158. The Head of Corporate Governance will be responsible for recording the breach and informing the Conflicts of Interest Guardian. Where further investigation of the breach is required this will be done in conjunction and advice sought from the Conflicts of Interest Guardian and, where appropriate advice sought from NHS England or legal advisers. The breach may be of such significance and therefore reportable to NHS England at the earliest opportunity.

159. Employees, Board members, committee or sub-committee members should be aware of how they can report suspected or known breaches of the ICB's conflicts of interest policies, including ensuring that they should generally contact the ICB's designated Conflicts of Interest Guardian in the first instance to raise any concerns. They should also be advised of the arrangements in place to ensure that they are able to contact the Conflicts of Interest Guardian on a strictly confidential basis.

160. Anyone who wishes to report a suspected or known breach of the policy, who is not an employee or worker of the ICB, should also ensure that they comply with their own organisation's whistleblowing policy, since most such policies should provide protection against detriment or dismissal.

161. The ICB will ensure that the Conflicts of Interest Guardian is in a position to cross refer to and comply with other ICB policies on raising concerns, counter fraud, or similar as and when appropriate.

162. All such notifications will be treated with appropriate confidentiality at all times in accordance with the ICB's policies and applicable laws, and the person making such disclosures should expect an appropriate explanation of any decisions taken as a result of any investigation.

163. Furthermore, providers, patients and other third parties can make a complaint to NHS Improvement in relation to a commissioner's conduct under the Procurement Patient Choice and Competition Regulations. The regulations are designed as an accessible and effective alternative to challenging decisions in the courts.

Fraud, Corruption and Bribery

164. It is vital that staff and Board members comply with all aspects of this policy as not to do so could lay them open to allegations of fraud, bribery or corruption. If in any doubt as to whether a particular interest should be declared, or a gift registered, individuals should take a cautious approach and do so.

165. The offering or taking of bribes are criminal offences under the Bribery Act 2010. Allegations of this sort do not only affect the individuals concerned, however, as the Bribery Act 2010 introduced a new corporate offence so that the ICB can be held responsible if it fails to enact adequate procedures to prevent bribery.

166. All allegations of suspected fraud, bribery and/or corruption must be reported to the ICB's Counter Fraud Specialist in accordance with the ICB's Fraud, Corruption and Bribery Policy.

Impact of non-compliance

167. Failure to comply with the ICB's policy on conflicts of interest management, pursuant to NHS England's statutory guidance, can have serious implications for the ICB and the individuals concerned.

Disciplinary implications

168. The ICB will ensure that 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 are 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.

Professional regulatory implications

169. Statutorily regulated healthcare professionals who work for, or are engaged by, the ICB are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest. ICBs ae required to report statutorily regulated healthcare professionals to their regulator if they believe that they have acted improperly, so that these concerns can be investigated. Statutorily regulated healthcare professionals should be made aware that the consequences for inappropriate action could include fitness to practise proceedings being brought against them, and that they could, if appropriate, be struck off by their professional regulator as a result.

Civil sanctions

170. If conflicts of interest are not effectively managed, the ICB could face civil challenges to decisions it makes – for instance if interests were not disclosed that were relevant to the bidding for, or performance of contracts. In extreme cases, staff and other individuals could face personal civil liability, for example a claim for misfeasance in public office.

Criminal sanctions

171. Failure to manage conflicts of interest could lead to criminal proceedings including for offences such as fraud, bribery and corruption. This could have implications for the organisation and linked organisations, and the individuals who are engaged by them.

Conflicts of Interest Training

172. Management of conflicts of interest training will be offered to all employees, Board members, members of ICB committees and sub-committees and practice staff with involvement in ICB business. This will be to ensure staff and others understand what conflicts are and how to manage them effectively.

173. The training will cover:
    - What is a conflict of interest;
    - Why is conflict of interest management important;
    - What are the responsibilities of the organisation you work for in relation to conflicts of interest;
    - What should you do if you have a conflict of interest relating to your role, the work you do or the organisation you work for (who to tell, where it should be recorded, what actions you need to take and what implications it may have for your role);
    - How conflicts of interest can be managed;
    - What to do if you have concerns that a conflict of interest is not being declared or managed appropriately;
    - What are the potential implications of a breach of the ICB's rules and policies for managing conflicts of interest.

174. NHS England is developing an online training package for ICB employees, Board members, members of ICB committees and sub-committees, and practice staff with involvement in ICB business. This training will be mandatory and need to be completed on an annual basis by 31 January of each year. Completion rates will be reported as part of the ICB's annual conflicts of interest audit. NHS England may also make available face-to-face training for specific individuals.

Policy review

175. This Policy will be reviewed annually by the Head of Corporate Governance for approval by the Audit Committee. The Policy will be regularly monitored to ensure it is compliant with new legislation and guidance.

Policy dissemination

176. The ICB will ensure that all employees and decision-makers are aware of the existence of this policy by:
    - An introduction to the policy being given during local induction for new starters to the ICB;
    - The Policy will be available to all members of staff; the Board; members of committees and sub-groups via the shared drive and via the intranet.
    - An annual reminder of the existence and importance of the policy delivered via internal communication methods; and
    - At least an annual reminder to update declaration forms sent to all members of the Board and any other committee, sub-group or decision-making group.

Monitoring and audit arrangements

177. NHS England will review the ICB's compliance with statutory conflicts of interest requirements through its review and assessment processes.

178. Adherence to this Policy will be reviewed regularly by the Head of Corporate Governance .

179. The ICB will need to undertake an audit of conflicts of interest management as part of their internal audit on an annual basis. The results of the audit should be reflected in the ICB's annual governance statement and should be discussed in the end of year governance meeting with NHS regional teams.

180. The Audit Committee will be responsible for undertaking reviews of decision-making processes to ensure that the Policy is applied effectively and where further controls are required will advise accordingly. The Audit Committee will ensure an audit of conflicts of interest forms part of the annual internal audit plan, and will also look to commissioning an audit review where policy has not been adhered to to identify any lessons learnt and advise on changes to systems and processes as appropriate.

Useful Documents and References

The ABPI Code of Practice for the Pharmaceutical Industry:
http://www.pmcpa.org.uk/thecode/Pages/default.aspx

The Bribery Act 2010 http://www.legislation.gov.uk/ukpga/2010/23/contents

The Equality Act 2010 http://www.legislation.gov.uk/ukpga/2010/15/contents

GMC | Good medical practice (2013) http://www.gmc-uk.org/guidance/good_medical_practice.asp and http://www.gmc-uk.org/guidance/ethical_guidance/21161.asp and http://www.gmcuk.org/guidance/ethical_guidance/21161.asp

The Good Governance Standards for Public Services , 2004, OPM and CIPFA
http://www.opm.co.uk/wp-content/uploads/2014/01/Good-Governance-Standard-for-Public-Services.pdf

Managing conflicts of interests in the NHS: Guidance for staff and organisations.2017
https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interestnhs.Pdf

NHS Commissioning Board (2012) *Standards of Business Conduct*
https://www.england.nhs.uk/wpcontent/uploads/2012/11/stand-bus-cond.pdf

National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) section

The NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013
http://www.legislation.gov.uk/uksi/2013/500/contents/made

The Public Contract Regulations 2015 http://www.legislation.gov.uk/uksi/2015/102/regulation/57/made

The 7 principles of public life https://www.gov.uk/government/publications/the-7-principles-of-publiclife

The seven key principles of the NHS Constitution
http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx

Standards for members of NHS boards and ICB governing bodies in England
http://www.professionalstandards.org.uk/publications/detail/standards-for-members-of-nhs-boards-andclinical-commissioning-group-governing-bodies-in-england

UK Corporate Governance Code https://www.frc.org.uk/Our-Work/CodesStandards/Corporategovernance/UK-Corporate-Governance-Code.aspx

Appendix A

Register of Interest Guidance

1. Why Do We Have a Register of Interests?

This guidance relates to the ICB Clinical Commissioning Group (ICB), in particular to the Board members (i.e. the ICB Board), to the members of the committees of the Board; and ICB employees.

1.1 All Board members and employees of the ICB have a legal obligation to act in the best interests of the ICB. Public service values matter in the NHS and those working in it have a duty to conduct NHS business with probity.

1.2 The *Code of Accountability for NHS Boards* sets out a requirement that chairs and all board directors should declare any conflict of interest that arises in the course of conducting NHS business.

1.3 Furthermore, given the requirements of the *Nolan Principles - The Seven Principles of Public Life*, all NHS organisations are required to maintain a Register of Interests to avoid any danger of board members, and employees of the ICB being influenced, or appearing to be influenced, by their private interests in the exercise of their public duties.

1.4 All members and employees of the ICB are therefore expected to declare any personal or business interest which may influence, or may be *perceived* to influence, their judgement. This should include, as a minimum, personal, direct and indirect financial interests, and should normally also include such interests of close family members.

1.5 You are also required to register any gifts or hospitality received in connection with your role in the ICB.

1.6 It is important to note that registration of interests does not imply any wrongdoing.

2. Duties of Board Members (Executive Directors, non-executive members and partner members) who are involved in ICB business, in Respect of Registration

2.1 You are required to make a full disclosure of your interest(s), and any gifts or hospitality received in connection with your role in the ICB. Appendix 1 below provides the declaration of interests form for your disclosure; and also details the types of interest you should declare. You may also need to complete the Declaration of Gifts and Hospitality Form (please refer to the guidance on gifts and hospitality), where applicable.

2.2 If you are not sure what to declare, or whether/when your declaration needs to be updated, please err on the side of caution.

2.3 If you have any doubt about the relevance of an interest, this should be discussed with the either the Executive Director of Finance or Head of Corporate Governance.

2.4 You are also formally required to review your entry in the Register of Interests at least annually at the start of the Financial Year.

2.5 To be effective, the declaration of interests needs to also be updated when any changes occur. It is your responsibility to notify the Head of Corporate Governance of any changes in your interests within four weeks of the change occurring. The same time frame applies to registering gifts and hospitality.

3. Data Protection

3.1 The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act 1998. Data will be processed only to ensure that all ICB Board members, who are involved in ICB business, and employees act in the best interests of the ICB. The information provided will not be used for any other purpose.

4. Publication and Public Inspection

4.1 The Register of Interests will be published in the ICB's annual report and accounts and will also be available on the ICB website.

4.2 Between publications of the annual report, the Register of Interests will be regularly updated in a loose leaf form, and in that form will be available for public inspection in the Corporate Office. At the discretion of the Head of Corporate Governance , copies of individual entries may be supplied on request, upon payment of a small charge, to cover photocopying and administrative costs.

5. Declaration of Interests

5.1 Where there is a potential for private interests to be material and relevant to the business being conducted, the relevant interest should be declared and recorded in the ICB Board minutes and entered in to the Register of Interests. When a conflict of interest is established, the Board member (Executive Directors, clinical leads and or employees of the ICB should withdraw from the meeting as appropriate and play no part in the relevant discussion or decision.

5.2 All decisions under a conflict of interest will be recorded by the Head of Corporate Governance and reported in the minutes of the meeting. The report will record:

- The nature and extent of the conflict;
- An outline of the discussion;
- The actions taken to manage the conflict.

5.3 Where a ICB Board member, or employee of the ICB benefits from the decision, this will be reported in the annual report and accounts accordingly.

6. Conclusion

6.1 This document only provides guidance. If you are unsure about any aspect of it, you should contact the Executive Director of Finance, Contracting and Corporate Governance or the Head of Corporate Governance in the first instance for advice.

APPENDIX 1

NHS LLR Integrated Care Board

Declaration of interests form for ICB members and employees

Name:	
Position within, or relationship with, the ICB (or partners and NHS England in the event of joint committees):	

Detail of interests held (complete all that are applicable):

Type of Interest* ***See following page 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 officer)**

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 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and 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, or internal disciplinary action may result.

I **do / do not [delete as applicable]** give my consent for this information to published on registers that the ICB holds. If consent is NOT given please give reasons:

Signed:		**Date**:
Signed: (Line Manager or Senior ICB Manager)	**Position:**	**Date:**

Please return to**:** **Daljit K. Bains, Head of Corporate Governance**
NHS LLR Integrated Care Board
Room G30, Pen Lloyd Building, County Hall,
Glenfield, Leicester, LE3 8TB.

Types of interest

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; • 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.
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.

LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD - REGISTER OF INTERESTS

Declarations of Interest - YEAR (updated [date])
N.B. including dates "to", "from" or both as per guidance relating to the interest where new or circumstances have changed through the year.

Name	Job Title / Role	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
insert details						

Appendix B

NHS LLR Integrated Care Board

Guidance on the acceptance of gifts and hospitality

Why do we need this guidance?

1. Leicester, Leicestershire and Rutland Integrated Care Board has a responsibility to ensure integrity and probity in its relationships with suppliers, contractors and service users; and ensure that robust systems of control are in place within the ICB to prevent fraud and corruption.

2. During the course of their work, staff will sometimes receive offers of gifts (which includes goods or payment) and hospitality. Openness in declaring and recording these matters is a safeguard for staff who might otherwise be perceived to be receiving a personal and direct benefit in contravention of the ICB Constitution (i.e. Standing Orders and Prime Financial Policies) and Fraud and Corruption Policy.

3. The current process / procedure / guiding principles covering the acceptance of gifts and hospitality are outlined within the Conflicts of Interest, Gifts and Hospitality and Sponsorship Policy, although it is not possible to provide for every eventuality and, therefore staff should not hesitate to seek advice from their line manager in the first instance, the Chief Finance Officer and / or the Head of Corporate Governance .

4. The benefits of such systems are both to the ICB and to individual members of staff, who by following the requirements and guidance in relation to gifts and hospitality, can be reassured that they are acting within the limits of acceptable business conduct.

What do I need to report and how?

5. The key guiding principle is that any gifts offered by contractors, suppliers or any other organisations that have a business relationship with the ICB, which might reasonably be seen to compromise their personal judgement or integrity, should be politely but firmly declined.

6. If you wish to record the acceptance of a gift or hospitality an “Acceptance of Gifts and Hospitality” form must be completed and returned to Daljit K. Bains (Head of Corporate Governance), who will ensure that the item is entered into the Register. A copy of this form is at Appendix 1.

7. Any member of staff who has been offered a gift / hospitality and refuses to accept it should also inform Daljit K. Bains, via the form at Appendix 1. Daljit K. Bains will ensure that this information is also entered on to the gifts and hospitality register as non-acceptance. Recording refusals can assist in ensuring members of staff are covered against any possible allegations.
8. Acceptance of hospitality should as a principle be limited in both frequency and in the value of the hospitality extended. A list is attached at Appendix 2 as a reference

(this is not an exhaustive list) and identifies items which are deemed as potentially acceptable and those which are specifically unacceptable.

Appendix 1

NHS LLR Integrated Care Board

Declarations of gifts and hospitality form

Recipient Name and Position	Date of Offer and / or Date of Receipt (if applicable)	Details of Gift / Hospitality	Estimated Value £	Supplier / Offeror Name and Nature of Business	Details of Previous Offers or Acceptance by this Offeror/ Supplier	Declined or Accepted?	Details of the officer reviewing and approving the declaration made and date	Reason for Accepting or Declining	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 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and 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.

I **do / do not (delete as applicable)** give my consent for this information to published on registers that the ICB holds. If consent is NOT given please give reasons:

Signed:		**Date**:
Signed: (Line Manager or Senior ICB Manager)	**Position:**	**Date:**

Please return to**:** **Daljit K. Bains, Head of Corporate Governance**
NHS LLR Integrated Care Board
Room G30, Pen Lloyd Building, County Hall,
Glenfield, Leicester, LE3 8TB

Appendix 2

NHS LLR Integrated Care Board

Template: Register of gifts and hospitality

Recipient Name and Position	Date of Offer and / or Date of Receipt (if applicable)	Details of Gift / Hospitality	Estimated Value £	Supplier / Offeror Name and Nature of Business	Declined or Accepted?	Reason for Accepting or Declining

Appendix 3

GIFTS AND HOSPITALITY

Gift / Hospitality	Acceptable	**Potentially unacceptable** (Prior approval and Declaration required)	Unacceptable	Declarable	Non-declarable
Low value promotional gifts such as: Diaries/calendars	√			√	
Token gifts given at courtesy visit	√			√	
Gifts of low value (e.g. chocolates, biscuits – **not** money) from patients/relatives/friend of patients – although acceptable, persons offering such gifts should be advised of the existence of Charitable Funds as an alternative.	√ (if in doubt seek approval)			Individual value of up to £10.00	
Infrequent working breakfast	√				√
Infrequent working lunch	√				√
Formal dinners/evening		√		√	
Visits to view equipment paid for by outside companies		√		√	
Other forms of commercial sponsorship – including drug company sponsorship		√		√	
Gifts which would cause offence to return		√		√	
Gifts to relative / friends			√	√ if offered	
Holiday accommodation			√	√ if offered	
Casual gifts offered by contractors			√	√ if offered	
Promotional offers i.e. personal discounts / discount vouchers			√	√ if offered	
Other promotional gifts			√	√ if offered	
Attendance at sporting events			√	√ if offered	
Invitation to cultural events			√	√ if offered	

Appendix C

NHS LLR Integrated Care Board

Declarations of interest checklist for meeting Chairs

Under the Health and Care Act 2022, there is a legal obligation to manage conflicts of interest appropriately. It is essential that declarations of interest and actions arising from the declarations are recorded formally and consistently across the Board of the ICB, committee and sub-committee meetings. This checklist has been developed with the intention of providing support in conflicts of interest management to the Chair of the meeting- prior to, during and following the meeting. It does not cover the requirements for declaring interests outside of the committee process.

Timing	Checklist for Chairs	Responsibility
In advance of the meeting	**1. The agenda** to include a standing item on declaration of interests to enable individuals to raise any issues and/or make a declaration at the meeting.	Meeting Chair and secretariat
	2. A **definition of conflicts of interest** should also be accompanied with each agenda to provide clarity for all recipients.	Meeting Chair and secretariat
	3. Agenda to be circulated to enable attendees (including visitors) to identify any interests relating specifically to the agenda items being considered.	Meeting Chair and secretariat
	4. Members should contact the Chair as soon as an actual or potential conflict is identified.	Meeting members
	5. Chair to review a **summary report from preceding meetings** i.e., sub-committee, working group, etc., detailing any conflicts of interest declared and how this was managed. **A template for a summary report** to present discussions at preceding meetings is detailed below.	Meeting Chair
	6. A **copy of the members' declared interests** is checked to establish any actual or potential conflicts of interest that may occur during the meeting.	Meeting Chair
During the meeting	**7. Check and declare the meeting is quorate** and ensure that this is noted in the minutes of the meeting.	Meeting Chair

Timing	Checklist for Chairs	Responsibility
	8. Chair requests **members to declare any interests in agenda items**- which have not already been declared, including the nature of the conflict.	Meeting Chair
	9. Chair makes a decision as to how to manage each interest which has been declared, including whether / to what extent the individual member should continue to participate in the meeting, on a case by case basis, and this decision is recorded.	Meeting Chair and secretariat
	10. As minimum requirement, the following should be **recorded in the minutes of the meeting**: • 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 any individuals retired from and returned to the meeting - even if an interest has not been declared; • **Visitors in attendance** who participate in the meeting must also follow the meeting protocol and declare any interests in a timely manner. **A template for recording any interests during meetings** is detailed below.	Secretariat
Following the meeting	**11.** All **new interests declared** at the meeting should be promptly updated onto the declaration of interest form;	Individual(s) declaring interest(s)
	12. All new completed declarations of interest should be **transferred onto the register of interests.**	Designated person responsible for registers of interest

Appendix D

NHS LLR Integrated Care Board

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?[1]	

11. What additional external involvement will there be in scrutinising the proposed decisions?	
12. How will the ICB make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of any contract?	
Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply)	
13. How have you determined a fair price for the service?	
Additional questions when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) where GP practices are likely to be qualified providers	
14. How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	
Additional questions for proposed direct awards to GP providers	
15. What steps have been taken to demonstrate that the services to which the contract relates are capable of being provided by only one provider?	
16. In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	
17. What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?	

Appendix E

NHS LLR Integrated Care Board

Declaration of conflict of interests for bidders/contractors

(Bidders/potential contractors/service providers' declaration form: financial and other interests)

This form is required to be completed in accordance with the ICB's Constitution.

Notes:

- All potential bidders/contractors/service providers, including sub-contractors, members of a consortium, advisers or other associated parties (Relevant Organisation) and required to identify any potential conflicts of interest that could arise if the Relevant Organisation were to take part in any procurement process and/or provide services under, or otherwise enter into any contract with the ICB.
- If any assistance is required in order to complete this form, then the Relevant Organisation should contact the Head of Corporate Governance (daljitkaur.bains@nhs.net).
- Any changes to interests declared either during the procurement process or during the terms of any contract subsequently entered into by the Relevant Organisation and the ICB must be notified to the ICB by completing a new declaration form and submitting it by both email and signed hard copy to the Head of Corporate Governance .
- Relevant Organisations completing this declaration form must provide sufficient detail of each interest so that a member of the public would be able to understand clearly the sort of financial or other interest the person concerned has and the circumstances in which a conflict of interest with the business or running of the ICB might arise.
- If in doubt as to whether a conflict of interest could arise, a declaration of the interest/s should be made.

Interests that must be declared (whether such interests are those of the Relevant Person themselves or of a family member, close friend or other acquaintance of the Relevant Person), include the following:

- The Relevant Organisation or any person employed or engaged by or otherwise connected with a Relevant Organisation (Relevant Person) has provided or is providing services or other work for the ICB;
- A Relevant Organisation or Relevant Person is providing services or other work for any other potential bidder in respect of this project or procurement process;
- The Relevant Organisation or Relevant Person is providing services or other work for any other potential bidder in respect of this project or procurement process;
- The Relevant Organisation or any Relevant person has any other connection with the ICB, whether personal or professional, which the public could perceive may impair or otherwise influence the ICB's or any of its members' or employees' judgements, decisions or actions.

Declaration of conflict of interests for bidders/contractors form

Name of Organisation:	
Details of interests held:	
Type of Interest	**Details**
Provision of services or other work for the ICB or NHS England	
Provision of services or other work for any other potential bidder in respect of this project or procurement process	
Any other connection with the ICB or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the ICB's or any of its members' or employees' judgements, decisions or actions	

Name of Relevant Person	[*complete for all Relevant Persons*]	
Details of interests held:		
Type of Interest	**Details**	**Personal interest or that of a family member, close friend or other acquaintance?**
Provision of services or other work for the ICB or NHS England		
Provision of services or other work for any other potential bidder in respect of this project or procurement process		
Any other connection with the ICB or NHS England, whether personal or		

professional, which the public could perceive may impair or otherwise influence the ICB's or any of its members' or employees' judgements, decisions or actions		

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information.

Signed:

On behalf of:

Date:

Appendix F

NHS Leicester, Leicestershire and Rutland Integrated Care Board

Template form and register: Procurement decisions and contracts awarded

Ref No	Contract / Service title	Procurement description	Existing contract or new procurement (if existing include details)	Procurement type – ICB procurement, collaborative procurement with partners	ICB clinical lead (Name)	ICB contract manger (Name)	Decision making process and name of decision making committee	Summary of conflicts of interest noted	Actions to mitigate conflicts of interest	Justification for actions to mitigate conflicts of interest	Contract awarded (supplier name & registered address)	Contract value (£) (Total) and value to ICB	Comments to note

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information.

Signed:

On behalf of:

Date:

Please return to**: Daljit K. Bains, Head of Corporate Governance , NHS LLR ICB, G30, Pen Lloyd Building, County Hall, Glenfield, Leicester, LE3 8TB.**

Appendix G

Sample template for recording minutes

***XXXX* Committee Meeting**

Date: ***DD MONTH YYYY***
Time: ***2pm to 4pm***
Location: ***Room B, XXXX ICB***

Attendees:

Name	**Initials**	**Role**
Name	SK	Role / job title (Chair)
Name		Role / job title

In attendance:

Name	NF	Role / job title

Item No	Agenda Item	Actions
1	**Chairs welcome**	
2	**Apologies for absence** <apologies to be noted>	
3	**Declarations of interest** *SK reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of XXX ICB..* *Declarations made by members of the XXX Committee are listed in the ICB's Register of Interests. The Register is available either via the secretary to the Board or the ICB's website at the following link: ……* **Declarations of interest from sub committees.** *None declared* **Declarations of interest from today's meeting**	

	The following update was received at the meeting: • *With reference to business to be discussed at this meeting, MS declared that he is a shareholder in XXX Care Ltd.* *SK declared that the meeting is quorate and that MS would not be included in any discussions on agenda item X due to a direct conflict of interest which could potentially lead to financial gain for MS.* *SK and MS discussed the conflict of interest, which is recorded on the register of interest, before the meeting and MS agreed to remove himself from the table and not be involved in the discussion around agenda item X.*	
4	**Minutes of the last meeting** <*date to be inserted*> ***and matters arising***	
5	**Agenda Item** <*Note the agenda item*> *MS left the meeting, excluding himself from the discussion regarding xx.* ***<conclude decision has been made>*** ***<Note the agenda item xx>*** *MS was brought back into the meeting.*	
6	**Any other business**	
7	**Date and time of the next meeting**	

Appendix H

Summary of key aspects of the guidance on managing conflicts of interest relating to commissioning of new care models
(in line with guidance from NHS England)

Introduction

1. Conflicts of interest can arise throughout the whole commissioning cycle from needs assessment, to procurement exercises, to contract monitoring. They arise in many situations, environments and forms of commissioning.

2. Where ICBs are commissioning new care models, particularly those that include primary medical services, it is likely that there will be some individuals with roles in the ICB (whether clinical or non-clinical), that also have roles within a potential provider, or may be affected by decisions relating to new care models. Any conflicts of interest must be identified and appropriately managed, in accordance with this statutory guidance. Where we refer to 'new care models' in this note, we are referring to any Multi-speciality Community Provider (MCP), Primary and Acute Care Systems (PACS) or other arrangements of a similar scale or scope that (directly or indirectly) includes primary medical services.

3. This appendix is intended to provide further advice and support to help ICBs to manage conflicts of interest in the commissioning of new care models. It summarises key aspects of the statutory guidance which are of particular relevance to commissioning new care models rather than setting out new requirements. Whilst this appendix highlights some of the key aspects of the statutory guidance, ICBs should always refer to, and comply with, the full statutory guidance.

Identifying and managing conflicts of interest

4. The statutory guidance for ICBs is clear that any individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to a ICB (whether as a provider of healthcare or provider of commissioning support services, or otherwise) should recognise the inherent conflict of interest risk that may arise and should not be a member of the Board or of a committee or sub-committee of the ICB.

5. In the case of new care models, it is perhaps likely that there will be individuals with roles in both the ICB and new care model provider/potential provider. These conflicts of interest should be identified as soon as possible, and appropriately managed locally. The position should also be reviewed whenever an individual's role, responsibility or circumstances change in a way that affects the individual's interests. For example where an individual takes on a new role outside the ICB, or enters into a new business or relationship, these new interests should be promptly

declared and appropriately managed in accordance with the statutory guidance.

6. There will be occasions where the conflict of interest is profound and acute. In such scenarios (such as where an individual has a direct financial interest which gives rise to a conflict, e.g., secondary employment or involvement with an organisation which benefits financially from contracts for the supply of goods and services to a ICB or aspires to be a new care model provider), it is likely that ICBs will want to consider whether, practically, such an interest is manageable at all. ICBs should note that this can arise in relation to both clinical and non- clinical members/roles. If an interest is not manageable, the appropriate course of action may be to refuse to allow the circumstances which gave rise to the conflict to persist. This may require an individual to step down from a particular role and/or move to another role within the ICB and may require the ICB to take action to terminate an appointment if the individual refuses to step down. ICBs should ensure that their contracts of employment and letters of appointment, HR policies, Board and committee terms of reference and standing orders are reviewed to ensure that they enable the ICB to take appropriate action to manage conflicts of interest robustly and effectively in such circumstances.

7. Where a member of ICB staff participating in a meeting has dual roles, for example a role with the ICB and a role with a new care model provider organisation, but it is not considered necessary to exclude them from the whole or any part of a ICB meeting, he or she should ensure that the capacity in which they continue to participate in the discussions is made clear and correctly recorded in the meeting minutes, but where it is appropriate for them to participate in decisions they must only do so if they are acting in their ICB role.

8. ICBs should take all reasonable steps to ensure that employees, committee members, contractors and others engaged under contract with them are aware of the requirement to inform the ICB if they are employed or engaged in, or wish to be employed or engaged in, any employment or consultancy work in addition to their work with the ICB (for example, in relation to new care model arrangements).

9. ICBs should identify as soon as possible where staff might be affected by the outcome of a procurement exercise, e.g., they may transfer to a provider (or their role may materially change) following the award of a contract. This should be treated as a relevant interest, and ICBs should ensure they manage the potential conflict. This conflict of interest arises as soon as individuals are able to identify that their role may be personally affected.

10. Similarly, ICBs should identify and manage potential conflicts of interest where staff are involved in both the contract management of existing contracts, and involved in procurement of related new contracts.

Governance arrangements

11. Appropriate governance arrangements must be put in place that ensure that conflicts of interest are identified and managed appropriately, in accordance with this statutory guidance, without compromising the ICB's ability to make robust commissioning decisions.

12. We know that some ICBs are adapting existing governance arrangements and others developing new ones to manage the risks that can arise when commissioning new care models. We are therefore, not recommending a "one size fits" all governance approach, but have included some examples of governance models which ICBs may want to consider.

13. The principles set out in the general statutory guidance on managing conflicts of interest, including the Nolan Principles and the Good Governance Standards for Public Services (2004), should underpin all governance arrangements.

14. ICBs should consider whether it is appropriate for the Board to take decisions on new care models or (if there are too many conflicted members to make this possible) whether it would be appropriate to refer decisions to a ICB committee.

15. Where a ICB has full delegation for primary medical care services, ICBs could consider delegating the commissioning and contract management of the entire new care model to an appropriate committee / group, in line with current national guidance there is no requirement to convene what was previously a primary care commissioning committee. Where such decisions are made the principles and approach outlined in this policy should be adhered to to manage any perceived and actual conflicts.

Provider engagement

16. It is good practice to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient needs. This may include providers from the acute, primary, community, and mental health sectors, and may include NHS, third sector and private sector providers. Such engagement, done transparently and fairly, is entirely legal. However, 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 (be they incumbent or potential new providers) in developing a service specification for a contract for which they may later bid. ICBs should be particularly mindful of these issues when engaging with existing / potential providers in relation to the development of new care models and ICBs must ensure they comply with their statutory obligations including, but not limited to, their obligations under the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 and the Public Contracts Regulations 2015.

3

LEICESTER, LEICESTERSHIRE & RUTLAND

DIGITAL STRATEGY

2022-2025

A **bright** future

for health, care and wellbeing in Leicester, Leicestershire and Rutland

Version V0.23

Status ..... Draft

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Author: ..... Ian Wakeford

CONTENTS

GLOSSARY OF TERMS

ABBREVIATION / TERM	MEANING
BI	Business Intelligence
CDDO	Central Digital and Data Office
CDO	Chief Data Officer
CIS	Core Information Standard (see PRSB)
DHSC	Department of Health and Social Care
DITT	Digital Innovation and Transformation Team
DTAC	Digital Technology Assessment Criteria for Health and Social Care
dm+d	Dictionary of Medicines and Devices
FHIR	Fast Healthcare Interoperability Resources
HEE	Health Education England
HWB	Health and Wellbeing Board
HWP	Health and Wellbeing Partnership
ICB	Integrated Care Board
ICS	Integrated Care System
KLOE	Key Lines of Enquiry
$ktCO_2e$	Kilotonnes of carbon dioxide equivalent
LHCR	Local Health and Care Records
LLR	Leicester, Leicestershire, and Rutland
LLRCR	LLR (Shared) Care Record
LPT	Leicestershire Partnership Trust
LTP	NHS Long Term Plan
PAM	Professions Allied to Medicine
PHM	Population Health Management
PRSB	Professional Records Standards Body
RPA	Robotic Process Automation
ShCR	Shared Care Record
TCoP	CDDO Technology Code of Practice
UHL	University Hospitals of Leicester NHS Trust
VCFS	Voluntary, Community, and Faith Sector
VCSE	Voluntary, Community, and Social Enterprise

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The future of healthcare: our vision for digital, data and technology in health and care	https://www.gov.uk/government/publications/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care
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Wachter Report	https://www.gov.uk/government/publications/using-information-technology-to-improve-the-nhs
CDDO Technology Code of Practice	https://www.gov.uk/guidance/the-technology-code-of-practice
DAPB4020: UK Core FHIR R4	https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dapb4020-uk-core-fhir-r4-governance
SCCI0052: dm+d	https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/scci0052-dictionary-of-medicines-and-devices-dm-d
Coronavirus (COVID-19): notification to organisations to share information	https://www.gov.uk/government/publications/coronavirus-covid-19-notification-of-data-controllers-to-share-information
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FIGURES & TABLES

FIGURES

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1. FOREWORD

In the last two years, the pandemic has forced the NHS to undertake transformation at pace in the way that it delivers its services, and technology has underpinned much of that transformation.

Working with our health and care partners we must ensure that we continue to transform culture, processes and operating models, harnessing the technologies of the internet era to respond to these raised expectations of the public, whilst recognising the impact a lack of access to technology may have on health equity.

The big challenge for the LLR ICS will be to keep the really good and innovative digital transformations, accelerate that gain by describing a clear vision for the next three years, and ensure that our staff and our population are empowered to improve care with digital innovation.

This document will set out our clear vision to enable our collective transformation.

Andy Williams
Designate Chief Executive
Leicester, Leicestershire, and Rutland ICS

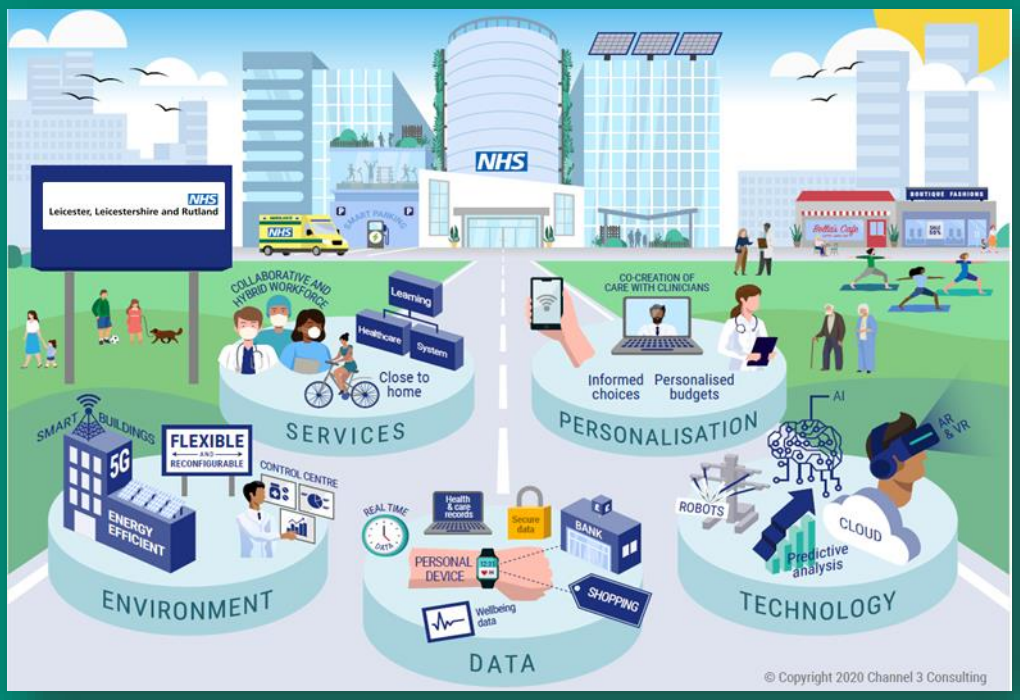
2. Introduction

The Leicester, Leicestershire, and Rutland Integrated Care Service (ICS) is accountable for improving outcomes, tackling inequalities, enhancing productivity in health and social care across the region.

National strategies for integration of local health and care services conforming to national policies and standards have led to the creation of ICSs.

New legislation is providing these statutory bodies with the mandate to achieve the vision of a person-focused delivery of health and social care in their region through new models of care, greater integration between partner organisations, and the use of digital tools and technology.

The Leicester, Leicestershire & Rutland Digital Strategy (2022-2025) aims to provide a unified direction for the key digital initiatives that we will deliver over the next three years, and the context for them.



2.1 ABOUT THIS DOCUMENT

The 2017 NHS Five Year Forward View noted the pressures faced by the health and social care systems, the opportunities available to address those challenges, and called for better integration of General Practice, community health, mental health, and hospital services, as well as more joined up working with home care and care homes under the accountability of localised Integrated Care Systems.

Working together with patients and the public, NHS commissioners and providers, as well as local authorities and other providers of health and care services, the government has provided ICSs with new powers to plan how best to provide care, while taking on new responsibilities for improving the health and wellbeing of the population they cover.

Over the past twenty years, technology has significantly changed our lives. The COVID-19 pandemic showed how important digital interactions have become and how quickly the health and social care system can respond, from online consultations to remote working.

Although technology is an enabler of the new patterns of work and care delivery, this document will also look to ensure that people with disabilities, impairments, or existing conditions, people from minority ethnic cultures and people from low socio-economic backgrounds will not be excluded from or vulnerable to transformation.

The Integrated Care System for Leicester, Leicestershire, and Rutland has developed a strategy to deliver more integrated care for our citizens. The Digital Strategy will describe how digital tools and modern ways of working will support the aims and principles of the ICS.

2.2 PURPOSE

The pandemic has shown the willingness of many patients to use and reap the benefits of digital care, indeed digital care is now an expectation of many citizens who are accustomed to these interactions in other aspects of modern life. New digital healthcare technology and services such as integrated care records must make patient experiences better.

Against a background of national strategy to improve and integrate care and leverage the benefits of modern technology, this document will highlight the key outcomes from the planned digital transformation and the actions we will take to achieve this.

The Digital Strategy will provide a consistent direction to all digital initiatives across LLR to facilitate the necessary cross-organisational collaboration to achieve our vision for improved health and social care.

2.3 CONSULTATION PROCESS

In the production of this Digital and Data Transformation plan we have engaged with many partner organisations and key individuals to ensure that this document is co-designed, and our target audience will recognise their contribution reflected in our vision.

It was really important to capture current intentions and future digital ambitions and over 50 stakeholders including, technical and design groups, organisational leads, clinical leads, and operational leads were interviewed. In addition, a review of respective organisational and digital strategies was conducted. Additional artefacts were requested and reviewed where appropriate to understand roadmaps that this strategy needed to take account of.

3. National Strategic Context

For some time, the government has encouraged a greater use of technology to support and improve health and social care. The 2019 NHS Long Term Plan has been followed by a series of policy documents to drive the opportunities of a vision of digitally-enabled care forwards in healthcare and social care.

The Department for Health and Social Care has set a series of ambitions to achieve this vision and has published national guidelines and frameworks to create greater integration of systems and remove barriers to digital adoption.

The creation of Integrated Care Systems as statutory bodies has enabled a cohesive system of health and social care across organisational boundaries, leading towards a vision of integrated care with the citizen at the centre rather than navigating a journey across multiple siloed providers.

The commercial sector has elevated people's expectation of how digital tools can support new ways of interacting which delivers services to a person rather than expecting the person to travel to the service provider. This model has not yet been fully matched in statutory health and social care.

The COVID-19 pandemic showed the benefits of digital tools and recent legislation has provided greater local powers to progress this further with a higher level of ICS accountability to deliver transformation in health and social care integration, including digital tools and care models.

National guidance has set standards for ICSs to achieve, and the adoption of open standards is enabling and encouraging technology solution providers to support greater data integration.

3.1 NHS LONG TERM PLAN

Prior to 2019, the national IM&T strategic direction was regularly refreshed but there was not a long-term strategic plan for the NHS to contextualise the digital projects. Consequently, technology improvement over the previous 20 years in health and social care had predominantly been organic and did not reflect the pace of change seen in commercial sectors.

In January 2019, the NHS published the NHS Long Term Plan [i](LTP). The LTP described a sweeping vision that "Digitally-enabled care will go mainstream across the NHS" alongside 135 specific "asks" to set the digital agenda.

The LTP noted that "*the way we deliver care remains locked into the service model largely created when the NHS was founded in 1948… Digital services and data interoperability give us the opportunity to free up time and resources to focus on clinical care and staying healthy*".

Figure 1 – NHS Vision for Digitally-enabled Models of Care

> *In ten years' time, we expect the existing model of care to look markedly different. The NHS will offer a 'digital first' option for most, allowing for longer and richer face-to-face consultations with clinicians where patients want or need it. Primary care and outpatient services will have changed to a model of tiered escalation depending on need. Senior clinicians will be supported by digital tools, freeing trainees' time to learn. When ill, people will be increasingly cared for in their own home, with the option for their physiology to be effortlessly monitored by wearable devices. People will be helped to stay well, to recognise important symptoms early, and to manage their own health, guided by digital tools.*

The vision that was set out in the LTP has subsequently been embedded into specific plans and frameworks which are aimed at improving statutory health and social care and ensuring that digital technologies and ways of working support that improvement. This ensures that digital transformation is at the heart of future care models and reinforces the demands on the IM&T community to support these care models.

The commitment made in the LTP was that there would be:

- Comprehensive digitisation of the health and care system
- Locally based shared records supporting high quality care
- Digitally skilled workforce, supported by those with transformation skills
- Centrally delivered capabilities, where necessary
- Enabling a digital ecosystem
- Digital care plans and Personal Health Records available to patients

The subsequent NHS Long Term Plan Implementation Framework set out the approach that Integrated Care Systems were asked to take to create their strategic plans to deliver the commitments of the LTP.

[i] *https://www.longtermplan.nhs.uk/*

3.2 INTEGRATED CARE SYSTEMS

The 2019 LTP placed Integrated Care Systems at the centre of the delivery of the commitments by bringing together local organisations in redesigning care, improving population health, creating shared leadership, and being accountable for the actions taken.

In November 2020 NHS England and NHS Improvement published 'Integrating care: Next steps to building strong and effective integrated care systems across England'. It described the core purpose of an ICS as:

- 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

The 2021 "Integrated Care Systems: Design Framework"[i] further described the ambitions for Integrated Care Systems to build on previous progress and to provide guidance on developing plans in preparation for the establishment of statutory ICS bodies from April 2022.

The Design Framework set clear expectations on ICSs to provide digital and data capabilities in place at system and place levels, and across provider collaboratives, including:

- A renewed digital and data transformation plan to meet 'What Good Looks Like'.
- Clear accountability for digital and data, with a named SRO with the appropriate expertise, underpinned by governance arrangements that have clear oversight and responsibility for digital and data standards and requirements for the ICS and enabling partner organisation programmes and services.
- Investment in levelling-up and consolidation of infrastructure, linked to the future ICS reference target architecture and data model, adopting a simplified cloud-first infrastructure that provides agility and frictionless cross-site working experience for the workforce.
- A shared care record that allows information to follow the patient and flow across the ICS to ensure that clinical and care decisions are made with the fullest of information.
- Ensure adherence by constituent partners to standards and processes that allow for interoperability across the ICS, and alignment to forthcoming national guidance.
- A single co-ordinated offer of digital channels for citizens across the system and remote monitoring technologies to help citizens manage their care at home.
- A cross-system intelligence function to support operational and strategic conversations, as well as building platforms to enable better clinical decisions. This will require ICSs to have linked data, accessible by a shared analytical resource that can work on cross-system priorities.
- A plan for embedding population health management capabilities and ensuring these are supported by the necessary data and digital infrastructure

The Department of Health and Social Care has recently published the government's proposals[ii] for health and care integration which details the new legislation which will "give ICSs stronger and more streamlined decision-making authority, and to embed accountability for system performance and delivery into the

[i] *https://www.england.nhs.uk/publication/integrated-care-systems-guidance/*

[ii] *https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations*

accountability arrangements of the NHS to government and Parliament" with the aim of establishing the accountability of ICSs in the health and social care outcomes in their region.

3.3 ADULT SOCIAL CARE REFORM

The government's 2021 policy paper "People at the Heart of Care: adult social care reform"[i] was presented to Parliament by the Secretary of State for Health and Social Care in December and set out the government's ten year vision for the modernisation of adult social care to deliver person-centred care with three key objectives:

- People have choice, control, and support to live independent lives.
- People can access outstanding quality and tailored care and support.
- People find adult social care fair and accessible.

The white paper recognises the benefits of digital transformation in achieving this vision, the challenges to be addressed, and the progress that has been made:

Figure 2 – Accelerating Adoption of Technology

> ***Accelerating Adoption of Technology***
>
> *During the COVID-19 pandemic, the use of digital technologies transformed the delivery of care and helped people stay connected with friends and family. These digital tools supported people's care through remote monitoring, ensured care teams had the right information at their fingertips and helped services to identify those in need. Looking ahead, in a recent survey, 90% of care providers said they will continue to use technology as they have during the pandemic.*
>
> *Although technology has been a lifeline for millions of people, it has also laid bare inequalities in access. Recent research by Age UK highlighted that the older population are still less likely to be digitally included – among those aged 75+, more than 40% do not use the internet. Office for National Statistics data shows that 14.9% people with a disability have never used the internet, compared with 6.3% of the UK population.*
>
> *Recent research showed that 23% of care home staff cannot access the internet consistently at work. In addition, 45% of providers express concern that care staff lacked digital skills*
>
> *Providing the right care in the right place at the right time sets out a range of measures to accelerate digitisation and adoption of technology across social care."*

In support of the white paper, Alice Ainsworth (Deputy director for adult social care technology policy, NHSX) committed to:

- Launch a new scheme to test care technologies and scale those where there is proven benefit to people, building the case for change for local organisations.
- Ensure that at least 80% of care providers put a digitised care record in place that can connect to a shared care record.

[i] *https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper*

- Support care homes that lack basic infrastructure to improve their broadband connections by delivering fibre upgrades. We will also work with government and industry to ensure homecare providers have the infrastructure they need to work digitally.
- Deliver a comprehensive digital learning offer to support a step-change in digital skills and confidence, including targeted digital leadership support for decision-makers who can drive cultural change at a senior level.

3.4 NHS PEOPLE PLAN AND PEOPLE DIGITAL STRATEGY

The 2020 NHS People Plan set out what the people of the NHS can expect from their leaders and from each other in supporting transformation across the whole NHS to "*foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care.*"

It established a plan which focused on:

- **Looking after our people** particularly the actions we must all take to keep our people safe, healthy, and well – both physically and psychologically.
- **Belonging in the NHS** highlighting the support and action needed to create an organisational culture where everyone feels they belong.
- **New ways of working and delivering care** emphasising that we need to make effective use of the full range of our people's skills and experience to deliver the best possible patient care.
- **Growing for the future** particularly by building on the renewed interest in NHS careers to expand and develop our workforce, as well as retaining colleagues for longer

Supporting the NHS People Plan, the NHS People Digital Strategy is currently in development to build a single cohesive strategy to unite the digital initiatives with the aim of improving the experience of the people working within the NHS.

The NHS People Digital Strategy will review the people digital tools in use, such as:

- Workforce Management & Engagement
- Enabling Staff Movement
- Workforce Deployment
- Talent Management / Career Development
- Education and Training

Ensuring that our workforce has access to the digital tools and technologies which support them as a professionals and individuals, works efficiently and reliably, and for which they are suitable skilled is a key factor in the success of achieving the future vision of the NHS.

3.5 NATIONAL DIGITAL AMBITIONS

In October 2018, the Department for Health and Social Care published the policy paper "The future of healthcare: our vision for digital, data and technology in health and care"[i] which set out the government's vision for the use of technology, digital and data within health and care with the ultimate objective of

[i] *https://www.gov.uk/government/publications/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care*

providing better care and improved health outcomes for people in England with a clear focus on improving the technology used.

To lead and coordinate the digital transformation of the NHS and Social Care that was needed to deliver this vision, NHSX was established in 2019 as the DHSC policy unit for digital health and care. While NHSX has recently been integrated with the NHS England Transformation Directorate, its missions remain the same:

- Reducing the burden on clinicians and staff, so they can focus on patients
- Giving people the tools to access information and services directly
- Ensuring clinical information can be safely accessed, wherever it is needed
- Improving patient safety across the NHS
- Improving NHS productivity with digital technology

When created, the Department for Social Care noted that "*… much NHS technology relies on systems designed for a pre-internet age. Patients are not getting the care they need because their data does not follow them round the system. Change has been slow because responsibility for digital, data and tech has been split across multiple agencies, teams, and organisations. NHSX will change this by bringing together all the levers of policy, implementation and change for the first time.*"[i]

The CEO of NHSX held strategic responsibility for setting the national direction on technology across organisations. NHSX responsibilities included:

- Setting national policy and developing best practice for NHS technology, digital and data - including data-sharing and transparency
- Setting standards – developing, agreeing, and mandating clear standards for the use of technology in the NHS
- Ensuring that NHS systems can talk to each other across the health and care system
- Helping to improve clinical care by delivering agile, user-focused projects
- Supporting the use of new technologies by the NHS, both by working with industry and via its own prototyping and development capability
- Ensuring that common technologies and services, including the NHS App, are designed so that trusts and surgeries don't have to reinvent the wheel each time
- Making sure that all source code is open by default so that anyone who wants to write code for the NHS can see what we need
- Reforming procurement – helping the NHS buy the right technology through the application of technology standards, streamlined spend controls and new procurement frameworks that support our standards
- Setting national strategy and mandating cyber security standards, so that NHS and social care systems have security designed in from the start
- Championing and developing digital training, skills, and culture so our staff are digital-ready
- Delivering an efficient process for technology spend, domain name management, and website security

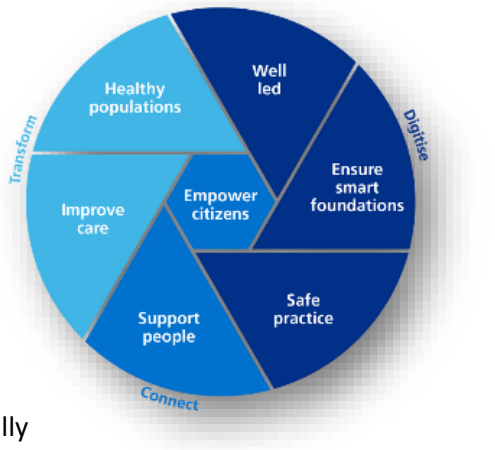
[i] *https://www.gov.uk/government/news/nhsx-new-joint-organisation-for-digital-data-and-technology*

3.6 'What Good Looks Like' Framework

NHSX's What Good Looks Like (WGLL) framework emphasises the role of ICSs as the centre of decision-making on digital strategy and related investment decisions. ICS boards must ensure investment is maximised in technology and innovation to improve the experience of both clinicians and patients.

WGLL is directed at all NHS leaders, as they work with their system partners, and sets out a model for success at both a system and organisation level. It describes how arrangements across a whole ICS, including all its constituent organisations can support success.

WGLL is included in both the ICS design framework and the NHS Operational Planning and Contracting Guidance, reflecting the expectation that the standards in the WGLL framework will be used to accelerate digital and data transformation.



The WGLL framework has 7 success measures:

1. Well led

The ICS has a clear strategy for digital transformation and collaboration. Leaders across the ICS collectively own and drive the digital transformation journey, placing citizens and frontline perspectives at the centre. All leaders promote digitally enabled transformation to efficiently deliver safe, high quality care.

Integrated Care Boards (ICBs) build digital and data expertise and accountability into their leadership and governance arrangements and ensure delivery of the system-wide digital and data strategy.

2. Ensure smart foundations

Digital, data and infrastructure operating environments are reliable, modern, secure, sustainable, and resilient. Across the ICS, all organisations have well-resourced teams who are competent to deliver modern digital and data services.

3. Safe practice

Organisations across the ICS maintain standards for safe care, as set out by the Digital Technology Assessment Criteria for health and social care (DTAC). They routinely review system-wide security, sustainability, and resilience.

4. Support people

The workforce is digitally literate and are able to work optimally with data and technology.

Digital and data tools and systems are fit for purpose and support staff to do their jobs well.

5. Empower citizens

Citizens are at the centre of service design and have access to a standard set of digital services that suit all literacy and digital inclusion needs.

Citizens can access and contribute to their healthcare information, taking an active role in their health and well-being.

6. IMPROVE CARE

The ICS embeds digital and data within its improvement capability to transform care pathways, reduce unwarranted variation and improve health and wellbeing.

Digital solutions enhance services for patients and ensure that they get the right care when they need it and in the right place across the whole ICS.

7. HEALTHY POPULATIONS

The ICS uses data to design and deliver improvements to population health and wellbeing, making best use of collective resources. Insights from data are used to improve outcomes and address health inequalities.

Within each of these success measures are suggested supporting actions. These actions are listed in Appendix B - 'What Good Looks Like' Measures and Actions [Page 72].

3.7 'WHO DOES WHAT' PROPOSED GUIDANCE

The NHS Transformation Directorate (formerly NHSX) is looking to address the operational challenges which emanate from the competing visions of national bodies and locally-focused ICSs.

In keeping with the accountability of ICSs within a national structure, its proposed principle is to devolve activities and decision-making away from central bodies to the ICSs, unless there is a clear benefit or over-riding national interest at stake to do otherwise.

At this stage, "Who Does What" is in a consultation phase aimed at providing guidance later in 2022. Its aims are to:

- Provide clarity on responsibilities at provider, ICS, multi-ICS, and national level
- Ensure that collective activities work across ICS boundaries, remains patient-centred, and drives consistency where this is important
- Understand and address challenges in collaboration within the local and national landscapes

3.8 'WHO PAYS FOR WHAT' PROPOSAL

The NHS Transformation Directorate's proposed "Who Pays for What" guidance aims to describe the investment barriers to digital transformation and support ICSs to move forward by decentralising funding of frontline technology.

Challenges which have been identified as slowing transformation include:

COMPLEX FUNDING ARRANGEMENTS

- Uncertainty over what is funded nationally, and by which pots of money.
- Lack of visibility by systems of future national funding opportunities.
- Misalignment of local and national priorities.
- Single-year budgets and late notification leading to poor investment decisions.
- Burdensome and duplicative bidding processes.
- Wrong mix of capital and revenue to support optimal tech spending including a lack of recognition of the revenue consequences of capital investment. This is an increasing problem as tech shifts to being consumed and managed as a utility.
- Allocations focused on providers rather than ICSs and uncertainty over how to deal with shared tech assets within ICSs.

PAYMENT, FINANCIAL AND OTHER POLICIES THAT IMPEDE INNOVATIVE TECH INVESTMENT

- Aspects of the previous financial system have hindered the shift to digital pathways, for example, organisational financial targets focused on non-recurrent savings, and activity-based payments in outpatient settings.
- Current policies address these issues but provide limited incentives for digital transformation.

LACK OF INFORMATION AND MEASUREMENTS FOR OPTIMISING TECH INVESTMENT

- Organisations do not know how much they are spending on technology, how much they should be spending, or the cumulative impact of under-investment.
- Measurable benefits of digital investment are not widely understood.
- Some worthwhile investments have no measurable financial payback, for example an investment which reduces the chance of catastrophic failure from 1% to 0.1%.

From 2022/23, there will be a move away from the central funding of frontline technology and ICSs will be able to fund the delivery of their digital and technology plans from their own budgets and will be given the resources to do this with funding allocated ahead of the financial year rather than a requirement to bid for the funding.

National funding will remain but there will be clearer delineation:

ICS FUNDING

- Applications such as EPRs - procurement, development, and management
- Cloud services and data centres
- Core kit and supplies including laptops, printers, telecoms, and networks
- Local cybersecurity measures

- IT programme management
- Training
- IT service management
- System transformation, for example shared care records

NATIONAL FUNDING

- National products such as the NHS App
- National infrastructure
- Pilots linked to the NHS Long Term Plan commitments in advance of national scaling
- Things that need to be done across multiple ICS areas - such as Office 365

3.9 HEALTH AND CARE INTEGRATION

In February 2022, the government published the "Joining up care for people, places, and populations" white paper[i]. This has the stated aim of bridging gaps between health and social care by further integrating the NHS and local government through the introduction of a single person accountable for the delivery of a shared health and social care plan at a local level.

This white paper highlights how digital and data can act as an enabler, sets challenging but achievable expectations, and demands a minimum level of digital maturity of the health and social care providers within an ICS.

The digital expectations placed on each ICS include:

- Digitising: records of health and care delivery to be digital, not paper, everywhere
- Connecting: different systems to exchange information
- Appropriate Information Governance
- Transforming: Digitally enabled transformation and the funding, skills, and time needed to do it well
- Skills and workforce
- Population health management
- An ICS-focused approach to systems, information sharing, and procurement
- Rapid digital adoption

[i] *https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations*

4. Local Context

Locally, we have had great success in collaborating across our partners to improve health and social care outcomes for our population. Our health and care system already delivers so much in serving our citizens.

New mandates and accountabilities handed to our Integrated Care System will enable a unified and consistent approach to health and social care across our region.

Our wide diversity enriches our region, but deprivation creates challenges for health equality and digital inclusion.

Our purpose is clear and drives all our initiatives:

TO WORK TOGETHER FOR

EVERYONE IN LEICESTER, LEICESTERSHIRE, AND RUTLAND

TO HAVE HEALTHY, FULFILLING LIVES.

Our aim is to deliver a health and care system in Leicester, Leicestershire, and Rutland that tackles inequalities in health, improves the health, wellbeing, and experiences of local people, and provides value for money.

Our key priorities are:

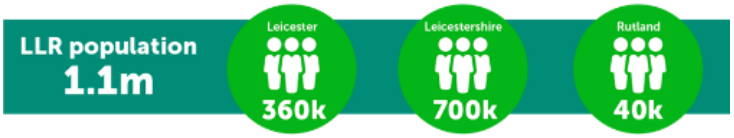
Delivering against these priorities will give:

- quicker diagnosis,
- care closer to home in improved facilities,
- higher quality services,
- earlier intervention in long-term conditions,
- improved wellbeing,
- more digital healthcare options where appropriate, and
- greater integration between healthcare providers so patients have seamless care between organisations

4.1 Leicester, Leicestershire, and Rutland

Leicester, Leicestershire, and Rutland have a combined population of around 1.1 million people. Of these, around 360,000 people live in the city of Leicester and 40,000 in the county of Rutland.

It is a diverse area, ranging from inner city and urban centres, through to very large expanses of rural countryside.

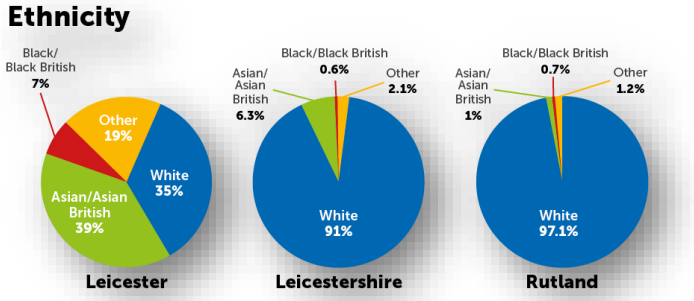


Like many areas of England, the population is growing, and its health and social care needs are also changing. Our region contains some of the most deprived and diverse communities in the UK which have been hit particularly hard by COVID-19, reflecting some of the underlying poor health and inequalities experienced by many of the communities we serve.

Population Diversity

In some wards within the city, up to 80% of residents are from ethnic minority groups. Leicester is a growing city with a younger than average population, in part due to its two universities as well as the high number of children that call it home.

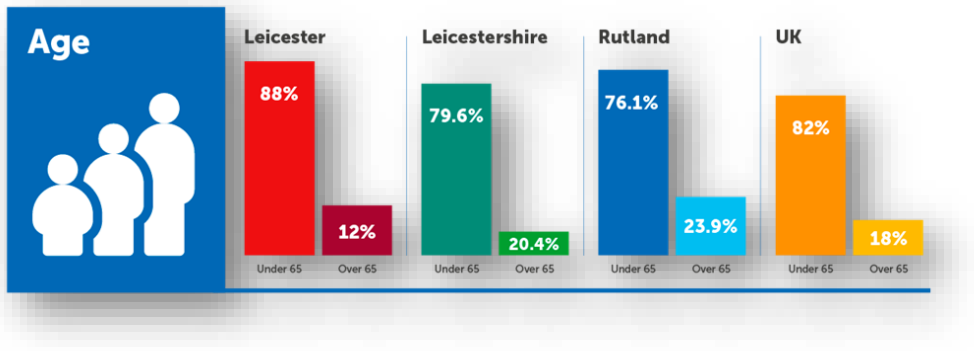
Typically, Leicester is characterised by its high levels of ethnic diversity, with more than 50% of the city's population belonging to an ethnic minority, and high levels of migration into the city.



Leicestershire and Rutland are less diverse, with around 10% and 3% respectively belonging to ethnic minority groups.

Leicester is a 'City of Sanctuary' welcoming asylum seekers and refugees. Recently this has seen Leicester receive a number of Afghan refugees, with our system responsible for ensuring they were safe and looked after following their initial arrival into the country.

Rutland has an older population, on average, with nearly 24% aged over 65.

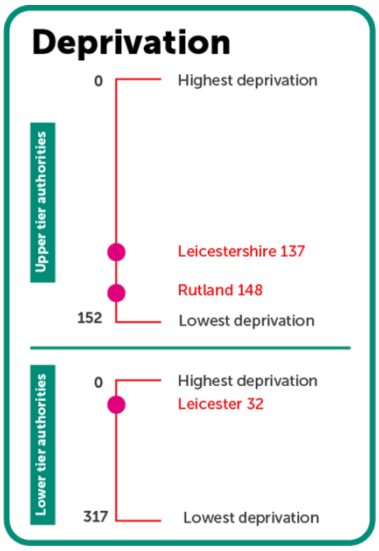


Deprivation and Health Inequality

We have many stark health inequalities across our area.

In Leicester we serve some of the poorest areas of the country alongside some of the most affluent in Rutland.

Leicester is ranked as the 32nd most deprived local authority area in the country (out of 317). Just over a third (35%) of our residents live in an area classified as being in the most deprived 20% nationally.



Although Leicestershire is not particularly deprived there are some small pockets of significant deprivation for a proportion of the population, particularly in parts of Loughborough and Coalville.

Often the localities with the highest deprivation are also those with the highest number of citizens from ethnic minority backgrounds. Rutland is more affluent than England as a whole.

However, issues regarding rurality and access contribute to inequalities of other kinds. In Leicestershire life expectancy for both men and women is slightly above the national average and in Rutland men tend to live for around 1.4 years longer than national average for both men and women.

Whilst life expectancy is improving in Leicester, it is rising slower than the national average. Women live 1.2 years less than the national average and men live 2.3 years less.

On average more than 17 years for men and 25 years for women are spent in poor health, whilst life expectancy varies significantly across the city with a difference of 8.3 years for men and 5.9 years for women between areas with the highest deprivation and the least deprived areas.

These unacceptable gaps drive our relentless determination to put reducing health inequalities at the forefront of our strategy for the ICS.

4.2 The LLR Integrated Care System

Leicester, Leicestershire, and Rutland have a background of collaborative working across health and social care. We are committed to working together for everyone in Leicester, Leicestershire, and Rutland to have healthy and fulfilling lives now, and for generations to come. This will be formalised under the ICS statutory body from 01 July 2022.

Our aim is to deliver a health and care system in Leicester, Leicestershire and Rutland that tackles inequalities in health and delivers improves the health and wellbeing and experiences of local people and provides value for money.

Our Integrated Care System is a collaboration between the NHS and local government, working together with partners in the voluntary, community and independent sectors to find the most effective ways to manage the health and care needs of the population within the available resources – providing high quality and sustainable care for the future.

Our partnership brings together NHS and council partners with the voluntary, community and social enterprise sectors, to plan services and provide funds to address the needs of our population.

- **Local Authorities**

  Our current ICS boundary aligns directly with three upper tier local authorities: Leicester City Council, Leicestershire County Council and Rutland County Council.

- **NHS Statutory Bodies**

  Our three CCGs run and coordinate our hospitals and community care facilities, mental health services, community nursing, health visiting teams and GPs.

- **Wider Partners and Stakeholders**

  General practice, NHS providers, local government and the third sector are the foundation of our ICS.

  As a key delivery partner, our general practices, of which there are more than 130 across 25 Primary Care Networks, will have a key role for locality and place-based working that will integrate services and ensure they meet the needs of our diverse communities.

  Representatives of the voluntary and community sector are also actively engaged with ICS partners in shaping and supporting local services, along with Healthwatch.

4.3 ICS System Structure

Our new system will operate at three levels, building a better knowledge of the needs of people, so that:

- Patients receive more care closer to home, including some outpatient and diagnostics procedures.
- People can stay independent for longer because health providers, social care and community-based services will support those with the most complex needs.

Neighbourhoods

Neighbourhoods are the cornerstone of our ICS. Based on 25 groups of GP practices, known as primary care networks, they work together to manage care close to home for populations of 30-50k patients.

They develop multidisciplinary teams working with councils, the community and voluntary sector, to care for those with long-term conditions. GPs, practice and community nurses and staff will work with partners to wrap care around the most vulnerable.

Places

At the 'place' level, care alliances, including hospitals, local authorities (Health and Wellbeing Boards), urgent care, mental health and community services, transport providers and the newly formed primary care networks, plan the delivery of healthcare in response to local need.

Systems

At a system level, the statutory Integrated Care Body and its partners will analyse need, set priorities and desired health outcomes, and allocate funding.

4.4 Purpose and Principles of the ICS

Our Integrated Care System purpose is "**Working Together for Everyone in Leicester, Leicestershire, and Rutland to Have Healthy, Fulfilling Lives**". This underpins everything we do:

We are committed to working together with respect, trust, and openness to:

- Ensure that everyone has equitable access and high-quality outcomes
- Make decisions that enable great care
- Make decisions and deliver services (as) locally as possible

- Develop and deliver services in partnership with [our] citizens
- Make the Leicester, Leicestershire and Rutland health and care system a great place to work and volunteer
- Use our combined resources to deliver the very best value for money and to support the local economy and environment

4.5 ICS TRANSFORMATION PRIORITIES

To maximise the impact of the ICS, we have established four priority areas which will be the foundation for all key initatives across the region. We will transform these areas ensuring we take steps to improve the equity of access and outcomes.

Our priorities are:

We will focus on the first 1001 days of life to enable more equity in outcomes as we know this is critical to a child's life chances.

We will support our residents to live a healthy life and make healthy choices to maintain wellbeing and independence within their communities.

We will focus on supporting those with multiple conditions and who are frail to manage their health and care needs and live independently.

We will ensure people have a personalised, comfortable, and supported end of life with personalised support for carers and families.

These priorities will be demonstrated by improvements such as:

- quicker diagnosis,
- care closer to home in improved facilities,
- higher quality services,
- earlier intervention in long-term conditions,
- improved wellbeing,
- more digital healthcare options where appropriate, and
- greater integration between healthcare providers so patients receive seamless care.

4.6 Operational Priorities

The ICS has four operational priorities. While the digital strategy will support all operational priorities, it is expected that it will have the greatest impact on Operational Priorities three and four.

1. Work together across health and local authorities to deliver the COVID vaccination programme and winter Flu programme ensuring maximum uptake
2. Recover services across all sectors of our partnership that have been affected during the pandemic improving our communication with our residents as we do this
3. **Deliver changes to UHL hospitals and transform our mental health services ensuring appropriate local delivery**
4. **Work together across health and care to transform access to the health and care services we provide, with a focus on primary care, urgent care, chronic conditions, and mental health services**

These priorities will be the focus of the LLR ICS NHS Board to deliver working with partners as necessary.

5. Governance and Leadership

Currently:

Collaborative working across organisations has brought many benefits, but strategic priorities and plans are set by individual organisations.

Resource capacity is directly funded by individual partner organisations and there is limited shared capacity.

Nationally-distributed funding is based on achieving specific aims.

Meaning that:

The needs of the collective health and social care system defer to the needs and constraints of individual trusts or groups.

There is limited capability to deliver ICS-wide initiatives and the priorities of key digital resources is focused within individual organisations' priority operational service and local projects.

We are reactive to bidding for nationally funding made available.

Leading to:

Siloed planning and delivery with limited opportunities to realise the benefits of scale and cross-organisational synergies.

Citizens experiencing disjointed models of care.

Duplication of effort and missed opportunities for leveraging our scale.

Change programmes driven by the funding available rather than the identified need in LLR.

We want to:

Build an integrated model for health and social care to provide a coherent and connected service for the citizens of LLR and our workforce.

Which will improve:

The patient experience.

Overall efficiency.

Value for money.

We will achieve this by:

Building a collaborative Integrated Care System across LLR with a consistent strategy and priorities.

creating a seamless journey across health and social care for our citizens.

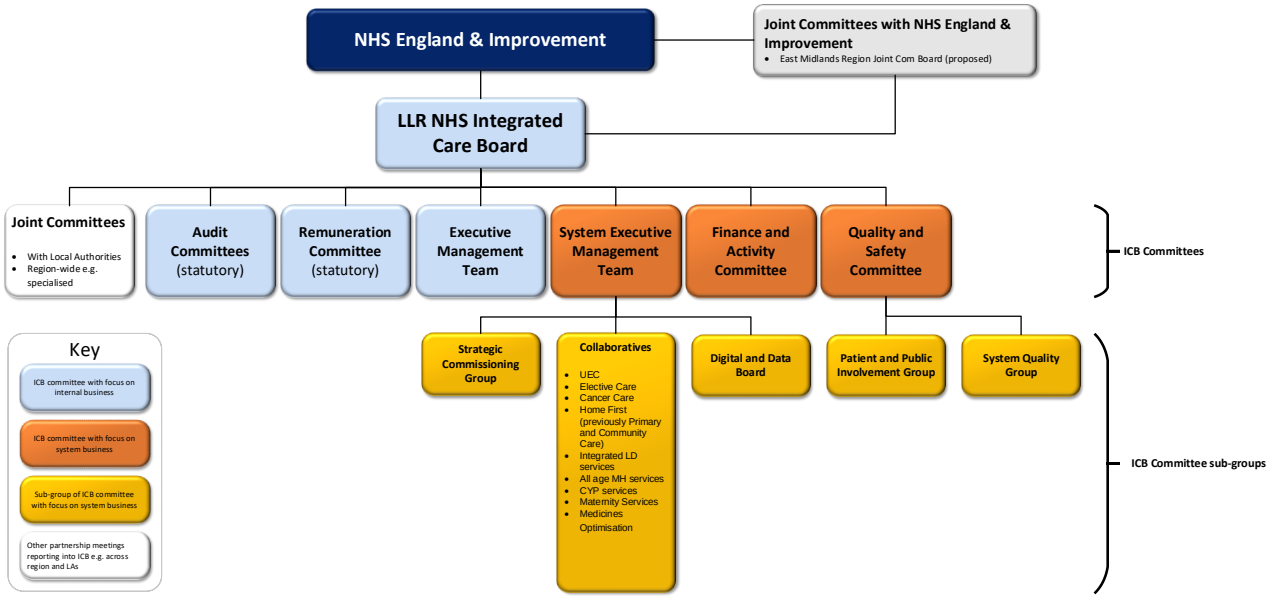
Sharing resources between partner organisations for the benefit of the whole region.

Consolidating digital technologies and consistently applying best practice across all our systems.

5.1 ICS GOVERNANCE

We will build a governance structure which brings together partner organisations at a system level to share resources, make decisions and plan jointly, with a single person accountable for the delivery of shared outcomes and plans, working with local partners.

Figure 3 – LLR ICB Governance Structure



5.1.1 ICS HEALTH AND WELLBEING PARTNERSHIP

This brings together health and care organisations, along with other partners, in a statutory committee to develop a single strategic vision and strategy for the system which sets out how the wider health needs of the local population of LLR will be met, informed by Joint Strategic Needs Assessments (JSNAs).

5.1.2 INTEGRATED CARE BOARD

The Integrated Care Board (ICB) will take on NHS planning functions held by current CCGs. The ICB will have its own leadership team, including chair and chief executive, and will also include members from NHS Trusts, local authorities, and general practice.

The ICB will produce a five-year plan (updated annually) for how NHS services will be delivered to meet local needs. This plan must have regard to the ICS Partnership Board's integrated care strategy.

5.1.3 PLACES

We have three established places: Leicester, Leicestershire, and Rutland and six localities (One for each of Leicester and Rutland, and four for Leicestershire). These will link with each of the three Health and Wellbeing Boards to translate the priorities of the ICS Partnership Board's integrated care strategy into local action to reduce health inequalities.

While retaining the cohesive integration of the System, reporting may be done at the Place or Neighbourhood levels to provide greater clarity and aid decision-making.

5.1.4 COLLABORATIVES

We are developing our provider collaborative arrangements in active consultation with providers. The purpose of the collaboratives is to:

- Build partnerships involving NHS providers working at scale across multiple places with a shared purpose.
- Build broader coalitions with community partners to promote health and wellbeing and reduce unwarranted variation and inequality in health outcomes, access to services and Residents and local population experience.

Our collaboratives each have a primary focus. These are:

- Urgent and Emergency Care
- Elective Care
- Cancer Care
- Home First (previously Primary and Community Care)
- Integrated Learning Disability services
- All age Mental Health services
- Children and Young People services
- Maternity Services
- Medicines Optimisation

All collaboratives will have IM&T representation and will seek approval of the Digital and Data Board to ensure the strategic fit of digital proposals.

5.2 DIGITAL GOVERNANCE

We will build a model which balances flexibility for clinicians and practitioners to operate effectively within their 'place' with the benefits of consistency across the ICS 'system'.

Governance and leadership of the digital and data transformation enables a cross system approach to the plan, so that changes to models of care and service redesign involve digital and data experts working with partners from all relevant sectors from across the system.

5.2.1 LEADERSHIP

Executive Directors with digital portfolios provide wider connections into organisations working together at ICS level on digital initiatives.

The ICB has appointed an interim Chief Information Officer (CIO) and substantive Chief Clinical Information Officer (CCIO) to be accountable officers. They act to provide the leadership capacity to drive forward the strategic programme. Substantive arrangements for the CIO will be established once the ICB is a legal entity from 1st July 2022.

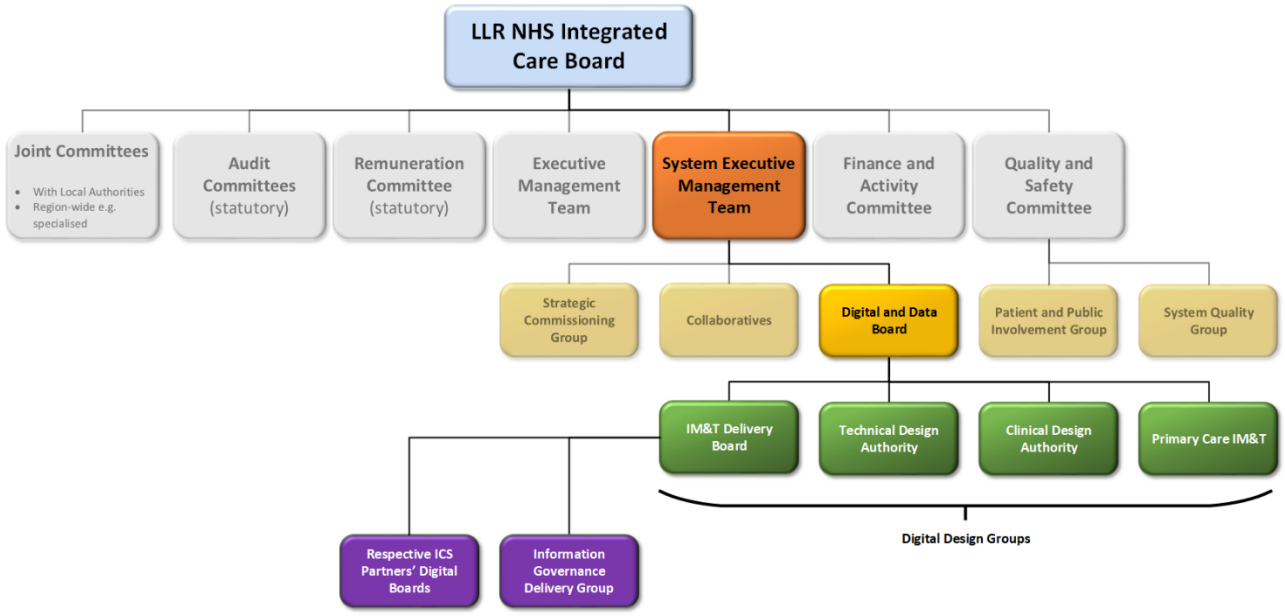
5.2.2 DIGITAL DESIGN GROUPS

The prospective design of how the ICB wants to ensure that digital supports service transformation and citizen experience with health and care is the responsibility of a system level design group. This represents not only the technology aspects of digital but also population health management and business intelligence, being a digital and data workstream.

This group sponsors strategic analysis, agrees strategic direction, and receives business cases for approval. It formally reports to the LLR ICB System Executive Group. Once a digital transformation is agreed it is then delegated to the LLR IM&T Delivery Board to manage.

The IM&T Design Authority will retain primacy over individual partner organisation's design and architecture functions to ensure that integration across the ICS is prioritized.

Figure 4 – LLR Digital Design Governance Structure



5.2.3 Delivery Groups

These groups act as programme boards for the digital and data projects that have a system level interest e.g., impacting a patient pathway throughout the system.

All LLR health and care organisations are members, and they present progress and escalate any risks and issues where organisations working together to a common objective requires additional direction.

5.3 Assurance

We will build ICS-wide assurance policies and functions to give confidence that our digital and data solutions meet all appropriate legislation, standards, and best practice.

5.3.1 Clinical Design Authority

In 2022/23, we will establish a Clinical Design Authority group under the leadership of the ICS CCIO to determine the impact of transformational opportunities presented by ICS Design Groups and major Trust-level transformations on the digital agenda.

The Clinical Design Authority will drive changes in working practices to ensure that there is optimised alignment with digital systems being used, their configuration, data collected, data presented, data shared and transferred.

This group will also receive assurance on clinical safety through the Clinical Safety Officer network in the ICS to guarantee that the clinical safety requirements the DTAC (Digital Technology Assessment Criteria

for Health and Social Care) are met, including the BCD0160: Clinical Risk Management[i] standard. Core membership of the group will be trust CCIOs with an ICS-wide commitment to much wider multidisciplinary representation across Health and Social Care.

The ambition is that digitally-enabled transformations can be described to IT colleagues as an agreed "ask" that has full support of clinical / practitioner colleagues.

The philosophy of the group will very much be aimed towards driving a forward thinking ambitious agenda of aligning progressive models of care and the opportunities made available through modern technology rather than holding onto heritage processes. The group will endorse an "ICS System First" approach with citizens' interests at the forefront of the ambitions. Driving a solution-focused approach, the group will frame problems and challenges as "this is where we are; this is where we need to be and why; what we need to do to get there".

5.3.2 TECHNICAL DESIGN AUTHORITY

In 2022/23, we will establish a Technical Design Authority group under the leadership of a System CIO to act as assurance of technical architecture across the ICS.

The Technical Design Authority will have a broad range of technical expertise to consider proposed future digital developments and to advise on security, compliance with architectural principles on messaging standards, data storage, reporting, and infrastructure.

The scope of the Technical Design Authority will include all patient-facing clinical systems that have any impact wider than an individual partner organisation.

This group will own and evolve the ICS Technical Architectural Principles and, through CIO membership of the ICS Digital Board, will assure that all proposed technical solutions are compliant with the architectural principles and the technical requirements of the DTAC (Digital Technology Assessment Criteria for Health and Social Care).

In line with the architectural and data standards outlined in Section 6 - Safety [Page 26], the group will ensure that:

- systems use open standards
- systems are not siloed and integrate into the wider ecosystem
- information can be shared across digital systems and organisations
- information is consistent along patient pathways
- data is codified and classified correctly so that meaningful information can be used elsewhere after initial data capture

[i] *https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb0160-clinical-risk-management-its-application-in-the-deployment-and-use-of-health-it-systems*

5.3.3 System-Level Assurance Function

In 2022/23, we will establish an ICS-wide function who will establish policies for key areas of compliance and provide assurance of functions', programmes', and solutions' adherence.

At a system level, we will create the Digital Innovation and Transformation Team (DITT). The key responsibilities of this team are explained in more detail in Section 12.1 - Digital Innovation and Transformation Team [Page 67].

The team will provide wide-ranging assurance that our digital initiatives are being "done well" and following best practice across the ICS.

The team will foster continuous improvement through the sharing of good practice identified within our region and by monitoring, reviewing, sharing, and responding to relevant recommendations and alerts, including those from the NHS Transformation Directorate.

6. Safety

Currently:

We have a good record of cyber security and information governance.

Architecture and data standards across health and social care have been slow to emerge and be adopted by solution vendors.

Meaning that:

Interconnecting systems is difficult.

We rely on converging onto single supplier platforms.

Greater integration of systems and increased public access will create new challenges for IG and cyber security.

Leading to:

Systems not being integrated, complex middleware being required, and integration projects being slow to deliver.

Supplier lock-in.

Disproportionate and duplicated effort required to maintain cyber security across a complex technology landscape.

We want to:

Build our digital landscape on open standards and best practice, reducing our dependence on bespoke or parochial technologies.

Create assurance functions for clinical and digital safety.

Which will improve:

The opportunity to securely access and share information across our partner organisations.

Have the confidence that we are providing consistently safe digital services which meet best practice.

We will achieve this by:

Deploying digital solutions based on open standards which will connect to our ecosystem.

Building the capability to take ownership of standards and best practice, shared with colleagues across the region, provide assurance that this is being applied, and drive continual improvement.

6.1 Architectural and Data Standards

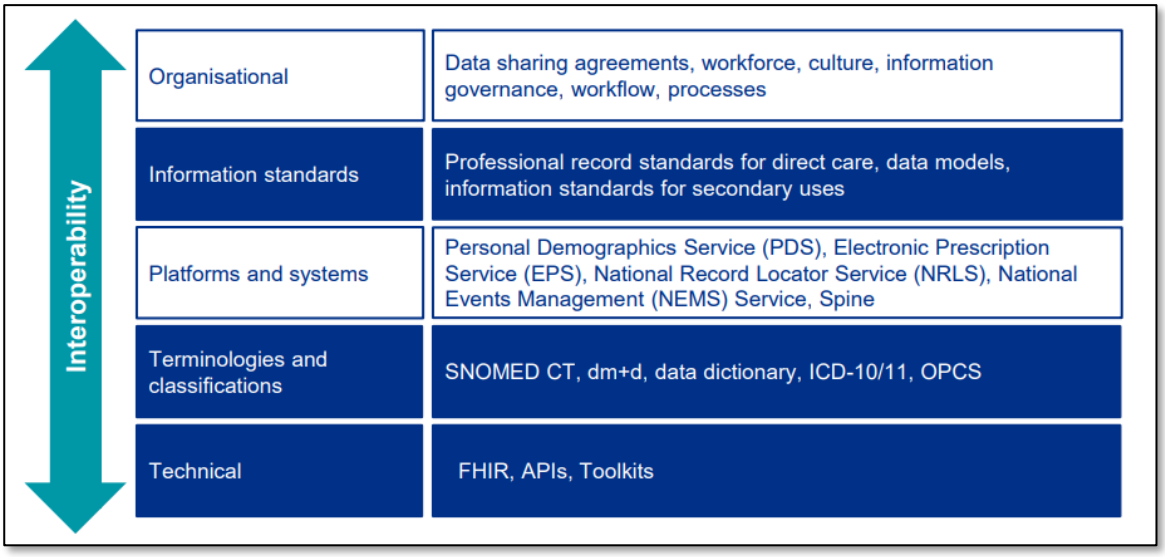
Greater multi-organisational collaboration and data sharing requires a consistent approach to technology standards. We fully support a standards-based approach to technology implementation, and this will underpin the technology roadmap across our partners.

In building, selecting, or implementing systems which are designed to interact with our staff or citizens, we ensure that we follow clear standards which support the design and delivery of secure, robust, and effective solutions.

The Wachter Report[i] proposed that "*The new effort to digitise the NHS should guarantee widespread interoperability ... to enable seamless care delivery across traditional organisational boundaries, and to ensure that patients can access all parts of their clinical record*"

NHSX has introduced a programme to drive interoperability and open standards across health and care systems. The scope of this programme is shown in Figure 5 – NHSX Standards and Interoperability Programme - Scope below

Figure 5 – NHSX Standards and Interoperability Programme - Scope



The following, while not exhaustive, highlights some of the key standards and principles to which we will adhere:

Architectural Principles

The Enterprise Architecture function within NHS Digital produced a set of Architecture Principles which are reviewed and, if necessary, refreshed and published twice yearly.

These Principles are approved by the Enterprise Architecture Board, a cross organisational body with NHSX members that provides strategic direction, governance, and assurance of enterprise architecture, including of architecture strategies, policies, patterns, and standards which support health and care strategy.

[i] *https://www.gov.uk/government/publications/using-information-technology-to-improve-the-nhs*

LLR has taken onboard the NHS Digital principles and the Central Digital and Data Office Technology Code of Practice (TCoP)[i], particularly reinforcing the importance of Cyber Security (See Appendix E - Architecture Principles [Page 82]).

FAST HEALTHCARE INTEROPERABILITY RESOURCE (FHIR) RELEASE 4

The Fast Healthcare Interoperability Resource, commonly known as FHIR, has quickly become one of the most popular protocols for joining together disparate systems. FHIR has been formalised through Information Standards Notice DAPB4020[ii].

This information standard introduces the governance process for the oversight, direction, and leadership of the UK Core Fast Healthcare Interoperability Resources (FHIR) R4. The standard mandates, within the health and care sector in England, a consistent approach to the development of UK Core resources, thereby facilitating clear interoperability in the sharing of data across the NHS, health services and adult social care in England.

Within the United Kingdom, it has been agreed that FHIR should be used across the home countries as the foundation of sharing data across health and care organisations. However, alignment of FHIR with UK healthcare requirements is needed and a UK Core FHIR Board has been established to oversee and assure this alignment and take responsibility for the promotion of the resulting resources, brought together as the UK Core.

With the adoption of FHIR R4 there is now an opportunity to create a unified approach to interoperability within health and social care systems across England, Scotland, Wales, and Northern Ireland. This will enable consistent information flows across borders to improve health and care outcomes for all citizens.

The FHIR standard is already being used to improve data sharing and data flows between providers and systems in services such as:

- Summary Care Record
- Electronic Prescription Service.
- E-Referral Service
- Electronic Prescribing and Medicines Administration

DICTIONARY OF MEDICINES AND DEVICES (DM+D)

The dm+d is a dictionary of descriptions and codes which represent medicines and devices in use across the NHS and provides:

- the recognised NHS standard for uniquely identifying medicines and medical devices used in patient care
- clear, consistent recording and communication of information relating to medicines and devices used in patient care
- consistency in how medicines and medical devices are expressed through a robust published editorial policy

[i] *https://www.gov.uk/guidance/the-technology-code-of-practice*

[ii] *https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dapb4020-uk-core-fhir-r4-governance*

The Standardisation Committee for Care Information (SCCI) has approved the NHS dictionary of medicines and devices (dm+d) as the NHS standard (SCCI0052[i]) for communicating medicines information.

This standard ensures that diverse clinical systems can effectively 'talk' to each other using a common coded language for the transfer of medicines information. The dm+d provides this common language using identifying codes with associated written descriptions.

The scope of the standard in terms of content is for medicines only; medical devices are currently excluded. The primary purpose is to support interoperability. Therefore, electronic systems that exchange or share information about medicines relating directly to a patient's care must adhere to the standard by using dm+d identifiers and descriptions when transferring information.

SNOMED CT

SNOMED CT is the information standard for clinical terminology; it is an international standard published by SNOMED International providing a global common language for health terms.

SNOMED CT gives clinical IT systems a single shared language, which makes exchanging information between systems easier, safer, and more accurate. It contains all the clinical terms needed for the whole NHS, from procedures and symptoms through to clinical measurements, diagnoses, and medications.

The UK edition of SNOMED CT also contains the UK extensions. These provide terms specifically required in the UK, such as UK screening procedures, assessment scales and British English spellings. SNOMED CT was first published as an information standard by the Information Standards Board (ISB) in August 2011 and the government's policy document, "Personalised Health and Care 2020: A Framework for Action", published November 2014, identified SNOMED CT as the required terminology to support direct management of care.

All NHS healthcare providers in England must now use SNOMED CT for capturing clinical terms within electronic patient record systems. The use of SNOMED CT is a National Information Standard (SCCI0034), and therefore a contractual requirement.

6.2 Cyber Security

We are creating the role of Security & Compliance Manager in our Digital Innovation and Transformation Team to define and assure our approach, procedures, and culture with regards to information security, data privacy and compliance.

The cyber security threat continues to be very dynamic, and public sector organisations remain prestigious targets. Although traditional threats remain e.g., phishing, ransomware, external attacks, etc., a renewed focus on system patching and upgrading has resulted from recent high-profile vulnerabilities.

To strengthen our position, the revisions to existing standards are also being deployed across the estate. This includes a recent update to the Cyber Essential standards and the DSP (Data Security and Protection) Toolkit assessment which includes a number of strengthened technical security controls.

The DAPB0086 Data Security and Protection (DSP) Toolkit is an online tool that enables relevant organisations to measure their performance against the data security and information governance requirements mandated by the Department of Health and Social Care, notably the 10 data security standards set out by the National Data Guardian in the 2016 Review of data security, consent, and opt-outs.

[i] *https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/scci0052-dictionary-of-medicines-and-devices-dm-d*

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. Such organisations are required to carry out self-assessments of their compliance against the assertions and evidence contained within the DSP Toolkit.

Across the ICS, our partners' IT Departments hold multiple cyber security accreditations such as ISO27001 and ISB1596, but we recognise that we cannot be complacent and cyber security is a constant and changing threat, particularly as we place more emphasis on our digital services. An example of this continued focus on cyber security has been LHIS increasing their NHSD / BitSight security rating, placing them in the top 10% of healthcare organisations for cyber security.

Within the ICS Digital Innovation and Transformation Team, a new role to co-ordinate Cyber Security between IM&T services, liaise with national cyber services, and provide upward assurance to our digital board will be established to further strengthen the LLR position.

6.3 INFORMATION GOVERNANCE

The LLR Information Governance Board is embedded into ICS delivery governance and proactively supports and advises our programmes. Early engagement and a solution-focused perspective keeps our citizens' data secure and facilitates the increased collaboration between ICS partner organisations

Across LLR, we have a successful history of collaboration between our health and social care partners to provide the best care to our citizens. This has been enabled by the data sharing agreements that have already been established to ensure that share confidential information effectively between professionals with a legitimate interest while meeting, or exceeding, the applicable information governance standards and legislation that keep our citizens' data safe.

Our Information Governance Board reports directly to the IM&T Delivery Board to maintain awareness and knowledge of all key programmes which may have data / information implications. This allows advice to be proactively provided at an early stage and confirm that best practice is applied.

While the COVID-19 pandemic highlighted the value of simplifying the sharing of patient information across statutory health and care organisations, Local Authorities, and DHSC arms-length bodies, the notice[i] which was issued under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002 (COPI) to process confidential patient information for the purpose of monitoring and managing COVID-19 will expire on 30 June 2022 and pre-existing legislation must be followed as partner organisations increase their data sharing.

The LLR Information Governance Delivery Board:

- Acts as the delivery arm for information governance to the IM&T Workstream
- Supports the development and delivery of initiatives enabling the delivery of integrated care to the patients of Leicester, Leicestershire, and Rutland in a seamless and patient focused manner, no matter where and by whom the patient is treated.
- Provides IG advice and support to the IM&T Delivery Board through two way dialogue on in-flight projects and the wider information governance agenda where it might impact future work. This includes the provision of updates on the latest national policy/legislation/rulings.

[i] *https://www.gov.uk/government/publications/coronavirus-covid-19-notification-of-data-controllers-to-share-information*

- Makes key programme level IG decisions and sponsors digital/integrated care developments that improve services within the LLR health and care economy.
- Works with work stream task and finish groups to resolve risks, issues, and blockers wherever possible through the scrutiny of data protection impact assessments, software approvals and sense checking on early thoughts around new ideas/initiatives.
- Acts as an advisory resource for the LLR ICS portfolio through screening and provision of assurance on preferred delivery options.
- Acts in an advisory capacity to the IM&T Delivery Board.
- Acts as liaison with the Information Commissioners Office for system queries

6.4 Commercial Management

We will use the scale of ICS to support our partners' supplier relationships to provide an over-riding focus on the holistic healthcare needs of the region as a whole and endorse the suppliers who best align with the regional vision.

The ICS has been handed the over-riding accountability for improving health and social care outcomes across the region. To fulfil this, all partner organisations must prioritise the regional collaborative working which will drive these improvements and ensure that technology choices and strategic partnerships do not create silos or restrict ICS-wide, person-centric care.

While partner organisations will continue to manage their supplier relationships, the ICS will work with our partners to support local programmes, projects, and technology choices which follow the standards given in Section 6 - Safety [Page 26] and challenge those which do not. We will take a holistic view of the initiatives planned across the region to align inter-connected programme deliveries to best meet the regional roadmap.

We will take advantage of the ICS relationships with strategic suppliers and leverage our scale to influence supplier roadmaps, priorities, quality, and commercial terms to confirm that they are aligned with our transformational vision.

6.5 Financial Management

We will ensure that digital spending is effective across LLR, driving efficiency gains through greater alignment of resources and taking opportunities to review technology consolidation when contractually feasible.

As the digital spending model changes with the introduction of the "Who Pays for What" framework, we will look to guide how budgets are utilised within the region by taking advantage of the wider view of our digital spend and how greater collaboration can improve financial efficiency.

We will achieve this through a system level prioritisation and approval process supported by financial capabilities and resources.

6.6 Business Continuity / Disaster Recovery

The ICS will provide assurance that partner organisations' BC/DR plans are effective as we increase our dependency on digital services and systems.

All partner organisations already maintain and test their own Business Continuity and IT Disaster Recovery plans.

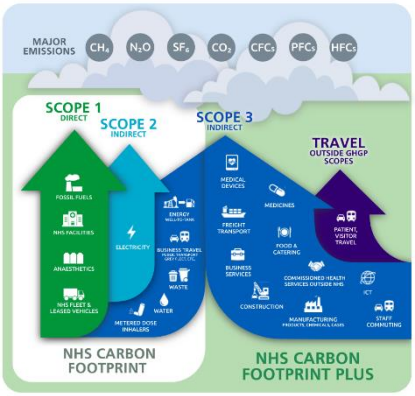
The newly-formed Digital Innovation and Transformation Team (DITT) will hold a remit for IT Security and Compliance across the ICS. A key activity within this area is to provide advice and assurance to partners on the continuity plans for their IT services, particularly during procurement and change programmes.

This role does not move the responsibility away from partner organisations, but independently provides the confidence that we have a cohesive plan to reduce risk exposure with contingency response action in place as our dependency on technology increases.

6.7 Environmental Impact

To support the NHS Net Zero commitment, we will provide and encourage the use of digital alternatives to paper and physical travel for our citizens and staff where this does not reduce the care we provide.

In October 2020, the NHS became the world's first health service to commit to reaching carbon net zero in response to the profound and growing threat to health posed by climate change.



The "Delivering a Net Zero Health Service" report[i] set out a clear ambition to be the world's first net zero national health service, and set two targets:

- *"For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032*
- *For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039"*

To achieve these targets, the report noted the achievements and opportunities, including those for which digital transformation can directly contribute:

- *"As part of the new service model for the 21st century, multiple commitments are in progress, including boosting 'out-of-hospital' care; empowering people to have more control over their health; digitally enabling primary and outpatient care; and increasing the focus on population health. Optimising the location of care ensures that patients interact with the service in the most efficient place, which may be closer to, or even in, their home. Not only does this improve patient experience and often offer greater access to care, but it also reduces emissions by helping to avoid unnecessary hospital visits and admissions. The urgent and emergency care programme is working in partnership with the primary care and community care teams on this approach, with NHS 111 First helping to rapidly triage and connect patients to the most relevant, and often community-based, health professional. It is estimated that accelerating this approach will directly improve patient treatment, avoiding approximately 8.5 million*

[i] *https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/*

km of unnecessary travel per year, to and from hospitals, with a carbon saving of 1.7 ktCO2e per year in the first instance.

- *The NHS will ensure that a trajectory compatible with a net zero health service is embedded in the digital transformation agenda, and work to continuously drive down residual emissions from digital services via a number of actions which include:*
    - *digitally enabled care models and channels for citizens that will significantly reduce travel and journeys to physical healthcare locations, with care closer to home being delivered through remote consultations and monitoring*
    - *developing a blueprint for 'What Good Looks Like' for low carbon digital care, across the system*
    - *building net zero into the digital maturity framework*
    - *issuing policy advice to ensure NHS data centres and companies providing these services minimise their environmental impact and support the drive to reach net zero*
    - *utilising levers, including local spend controls for technology, to incentivise a shift to net zero*
    - *supporting front-line digitisation of clinical records, clinical and operational workflow, and communications, aided by digital messaging and electronic health and care record systems."*

As part of the delivering a Net Zero NHS, LLR ICS will play its part to help the NHS reduce the environmental impact of digital services. Through its leadership, it will ensure that new or replacement digital services are sustainable and will engage with the NHSE cloud centre of excellence that will support us to shift to more resilient and sustainable cloud hosting arrangements. This will form part of our investment prioritisation process.

7. Infrastructure and Systems

Currently:

Many systems are locally hosted, segregated, and designed around organisational boundaries within a physical workplace setting.

Meaning that:

Systems and the data they hold are physically isolated.

Data security cannot easily be centrally governed.

Leading to:

Limitations on data sharing across organisational boundaries, or with patients.

Costly and complex middleware systems are required to provide limited data sharing.

Some of our workforce is required to unnecessarily travel to physical locations to access systems and data.

We want to:

Decouple front-line and supporting systems from physical locations.

Allow our workforce to securely access systems and information from any appropriate location including remote, blended and home working.

Reduce system duplication.

Which will improve:

Allow patients to access their data without costly and complex technologies.

System resilience and security.

Workforce experience by reducing the need to log into multiple systems, supporting remote working and reducing travel.

Value for money as maintenance, support, and training is reduced.

We will achieve this by:

Rationalising our digital landscape to avoid duplication, support, training.

Ensuring that our key digital technologies are able to securely communicate across our digital ecosystem.

Building our digital ecosystem on securely accessible cloud-first technologies.

7.1 Front-Line Infrastructure

We will provide our workforce with the tools which allow them to work remotely where possible, including internet-facing virtual desktops and supporting the adoption of cloud telephony in primary care.

LLR has made great strides in federating public sector Wi-Fi networks locally so that staff can search and find over 300 public service LLR Wi-Fi hotspots using an App to locate the nearest supporting agile working across the NHS, local authorities, care homes and libraries.

This infrastructure was designed in a pre-pandemic context where extensive home working combined with domiciliary visits was not the predominant model. The emphasis in the next three years will be to ensure that as new care models emerge with no reliance on a public sector building as a base that all applications can be access via domestic broadband and mobile data services using internet-facing services.

Supporting this will require additional investment in secure virtual desktop infrastructure for the workforce with published desktops and applications designed around a workgroup.

Along with UHL and LPT, we continue to support GP practices with video and online consultations and are providing business change support resources to help practices with their digital adoption. We are supporting practices with their transition to cloud telephony to provide a fully-remote working environment for primary care.

7.2 Cloud Architecture

Where appropriate, we will transition services to cloud-hosted platforms or cloud-based systems to provide resilience, scalability, and wider access.

The ICS supports the architectural principle of 'public cloud first', the NHS Cloud Strategy and its vision, and the NHS Cloud Principles as described in Appendix E - Architecture Principles [Page 82]. The pace of digital change has been so fast that many of the systems on which we depend were designed in a pre-cloud era. Consequently, these systems are often physically hosted on our premises, requiring access to VPN and installed client applications.

It must be recognised that 'cloud first' can represent several differing models (IaaS, PaaS, FaaS, or SaaS). Transferring physical servers into a virtual, cloud-hosted platform is fundamentally an infrastructure exercise (IaaS). In contrast, some of the significant benefits of 'cloud' are delivered through the development of software systems designed from the outset to use scalable cloud functionality (FaaS or SaaS).

As we look to renew our systems and infrastructure, we will take the opportunity to transition to cloud where this is appropriate and provides demonstrable benefit and we will endorse system suppliers who have cloud-designed offerings.

A dependency which adds to the complexity of a technology shift to cloud is the financial model for funding technology infrastructure. Primarily, conventional infrastructure requires the purchase of physical assets which necessitates capital funding. In contrast, cloud architecture represents a service, which requires revenue funding. While sitting outside the direct scope of a digital or technology-based roadmap, this may represent a challenge to meeting this transformation.

7.3 STRATEGIC SYSTEMS LANDSCAPE

We are rationalising the number of operational systems in use across the region to simplify support, increase data sharing, and improve training.

LLR wants to ensure that the best solutions are in place across the system, that they align and deliver best value and outcomes for patients in line with the 'what good looks like' (WGLL) framework.

In order to work towards a vision of having a simplified and optimised collection of systems across the region, the ICS has commissioned a review to clarify the current digital solution landscape and identify waste, fragmentation, duplication, and unnecessary costs that may have evolved through siloed organic digital growth.

We have a vision of a connected digital ecosystem of strategic solutions focused on the needs of the ICS and its citizens, allowing secure, seamless system interoperability and data sharing with benefits including cost optimisation, reduced system support, and improved user experience.

We will achieve this ecosystem through a rationalisation of our key systems to reduce and ultimately eradicate unnecessary system sprawl. The current landscape of duplicated and partially-connected systems is a huge obstacle to allowing people the transparency of accessing their own health data and providing true patient-centred care.

We are aligning the existing state with our future state vision so that opportunities for further optimisation, transformation and improvement can be determined, including understanding and rationalising our strategic supplier contracts.

Having already made significant progress along this journey, the largest remaining opportunity is the consolidation of the large number of systems within UHL. We have recently engaged external consultants to work with UHL to identify the potential future integrated system state and determine whether each can be integrated with, or replaced by the UHL EPR system (NerveCentre)

The resulting report, which has been agreed with the UHL CIO, has identified a roadmap based around the widespread distribution of the NerveCentre EPR within UHL. Some applications will be decommissioned and replaced by current or planned NerveCentre functionality. Of the remainder, some will be upgraded or retained as is with the intention that they have closer integration with NerveCentre. Systems where there is no clear long-term development roadmap, they cannot be integrated, or their benefit is limited will be decommissioned.

The applications which are planned for decommissioning and replacement with NerveCentre EPR functionality are listed in Appendix A - UHL Applications Assessment [Page 71].

8. Data and Information

Currently:

Data is siloed with questionable data quality.

Business Intelligence is predominantly historic and available at an organisational level only.

We have not had the capacity to explore or adopt modern technologies such as Machine Learning / Artificial Intelligence.

Meaning that:

There is limited real-time information available.

There is no longitudinal patient record.

Data quality affects our confidence that we can make informed decisions

Leading to:

We cannot give truly personalised care without the data about the whole person.

We are unable to react quickly to real-time events.

Business Intelligence is resource intensive.

We want to:

Be data-led in our decision making for the care given to individuals and to inform the preventative and reactive services we provide to our population.

Which will improve:

The level of personalised care based on access to a more complete and accurate set of information.

Visibility of the health of our population to inform proactive health and care initiatives.

The opportunity to react quickly based on real-time data.

We will achieve this by:

Having a longitudinal patient care record and population health management through central function.

Joining up our systems and making the data available promptly.

Utilising modern data techniques such as machine learning to identify actionable insights from the data we hold.

Taking steps to improve the overall quality of our data at the point of entry and across our operational systems.

8.1 Data Quality

We will build an ICS Intelligence function to drive improved use of data and Data Quality Assurance. We will introduce the new responsibility/role of Chief Data Officer who will be accountable for building a culture of data quality across the region.

While we have systems which can support our models of care, these are only as a valuable as the data that is entered. It is vital that we have good quality succinct data.

As we consolidate and capture increasing volumes of data and make it more widely available, it is vital that the data we hold is accurate. This means that we may need to introduce cleansing mechanisms, however this is more efficiently done by

It is important that everyone recognises the importance of entering data well and that we highlight to them why this is important. Information entered into key systems must be done so with regard to who will utilise that data in the future, both for direct care of the patient and for secondary use such as Population Health Management.

8.2 Record Sharing Across Health and Care

By March 2023, the LLR Shared Care Record (LLRCR) will support direct care across primary and secondary health organisations as well as the three local authorities within the LLR footprint.

The LLRCR Shared Care Record programme is delivering a unified view of person-centred health and social care records across the region. The primary aim of this programme is to improve the patient information available to health and social care professionals for the purposes of direct care.

The initial phases of this programme are providing this information across primary, secondary, acute, urgent, and emergency care settings.

By March 2023, 200 care homes, LOROS, the Rainbows Hospice, DHU and several community pharmacies will have also joined the LLRCR. Further to this, we will work to include an additional 100 care homes, roll out to further community pharmacies and gear up for a national exchange by March 2024.

As all of these organisations are onboarded to the LLRCR, we will continue to develop richer data sets as local digital maturity increases.

A challenge which has faced previous digital transformation and data sharing initiatives has been the volume of disparate systems which need to be connected. LLR has historically looked to reduce 'system sprawl' by collaboration of partners to find common platforms and solutions and share the resources, where appropriate e.g., TPP SystmOne and LiquidLogic.

The ICS is now developing a formal strategy of system consolidation with a reduction in the number of active EPR systems to two: TPP SystmOne and NerveCentre. This has benefits for information sharing, technical support, and training and forms a key part of the planned strategic system landscape detailed in Section 7.3 - Strategic Systems Landscape [Page 36]

NHS England plans to go to market to procure a federated data platform to integrate technologies and services implemented across the NHS in England. This will extend the model used by the NHS Palantir Foundry platform. LLR is recognises the benefits of an increased data ecosystem at a national level and we will monitor the progress of this programme to determine the local implications and benefits.

8.3 Operational Insights

We want to establish a platform to share real-time operational insights across health and social care partners which will help operational planning at a regional level.

Managing our capacity and patient flow across in-patient and community settings, patients will have a better experience removing unnecessary delays. From a system perspective, efficiently managing the flow of patients between settings will improve resource utilisation and reduce administration time for clinical staff.

We will look to deliver the tools which will enable to partners to proactively manage capacity and predicted demand, using real-time data in operational planning. For example, sharing care home bed capacity will allow hospital discharge teams to discharge patients quickly and confidently to a care home where this is appropriate.

8.4 ICS Intelligence Function

We will establish an ICS-wide function to drive improved reactive and pro-active use of data encompassing Population Health Management and Business Intelligence across LLR by March 2023.

8.4.1 Business Intelligence

Currently, our business intelligence services provide risk stratification on primary care data only. The Data fragmentation and low data quality across NHS partners and disconnected datasets in social care and care homes creates significant challenges in correlating patient-level data across multiple services.

As we integrate disconnected datasets, improve data quality, and correlate patient data, we will look to deliver the following:

- Compilation of service performance dashboards and analysis of trends
- Capacity and demand analysis and activity modelling
- Information to monitor targets, key performance indicators and metrics such as national targets or patient focussed outcome measures
- Interrogation of activity datasets to support service planning and redesign
- Identify data quality issues
- Supporting Recovery Framework through Modelling & Prioritisation of Waiting Lists

8.4.2 Population Health Management

Thanks to continuous innovations in healthcare, people are living much longer than previous generations. Unfortunately, for many people, this also means living longer with a long-term condition or persistent illness.

We know that health inequalities are present throughout across the region. Despite improvements in life expectancy, the region remains below the England average. As with the rest of England, there is a social gradient in health, the lower a person's socioeconomic position, the worse their health is likely to be. To reduce these health inequalities within LLR, there is considerable work to be done, but there is a wealth of historic data to draw upon in predicting preventable health issues.

At the LLR system level, there is an agreement to establish a collaborative approach to Population Health Management. Each ICS partner will support this agreement by developing a capability of analytics staff to feed into population health management and report at system, place, and neighbourhood levels.

Organisational Development Resource will be focussed on engaging BI/Analytics staff in all partner organisations and ensure that staff start to think about using population health analytics to support service delivery decisions.

The challenge will be the shift from utilising scarce analytics resource away from routine retrospective reporting to predictive analytics on population health, which is traditionally the domain of Public Health Medicine (PHM) only.

One hundred staff across eight analytics teams in LLR will form a collaborative multi-agency group to facilitate peer working, sharing tools, capacity, skills, and knowledge as the ICS matures. This group will support and contribute to a wider East Midlands PHM Analyst network to share secondary use data for the purposes of public health, research, and service redesign for the benefit of the wider community.

Beyond combining our workforce, there is a need to access and correlate a huge volume of data, analyse it, and make recommendations. This is expected to be a multi-year programme requiring significant investment and the use of new technologies and analytic skills, but with very clear benefits.

8.5 Machine Learning / AI / RPA

We aspire to research and adopt modern and emerging technologies such as ML and RPA where there is a clear benefit to doing so.

We recognise that there is still much to gain from better use of the technology we already have and ensuring that the ways in which we interact with technology allow us to 'work smarter' to gain the benefits of digital tools and new models of care. We also want to be able to take advantage of new and emerging technologies.

As we consolidate data which has for so long been siloed, we can make use of that data, at the patient, service, and population levels. Machine Learning is a key aspect in identifying new discoveries from our data. It is envisaged that an ICS Intelligence function, equipped with data analysis and modelling skills and machine learning tools will open new directions for investigation that could not be done easily using algorithmic data models.

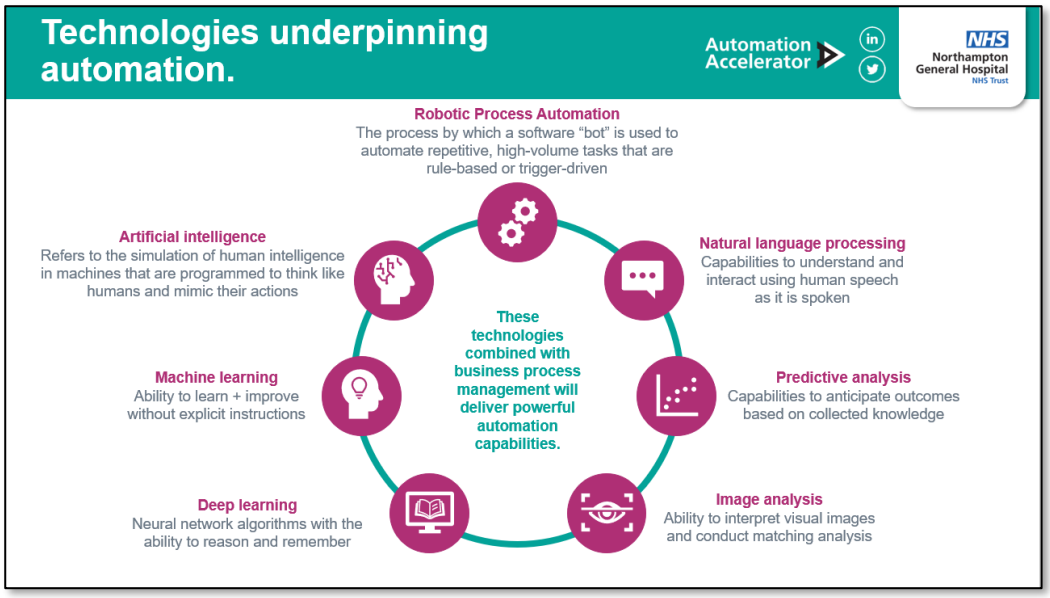
UHL have developed skills in process automation having initiated projects to explore this technology in areas such as operational visibility of the discharge prescription process and Patient-Initiated Follow-Up appointment processing. UHL are planning further projects to leverage this capability in the automation of back office processes.

We have agreed a joint bid to build an RPA (Robotic Process Automation) Centre of Excellence at Northampton General Hospital (NGH). This will allow us to:

- Improve efficiency by moving repetitive tasks to automation 'bots'
- Connect systems at a process level where they may not be easily integrated at a data level
- Free up more time to be spent on clinical care rather than administration

In automating the manual process of monitoring oxygen tank levels at NGH, the frequency of checks was increased, accuracy was improved and over 1500 hours were redirected to value-add activities.

Figure 6 – Technologies Underpinning Automation



8.6 Digital Communication and Transfer of Data

We will build upon existing initiatives by endorsing a greater availability of digital communication and information sharing for both our citizens and our workforce.

Alongside our strategic system rationalisation (Section 7.3 "Strategic Systems Landscape" [Page 36]), we are already working towards our vision of improving digital access to data and increasing digital communication.

In conjunction with this strategic system review, the LLR Digital Innovation Hub is investigating options to reduce the need to create and move physical copies of information through a "Paper Switch-Off" initiative.

We will achieve this reduction in physical movement of people and paper-based information through:

- Health and social care professionals accessing unified data through their key operational systems
- Increased secure data sharing between health and social care partners across our digital ecosystem of strategic systems
- Citizen access to their electronic records, including care plans and correspondence
- Increased adoption of remote consultations through telephone or video

These changes will support the NHS Net Zero commitment, provide greater efficiency, and support new models of care.

9. Workforce

Currently....

Backoffice systems, including HR, lack digital workflows, are labour intensive and slow.

Clinical systems are not intuitive.

There are gaps between the digital skills of our workforce and the systems they use.

Recruiting and retaining IT personnel is challenging.

Meaning that...

There are delays in processes such as staff being granted system access.

Clinical personnel can struggle to use systems as they were intended to be used.

IT teams have gaps in capacity and experience.

Leading to...

Our workforce is frustrated by our systems and processes.

Time available for front-line care is reduced.

Poor or incomplete data is being entered into key operational systems.

IT capacity limitations leads to a focus on operational service and limits change and improvement programmes. Staff retention creates risks for succession planning.

We want to...

Create and encourage a digital first approach across the ICS and share innovation improvement ideas from frontline health and social care.

Ensure that front line staff across the ICS have the information they need to do their job safely and efficiently at the point of care, including an ICS shared care record.

Create ICS-wide professional development, front-line skills development, peer support mechanism, and training opportunities.

Address the challenges of attracting and retaining IT personnel.

Which will improve....

Workforce satisfaction.

How our people use the systems which support their work.

Onboarding of personnel into a new role.

Time available to provide care.

We will achieve this by...

Co-design solutions with our workforce.

Ensuring that our workforce have the digital skills they need.

Modernising our IT technologies, delivery methods, and IT workforce offer.

9.1 DIGITAL CULTURE

We shall co-design our systems with our workforce, ensuring that our solutions are intuitive. We shall streamline the number of different systems our people need to learn and keep working processes and system processes aligned.

Our workforce is arguably the single most significant component of health and social care success. The tools and supporting service we provide to them must support their commitment and work with them and for them, acting as an enabler, not a barrier.

Our people experience digital services on a daily basis in their personal lives. Accelerated digital transformation in the commercial world over the past twenty years has set an expectation level for our workforce as high as for our patients and citizens. For younger members of our workforce, a high level of digital interaction may represent their baseline expectation; it is no longer considered optional, it is the minimum they expect. This is equally relevant for their daily working activities and their interaction with their employer.

User research which has informed the NHS People Digital Strategy identified that:

- People are frustrated when technology is not easy to navigate or when it does not work for them
- Repeated form filling, employment checks, and statutory and mandatory training irritates people
- Systems are clunky and "not like Amazon and Facebook"
- People want to help solve the problems and many have become clinical entrepreneurs
- There are too many workforce systems to learn, and they are not intuitive
- Data is often wrong or out of date
- Alerting, reminders, and escalations are often a manual process rather than automated

It is vital that our digital tools work in a way that people expect and reflect processes, not steer processes. Often, heritage software systems provide an outdated user experience which can be confusing for operators who have grown up with interactive design and monolithic systems can be slower to change often failing to maintain pace with organisational change. Both of these challenges can contribute to frustration and lead to a reduction in data quality.

The 2019 Topol Review[i] 'Preparing the healthcare workforce to deliver the digital future' noted the move towards a more agile workforce: "*The entry of millennials into the workforce has already resulted in changing expectations around work-life balance, flexible careers, rewards and incentives, relationships with employers and the use of technology. With increasing digitisation and digital literacy, the social and emotional skillset of the workforce will become increasingly important. Adoption of innovative technologies that automate repetitive and administrative tasks should also give the workforce more time to make use of cognitive skills.*"

The NHS operational planning guidance for 2021/22 set out a priority for systems and employers to embed the workforce transformations adopted during the pandemic to support recovery and longer-term changes.

These transformations include maximising the benefits of e-rostering and e-job-planning to give our people more control and visibility of working patterns so that they can manage their different responsibilities and broader interests, supporting service improvements and ensuring the most effective deployment of personnel.

[i] *https://topol.hee.nhs.uk/*

Local systems were also encouraged to make use of interventions to facilitate flexibility and staff movement across systems, which were an important part of the response to the pandemic. These interventions include remote working plans, technology-enhanced learning, and the option of staff digital passports.

9.1.1 DIGITALLY ENABLED NURSING

We will support our nurses, PAMs, and practitioners by collaborating with them to co-design digital systems which reduce unnecessary administration and allow them to focus on the care they give.

> *"What Good Looks Like (WGLL) is powered by cohesive, interdisciplinary teams. It presents a unique opportunity for the nursing profession in driving digital transformation.*
>
> *This guidance for board level nurse leaders accountable for digital transformation will work alongside and support the WGLL framework, through practically applying its success measures to nursing practice. By applying WGLL to nursing, we can showcase the importance of system-wide collaboration and community, with people and teams working together to achieve the overall WGLL aims.*
>
> *…*
>
> *As nurses, we are deeply connected to delivering high quality care for all people. Through shifts large and small in health systems, nurses are the constant and direct connection with people. It is hard to ignore the rapidly evolving landscape around us – from the opportunities to improve care in better connected systems and data sharing to our population becoming more digitally fluent.*
>
> *What Good Looks Like (WGLL) sets out an ambitious, common vision across seven success measures for digital transformation. We see a unique place for nurses and nursing practice to support the realisation of this vision. This Guidance for Nursing on WGLL aims to support strong nursing leadership and the practical application of WGLL to the nursing profession, enabling us to have a key role in delivering transformation."*

NHS England has provided guidance for nurse leaders supporting digital transformation aligned with the What Good Looks Like framework. The WGLL Guidance for Nursing[i] includes a "Unified Vision for Digitally-Enabled Nursing". This vision describes a landscape where:

- Nurses are empowered to practice and lead in a digitally enabled health and social care system, now and in the future.
- Nursing practice is fully supported by the use of digital technology and data science.

The guidance provides support for accountable nurse leaders, across ICSs and organisations, to achieve this vision and enable WGLL through:

- **Success measure 1 - Well led**

  "*Driving a supportive culture and enabling structure from board to point of practice.*"

- **Success measure 2 - Smart foundations**

  "*Building the right foundations for digitally enabled nursing practice will ensure our time is spent in the right place, at the right time, and providing the right care.*"

- **Success measure 3 - Safe practice**

[i] *https://www.nhsx.nhs.uk/digitise-connect-transform/what-good-looks-like/guidance-for-nursing-on-what-good-looks-like/*

"*Secure, sustainable and fit for purpose solutions are paramount in delivering safe person-centred nursing care.*"

- **Success measure 4 - Support nurses**

  "*Every nurse is equipped to ensure the service they work within is always striving to provide a better experience with better outcomes today than it did yesterday.*"

- **Success measure 5 - Empower people**

  "*Involve, don't just engage*"

- **Success measure 6 - Improve care**

  "*Continually aim to push the boundaries of what is possible - once one achievement becomes the norm, be safe and brave to see what is possible using the most up to date technology to improve care.*"

- **Success measure 7 - Healthy populations**

  "*Our vision is that we will use population health data to inform how we work, ensuring we provide services and care early and close to home."*

As part of our digital vision, we will work with our people to give them the tools they need, make them intuitive to use, and work for them both for their operational roles and their employment.

9.2 Digitally Enabled Workforce

We will promote an environment where intuitive digital tools support flexible working models and we will work with our people to give them the digital skills they need.

The national People Digital Strategy will be implemented through the Digital workstream of the LLR People Programme. We will map the digital people strategy across the partners, inclusive of social care and the external care market, to develop a plan that sees a digitally enabled workforce right across LLR, with a road map of key deliverables in year. Key digital interventions are already in place across the system, to support efficiency:

- Creation of virtual wards - patients remain under the care of a consultant but supported by community teams from district nursing and therapies – practice is enabled by digital technology. We aim to develop this model further. See Section 10.1 - Virtual Wards [Page 52].
- Use of interface technology to enable access of primary care records in secondary care.
- Increased adoption of the Digital Staff Passport
- Use of electronic rostering to facilitate workforce planning; LPT has begun piloting Safe Care in some inpatient wards. Safe Care works alongside electronic rostering to match staffing levels with patient acuity in real-time.
- Skills for Care are working with Social Care colleagues to identify "what good looks like" from a digital perspective. This is the Adult Social Care Reform White paper, 'People at the heart of Care' which has 'accelerating technology' as a core theme and sets out £150 million of additional funding to drive greater adoption of technology and achieve widespread digitisation across social care.

9.3 Digital Workforce Tools

Through our Digital Workforce Programme, we will build a workforce intelligence system which will digitise workflows, integrate core systems such as e-rostering and Electronic Staff Record within 18 months. This will reduce administration, improve staff experience, and release time for care.

Workforce Planning and Management

The NHS People Digital Vision sets out a blueprint for a digitally-enabled experience for NHS personnel, allowing them to complete tasks from any location.

Define Staffing Needs and Publish Vacancies / Shifts	**Easily Access Information and Activities on Any Device**	**Intuitive Workflow Tools to Complete Tasks Quickly**	**Present Credentials as Evidence and For Access**	**Maximise Time with Patients**
				
Evidence-based workforce planning and insights to define staff and skills needed. Staff records full and up to date. Employers publish vacancies and unfilled shifts bookings.	Staff use an app(s) to do basic tasks on the move like booking shifts, booking annual leave, viewing payslips etc. Carefully targeted notifications keep staff informed and engaged.	HR teams manage workflow to recruit, shifts booking, managing absence, employee relations and more rapidly with confidence that all safeguards have been met.	Staff control their data. Staff use an app(s) to hold their 'verified employment and skills credentials' securely. Staff able to access buildings and log into clinical systems.	Clinicians, managers, and support teams feel their time is valued. Processes fast-tracked. Patients can rest assured that all safeguarding checks have been completed and are up to date.

In implementing this blueprint, one platform will allow staff to:

- Control their own data
- Book annual leave
- Book shifts
- View payslips
- Auto-fill forms
- Apply for roles
- Onboard quickly and easily
- Build their own competency portfolio

Digital Staff Passport

Moving between NHS organisations traditionally results in staff, bank workers and HR teams having to repeat time consuming, yet important form filling, pre-employment checks and statutory and mandatory training. There has long been a call for some form of a 'passport' across the NHS.

To support the COVID-19 response, an interim COVID-19 Digital Staff Passport was developed to enable safe and rapid staff movements between NHS organisations. This was the first step by NHS England and NHS Improvement in their ambitions to build a Strategic Digital Staff Passport to use technology to simplify staff movement between NHS organisations, as outlined in 'We are the NHS: People Plan for 2020/21 – action for us all'[i].

A Staff Digital Passport will simplify the high volume of temporary staff movement between NHS organisations e.g., junior doctors, save time by providing a verified record of identity and employment, and allows colleagues to carry their credentials and professional registration on their smartphone.

9.4 Digital Skills

We will support our people through ICS-wide professional development in digital skills.

Everyone who works in health and social care needs to have digital capabilities grounded in knowledge, skills, attitudes, and behaviours that will enable them to provide the most effective and compassionate care for patients everywhere.

If the knowledge, attitudes, and behaviours around digital capability enable staff to provide the most effective care, then in order to really improve care for our patients, we need to promote the digital skills and confidence of our workforce. By improving digital literacy capabilities of health and social care colleagues, the uptake and adoption of new digital tools and technologies can be improved, and the provision of care transformed.

It is important to note that, while we expect our workforce to have the necessary digital skills to use their tools effectively, we should not expect them to have expert skills; our systems should be intuitive to use so they support our people when performing their main role. We will co-design our systems with our workforce to do this.

Lloyds Bank's UK Consumer 2020 Index[ii] estimated that 52% of people in the workforce lack digital skills in the workplace, and evidence has shown that this deficiency in digital skills extends into the health and social care workforce.

NHS Digital Academy

The NHS Digital Academy is the home for digital learning and development, set up to increase the digital skills of our workforce and to support a new generation of digital leaders who can drive the transformation of the NHS.

It was established following a 2017 Secretary of State commitment following the recommendations of the Wachter Report to invest in the capability and capacity of digital change leaders. HEE is now significantly expanding the Digital Academy model into a suite of learning artefacts – additional formal learning programmes, learning resources and tools – which will mean digital learning and development will be accessible to a much higher number and broader range of individuals across our workforce.

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[i] *https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/*

[ii] *https://www.lloydsbank.com/assets/media/pdfs/banking_with_us/whats-happening/lb-consumer-digital-index-2020-report.pdf*

DIGITAL CAPABILITY FRAMEWORK

We can only provide the best care to all if we can fully exploit the potential of digital and other technologies. We want the health and social care workforce to be fully competent, confident, and capable in the use of digital in the workplace in order to be able to provide that best care.

Excellent digital capabilities are not just about technical skills but include a positive attitude towards technology and innovation and its potential to improve care and outcomes.

To achieve this, we need to provide easy to access learning and development for everyone and for the professions. The HEE Digital Literacy Capability Framework[i] has been developed to support the improvement of the digital capabilities of everyone working in health and care. It is intended as a developmental and supportive tool that can empower and enable all staff.

A self-assessment diagnostic tool underpinned by the Health and Care Digital Capabilities framework will be used to support individuals to identify their digital skills learning needs and be intelligently signposted to appropriate learning resources. Work is also underway to create profession and service-specific digital capabilities frameworks.

9.5 IM&T CAPABILITY

We will work together with our technical personnel to establish an initiative to improve how we can best recruit and retain the best people to deliver and support our digital solutions.

AGILE DELIVERY

Accelerating our digital strategy will require a fast-paced, agile approach to technology delivery ensuring systems are aligned with new models of care and new ways of working. Many of the delivery methods on which public sector organisations have relied for decades no longer apply.

Public sector projects have long been characterised by monolithic, highly-governed, waterfall lifecycles. While this model was appropriate forty years ago, the fast pace of change of organisations and technology cannot be implemented in this way.

Agile delivery, as distinct from agile working models, supports frequent change, shorter delivery cycles, but with less governance and shorter planning horizons. This ultimately depends on a cultural shift and more flexible budget and requirements management. Agile delivery can be constrained by the architecture of the technology in place and the Technical Design Authority will assess the suitability of systems to supporting agile delivery methods.

IM&T CAPACITY – RECRUITMENT AND RETENTION

Attracting and retaining suitably experienced and skilled IM&T personnel is challenging in the face of a competitive IT skills marketplace. There are several challenges:

- Outdated technology is not seen as attractive to a workforce who sit at the leading edge of technology and aspire to work with new hardware and software.
- Many systems are outsourced or off-the-shelf requiring implementation and support roles within the public sector organisation with many key technical roles being supplier-based.

[i] *https://www.hee.nhs.uk/our-work/digital-literacy*

- As agile delivery methods have been commonplace in private sector technology for over two decades, many prospective IM&T workforce candidates can be discouraged from the public sector because of the highly governed nature of public sector projects.
- Public sector salaries are commonly lower than comparable private sector roles.
- Succession planning for future leaders can be compromised by personnel leaving the organisation in search of the above

In 2019, as part of the 'Building a Digital Ready Workforce Programme', Health Education England published a report[i] on Health Informatics Career Pathways which made the following recommendations across five areas across the NHS:

- **Articulating health informatics career pathways across the NHS**

  There is a need to agree and articulate the specialist areas within health informatics alongside skill requirements. Job titles and descriptions need to be in line with industry standards and be meaningful.

  Increased consistency in terminology will also enable us to measure and improve diversity in specific specialist areas as well as ensuring individuals seeking work are able to locate opportunities.

- **Nationally-supported recruitment and retention**

  Entry level roles require an improved foundation potentially with a basic education package to avoid being specialised too early on and gaining a better understanding as to how their specialism fits into the wider NHS.

  Mid-career roles need support to build specialist skills and be able to use them in practice. Senior managers require more knowledge and leadership support as their portfolios broaden.

  Leadership skills are required at all levels including those who do not wish to become managers.

  Individuals external to the NHS may need an orientation to the NHS initially but must not be automatically disregarded.

- **Defining the professional body offer and understanding health informatics network opportunities**

  Individuals were not always clear what the professional bodies were offering, what the overlap was and how they could benefit. There is real potential for the professional bodies and local training networks to support individuals in realising their goals; however, until we can articulate with consistent language what we are striving to achieve, this is difficult to match up.

  The professional bodies and training networks also have an opportunity to support organisations with understanding their profiles and developing meaningful succession planning, while supporting individuals with careers advice and development.

  There is a need to ensure that there is more consistency in training and support available and this is not down to luck or being in the right organisation.

- **Regional/System approaches to developing an informatics workforce**

  There are opportunities for organisations to tackle workforce challenges together at scale. This includes developing joint initiatives to enable staff to gain exposure through rotational, placement or secondments in system wide projects, developing new skills and experience valuable to the local system without the costs of unplanned succession planning and recruitment.

  Structured activities around networking, mentoring, and coaching should also be encouraged as part of this to build up individuals' support networks. This should be linked closely with local training networks

[i] *https://www.hee.nhs.uk/our-work/building-digital-ready-workforce/health-informatics-career-pathways-project*

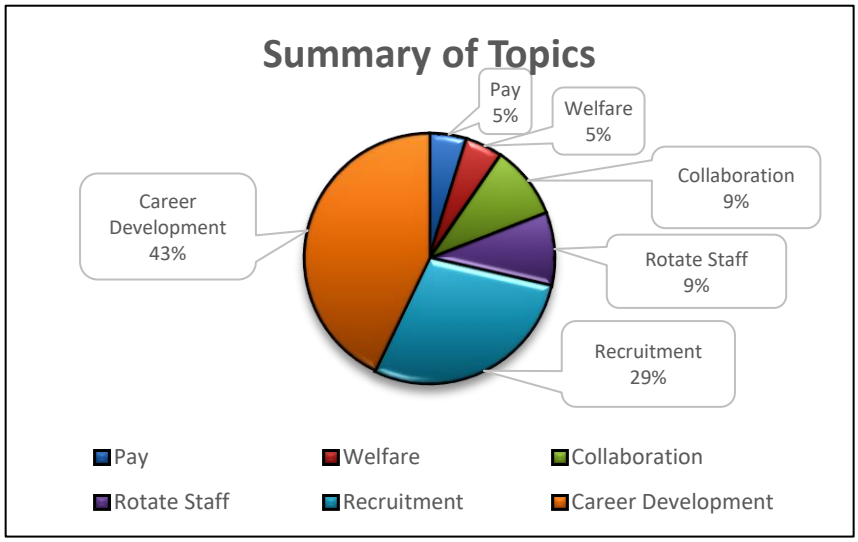
providing specialist training and linked to Regional Talent Boards to ensure this is considered as part of the mainstream and future proofing the local workforce.

We believe that the roles of professional bodies and informatics networks and regional/system workforce approaches are complimentary with the former providing advice and services, the latter identifying local supply and demand requirements.

- **What can senior leaders do now?**

  This section considers the cultural changes that all leaders can explore with their organisation including the importance of executives understanding what health informatics staff need in order to do their jobs effectively. Part of this is ensuring health informatics has a voice and is seen as integral to service transformation, rather than becoming a scapegoat and suffering from blame cultures. Those in a recruiting or line manager capacity can also do more to support and signpost their direct reports.

Figure 7 – Health Informatics Workforce Themes



Within this programme, two conferences were held in 2020 with Health Informatics professionals. Only the conference title was pre-set by the organisers– 'How can we Attract and Retain the Best Digital Talent'.

At the start of the conference, the delegates put forward themes they wanted to discuss, these were then ranked by all delegates, and the most popular themes became the workshop sessions. A summary of the distribution of these themes is shown in Figure 7, highlighting that Career Development and Recruitment were the two biggest topics chosen for discussion.

YEAR OF THE DIGITAL PROFESSION

Recognising that a sustainable, skilled, and supported workforce of digital, data, technology, and informatics experts in health and care is essential to meet the demands and ambitions of the sector, 2022 has been named the 'Year of the Digital Profession' with a national pledge to:

- Launch a 5-year strategy and roadmap for a sustainable digital and data workforce and developing the profession the workforce deserves.
- Create a career framework setting out core competencies to inform professional development and critical for both the recruitment and retention of those within the health and care sector.
- Deliver targeted campaigns to attract apprentices, graduates, and specialist skills in short supply, into the sector.

The Year of the Digital Profession will be promoted sector-wide to increase the understanding and visibility of the roles and will highlight their function and value across health and care to lay the right foundations upon which these professions can grow.

We will support this initiative and align with its work to inspire and recognise our digital workforce.

10. Improved Care

Currently:

There is limited integration between organisational systems and therefore organisations.

Our systems don't easily support multi-organisational pathways.

Transfers of care can require significant manual effort and communication.

Meaning that:

Models of care are aligned to individual organisations or locations.

Conventional referral mechanisms between organisations can be slow, resource intensive, and disjointed.

Patient discharge from an inpatient stay can be slower than possible.

Leading to:

A fragmented patient experience as the retell their story when they are referred between organisations.

High cost resources such as ward beds are used when alternative options are available.

We want to:

Provide person-centred care along care pathways rather than being organisation-specific.

Allow people to remain in their home when it is safe and appropriate to do so.

Digitally support models of care which provide a seamless patient experience along multi-organisation care pathways.

Which will improve:

The patient experience.

The efficiency of scarce, high-cost inpatient resources.

Upstream and downstream communication along care pathways.

We will achieve this by:

Increasing our use of virtual wards and remote monitoring.

Maximising the collaboration across all our partner organisations e.g., pharmacy, voluntary sector etc. through improved communication and information sharing.

Provide a cohesive any-to-any referral mechanism supporting new models of care.

Supporting patients in managing their physical and mental health.

10.1 Virtual Wards

Currently, we have 132 virtual wards beds with concrete plans for 287 beds to support patients receiving acute care in their own homes.

A virtual ward is a safe and efficient alternative to NHS bedded care that is enabled by technology.

Virtual wards support patients who would otherwise be in hospital to receive the acute care, monitoring, and treatment they need in their own home. This includes either preventing avoidable admissions into hospital or supporting early discharge out of hospital.

The NHS @Home Operating Model and principles of Virtual Wards are included in Appendix C - Virtual Wards and Remote Monitoring [Page 75].

LPT and UHL are recognised as leading NHS Trusts nationally in developing virtual ward support for patients on a pathway. LPT and UHL collaboratively have been sharing their success on regional and national platforms so that other Trusts can learn and build upon the work in Heart Failure and Respiratory patients. With the launch of the Elective Recovery Technology Fund, the ICS has been co-ordinating bids to attract transformational funding into LLR, so far within this fund £6.5m of investment has been secured with potentially more to be announced.

The teams at University Hospitals of Leicester, Leicestershire Partnership Trust, the CCGs, and Spirit Healthcare have rapidly expanded their remote monitoring schemes to care for patients with chronic conditions safely in the comfort of their own home.

Inspired by efforts to establish 'virtual wards' for heart and lung patients after the pandemic began, work has been taking place to extend the use of technology across more care pathways including heart failure and COPD. The technology is set up to help patients self-manage their condition at home while giving them support and reassurance that the monitoring equipment will ensure their clinical teams can act swiftly if their health deteriorates.

In its first year, more than 900 patients were supported including over 700 with heart failure and COPD. Fifty patients with heart failure and respiratory conditions were supported in the first six months through the digital rehabilitation pathway, while 172 COVID-19 patients have been discharged after a hospital admission with remote monitoring at home during an initial five-month period.

The Regional Office of NHSE have encouraged the LLR ICS to expand upon the two conditions being supported, so that we can demonstrate the scalability of the model and directly impact waiting lists both in terms of joining waiting lists and keeping patients fit while they are on waiting lists, to avoid failing a preoperative assessment. This learning can then be blueprinted for further national replication.

10.2 Remote Patient Monitoring

We will expand the capability of existing pathways through remote monitoring to maximise the prevention of avoidable admissions, improve patient readiness for surgery through prehabilitation, and support in-home monitoring patients being discharged.

Also allowing patients to receive care while remaining in their own home, remote patient monitoring differs from virtual wards as it is a mechanism intended for:

- enhanced primary care programmes,
- chronic disease management,
- intermediate or day care,

- safety netting,
- proactive deterioration prevention, or
- social care for medically fit patients for discharge.

Remote patient monitoring allows the provision of prehabilitation to allow patients to improve their general health and fitness at home ahead of surgery or treatment. LLR began a pioneering initiative in 2019 to provide a supervised exercise regime, nutritional support, education, and psychological support to improve outcomes for cancer patients.

Patients with poor physical fitness and/or a poor nutritional state before surgery are known to have a higher risk of complications after major surgery. Patients undergoing major cancer surgery face additional demands as their surgical treatment is often combined with chemotherapy or radiotherapy. Studies have shown that patients can improve their aerobic fitness by 20% in a six-week programme before surgery.

Prehabilitation is a programme of support and advice that covers three aspects of a patient's health:

- Nutrition and weight
- Physical activity and exercise
- Mental wellbeing

Monitoring progress and providing advice remotely will improve patients' preparedness for major surgery and treatment, reduce post-surgical complications, and improve outcomes.

Remote monitoring for patients in a social care context is included in Section 10.6 - Social Care below.

10.3 DIGITAL PRIMARY CARE

We will continue to support our GP practices with their provision of video and online consultations through dedicated business change support, move e-referrals to a more robust and resilient platform, and support practices with their adoption of cloud telephony to support flexible working.

GP IT systems have long sat at the heart of primary care technology facilitating and recording millions of interactions with patients every week. GP practices have led the way in the move from paper to digital record-keeping and are now well on the way to offering online transactions, such as appointment bookings and repeat prescriptions, across all practices in England.

Since April 2015, all practices have been required to offer patients access to online GP services. Latest data shows that 15.1 million people are registered to book their GP appointments, order their repeat prescriptions, and view their health records online.

The 2019 NHS Long Term Plan commits to every patient having the right to be offered digital-first primary care by 2023/24.

The five-year framework for GP contract reform published in January 2019 to implement The NHS Long Term Plan, introduced a bold set of commitments related to digital services in general practice, agreed by NHS England and NHS Improvement and the British Medical Association (BMA). These commitments have been introduced gradually every year through the GP contract since 2019-2020.

From October 2021, amendments to the GMS and PMS regulations came into effect, bringing into force a number of the agreements reached by NHS England (NHSE/I) and the British Medical Association (BMA) General Practitioners Committee (GPC) England.

GPs are now required to "offer and promote" to their patients (and those acting on their behalf) the following tools and services for their patients:

- an online consultation tool
- a video consultation tool
- a secure electronic communication method
- an online facility to provide and update personal or contact information.

These requirements are all subject to existing safeguards for vulnerable groups and third-party confidentiality. They are to be in place alongside, rather than as a replacement for, other access and communication methods, for example, telephone and face to face contact.

Within LLR we have a well-established pathway referral management solution supporting both our primary care teams and services for the appropriate care pathway to be identified for the patient need. This solution is fundamental at supporting accurate and appropriate patient referral but is now in need of replacement. We will look to ensure we have a robust and resilient platform to continue our pathway referral management and supporting our patients with the right pathway at the right time. The long-term ambition is for the NHSE e-Referral Service (e-RS) to become an 'any-to-any health sector triage, referral and booking system' by 2025, which local systems will need to integrate with.

10.4 COMMUNITY PHARMACY

We will continue to include community pharmacy in our digital initiatives to provide a truly joined-up patient experience.

Community pharmacy is a pivotal part of the NHS family, and the healthcare people receive. The traditional role of the pharmacist as the dispenser of medication prescribed by a GP is evolving and in recent years community pharmacists have been developing clinical services in addition to the traditional dispensing role to allow better integration and team working with the rest of the NHS.

Community pharmacy is consequently a socially inclusive healthcare service providing a convenient and less formal environment for those who cannot easily access or do not choose to access other kinds of health service. Most pharmacies now have a private consultation area specifically for confidential or sensitive discussions.

The NHS Long Term Plan set out how patients and the public will increasingly rely on clinical care provided by pharmacy professionals.

Increasing the services which can be provided by community pharmacists will be supported by providing access to the LLRCR and the implementation of EPS (Electronic Prescription Service) in secondary care outpatients departments in UHL and LPT.

Many people live near to a pharmacy and appointments are not required to speak with the pharmacist. They are often open in the evenings and at weekends, so they offer fast, convenient support.

Sometimes GP practices will directly refer patients to their community pharmacist for appropriate health conditions, through the Community Pharmacist Consultation Service.

As services increase and community pharmacy transacts more closely with the wider NHS, the ability to make appointments will become important. We will deliver the tools and processes which enable this.

10.5 INTEGRATION WITH VOLUNTARY SECTOR

We will identify how we can collaborate and communicate digitally with the voluntary sector on a case-by-case basis.

LLR's voluntary and community organisations are a vital component of the support and care available to our citizens. The ICS is committed to including voluntary and community services to provide our vision of integrated person-centred care. Our digital tools will support the new care pathways that support this integration.

We are already integrating our systems and securely sharing patient information with Rainbows Children's Hospice and LOROS Hospice to reduce unnecessary administration.

The voluntary and community sector encompasses organisations of many shapes, sizes, and types. The new digital tools we are introducing such as the LLRCR give us a clear opportunity to ensure that we have a clear catalogue of these organisations, and we refer, signpost, or socially-prescribe to them appropriately and securely.

New legislation removes legal barriers to integrated care for patients and communities and allows for greater inclusion between statutory services and the voluntary sector. We remain dedicated to the security of patient data and appropriate levels of information governance, and we will review our digital integration with voluntary and community organisations on a case-by-case basis following the required levels of governance and due-diligence.

10.6 SOCIAL CARE

We will support digital services and tools in social care to provide citizens with access to the same levels of information and advice as the NHS services.

We will continually review the opportunities of remote monitoring and assistive technologies to support service users in their own homes.

We will ensure that our social care workforce is able to access and use modern technologies and share information to improve productivity and service quality.

It is vitally important for people to receive the best care and support in their homes and their community and lead healthy and fulfilling lives and retain their independence and self-esteem. Digital technology can enable this in ways which previously seemed impossible.

Approximately 30% of social care providers nationally are still using entirely paper-based systems. Digital transformation can dramatically improve the quality and safety of care, with real time data integrated into the NHS. This ensures people receive the right care, at the right time, and the right people have access to the information they need. As an example of the opportunities, falls in care homes cost the NHS over £2 billion a year; data from NHSX suggests that the use of innovative care technologies, such as acoustic monitoring, could reduce these falls by over 20%.

The recent "Busting Bureaucracy"[i] report outlined the ambition for all social care providers to have access to a digital social care record (DSCR) that can interoperate with a local Shared Care Record by 2024. These records will play an important role in joining up care across social care and the NHS, freeing up time spent

[i] *https://www.gov.uk/government/consultations/reducing-bureaucracy-in-the-health-and-social-care-system-call-for-evidence*

by care workers and managers on administrative tasks whilst equipping them with the information they need to deliver care.

Social care is at the heart of our communities, providing support to those who need it so that as many people as possible can live the life they want to lead. Social care supports adults of all ages – including young people moving into adulthood and those of working age – with a diverse range of needs, including:

- autistic people
- people with a learning disability or physical disability
- people with mental health conditions
- people with sensory impairments
- people who experience substance misuse
- people with dementia
- other people with long-term conditions

The use of technologies in social care should enhance the quality of care, free up time for meaningful human interactions, and create stronger connections between people and their friends, family, and care networks. We must ensure that technology reduces rather than exacerbates loneliness and isolation, and that it supports the mental health and wellbeing of people and carers. And while not all people will want to use technology as part of their care or daily life, we must make sure that professionals and care teams have the right digital tools and data to provide the outstanding, safe care that all people deserve.

The 2021 Policy Paper "People at the Heart of Care: adult social care reform"[i] describes a vision of person-centred care which revolves around three objectives:

1. People have choice, control, and support to live independent lives.
2. People can access outstanding quality and tailored care and support.
3. People find adult social care fair and accessible.

Supporting wider improvements in social care, we will provide digital tools and services which help to deliver these objectives. Our digital offer will improve the experiences of our citizens through advancing integration between systems, self-care, access to services, aids and adaptations including the introduction of smarter or technology enabled care.

ACCESS TO INFORMATION

Access to information, including self-care advice, details of available services, and self-referral guidance can be fragmented. We will look to make it easier for people to access our services through easy-access information and digital channels.

We will make accessing services as consistent and as simple as possible and embrace digital and virtual opportunities to enhance access and participation.

Our first line of preventative action will always be high quality information and advice in an accessible format to meet a person's needs, building on increased accessing of our online communications during the COVID-19 crisis.

We will ensure that improved access to information is equally applicable to service users and carers, social care professionals, clinicians, and citizens and that this is both inclusive and meaningful to its audience.

[i] *https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper*

CHOICE

By providing our citizens with access to more information about the services available to them, we aim to give them access to greater choice about how they want to be supported.

We will help them to manage personal budgets and direct payments and select the range of services which supports them best.

TECHNOLOGY ENABLED CARE

We can make better use of Technology Enabled Care (TEC) to meet service user outcomes. It is important over the period of this strategy to ensure that digital capacity is enhanced to improve outcomes for service users. The emphasis placed on the appropriate use of digital technology to drive progress will have an impact on future investment and resources and improve digital access to services.

We understand the benefits of people staying in their own home as long as possible or returning home from hospital. Assistive technology can support this through remote monitoring and adaptations which can provide convenience and security for vulnerable people who might otherwise require residential care.

We will support the evaluation and deployment of assistive technologies, remote monitoring technology and telecare solutions which improve the lives of our citizens and allow them to lead fulfilling lives while reducing demand on NHS services

INTEGRATION WITH HEALTH CARE

The LLRCR Shared Care Record Programme will provide greater information sharing across health and social care with the three Local Authorities integrated into the federated data ecosystem. This will allow healthcare clinicians to view a patient's social care data and social care workers to view relevant healthcare information.

At this stage, the LLRCR programme scope is data view access only. Data is entered in the clinician / social care worker's own key system and transactional activities are performed using existing methods.

As citizens gain access to their own information and have the opportunity to add and update data and undertake transactional activities, functionality that allows multi-disciplinary teams across health and social care to communicate and transact will also be added to our ecosystem.

WORKFORCE SUPPORT

To underpin the improvements, we will make to support digital care and digital channels, we will support our social care workforce through:

- Ensuring that they have equipment that enables them to perform their roles flexibly and securely, including remotely.
- Providing access to service information, including assured suppliers, to know the services which are available to citizens, their capacity e.g., care home beds, and simplify the referrals process where needed.
- Providing access to citizen data so social care professionals can best understand the needs of the people they support.
- Providing access to digital workforce tools such as e-rostering so they can manage their own employment efficiently.
- Ensuring that social care professionals have the digital skills they need to support the care they provide and access to the digital learning and training that develops these skills.

10.7 Care Homes

We remain on target to achieve our target of digitally-enabling 80% of our care homes by March 2024 and we are working to ensure that there is a financially-sustainable model to continually support the homes.

There are 300 independent and council-run care homes in LLR. Regionally, we have been supporting their digital-enablement through the provision and support of:

- Wi-Fi networking
- Secure, managed laptops
- Printers
- Access to NHS Mail, TPP SystmOne, and ultimately the LLR Shared Care Record
- Training for care home personnel in the use of the equipment and tools provided

We have successfully reduced the need for care home residents to be admitted to hospital through the new Pre-Transfer Clinical Discussion and Assessment (PTCDA) scheme.

Led by geriatricians and GPs, a discussion takes place between all relevant parties when a care home resident is deemed at risk of hospitalisation to explore safer alternatives. If staying in the care home the patient is visited by either a GP or geriatrician with a special interest in care home medicine to put an appropriate package of care and support in place.

During the initial period, the initiative led to the appropriate avoidance of 577 hospital admissions and 2,885 bed days, the saving of 730 ambulance journeys. Most importantly, it has kept many frail people in a supportive and safe environment rather than in a hospital unnecessarily.

By supporting the digitisation of care homes, we will ensure that initiatives such as this continue to improve the collaboration between care homes and primary care, community care, secondary care, ambulance services, and social care to provide the best support for our older citizens.

As we increase care home access to information and increase the skills and confidence of care home staff, we will investigate how we can share care home information out to the wider health and social care system such as sharing capacity information with social care and secondary care to streamline discharge processes and free hospital beds earlier.

10.8 Mental Health

We will provide digital tools and services to increase access to mental health services, work with voluntary and community partners, broaden the range of information and advice to our citizens, make better use of data, and align our ways of working with the digital tools and channels we have to simplify the mental health journey and help people meet their goals effectively, including through new digital models of care.

Key Lines of Enquiry (KLOE) for mental health have been established. At a summary level, these are:

- **Real-time information is available to support direct care across all ages**

  By 2023/24, all mental health staff will be able to easily input, access and modify the information that they need, at the point of need (typically via an EHR), in mental health systems and across physical health records and primary care

- **Real-time information supports proactive care, better system planning, and research**

  By 2023/24, the ICS is focused on system wide Population Health Management solutions, using high quality data from across the health and social care system, to show the areas of greatest health need, and are directing services to those areas / populations

- **Deliver personalised and inclusive care through digitally enabled pathways**

  By 2023/24, every child, adult and older adult receiving mental health care will be given the option to access their care digitally

Integrated with the digital transformation of physical health, the ICS will deliver significant improvements for our citizens in choice, communication, and the provision of trusted advice and information to support their mental health. It will give health and social care professionals greater access to the information they need to improve patient outcomes and allow people to meet their mental health goals.

Providing a digital framework will give patients and their carers access to trusted advice, give them greater choice in the services provided, and improve communication with their health and care professionals. They will be able to make their choices based on the feedback of people who have been in their position, and they will not need to be experts in the health and social care system to find the right support.

Health and social care teams will have secure access to the information which will enable them to make informed decisions on the treatment of the people in their care and digital systems will be continually aligned with the services they provide.

Voluntary, Community and Social Enterprise organisations will have a digitally-connected framework within which to provide services as important partners of the statutory health and social care agencies.

Commissioners and NHSE&I will have accurate information based on the data captured electronically to support optimised targeting of funds to the services most needed and most successful in meeting patients' mental health goals.

11. Citizens

Currently:

Patients have no access to their health information beyond basic primary care information.

Patients have limited knowledge of our services.

Patients are often required to travel to physical locations to transact with clinicians.

Use of paper-based communication.

Meaning that:

Patient interaction with their clinicians can be a major undertaking requiring significant expenditure of time and travel.

Paper-based interaction adds increased cost and delay to communication

Citizens are not aware of the help and support that is available to them.

Leading to:

Patients using their GP when more appropriate alternatives are readily available.

A high level of missed appointments.

Significant changes in circumstances or health conditions during large gaps in appointments not being communicated.

We want to:

Provide patients with improved access to their information and health and social care professionals.

Allow patients to easily communicate with their professionals without unnecessary travel.

Empower patients to manage their physical and mental health where it is clinically appropriate to do so.

Which will improve:

Greater empowerment for the citizen over the data that is held about them.

The opportunity for patients to transact with their clinicians and share information in real-time.

Cost and time saved by reducing unnecessary travel.

The environmental impact of travel.

We will achieve this by:

Providing digital tools directly to the citizen to allow them to engage with clinicians and manage their data.

Co-designing accessible systems with citizen groups.

Working with partners to address digital exclusion to provide these benefits to all our citizens.

11.1 Service and System Co-Design

We will put the needs of patients, family, carers, and staff at the heart of our system and service design processes by having dedicated roles with clear responsibility for understanding and meeting their emotional, physical, and technical needs.

We are dedicated to ensuring that all our digital services and services are designed in collaboration with the people who are most impacted by them, following the perspective that there should be "nothing about us, without us".

We will work to understand why some people avoid using digital services or choose non-digital alternatives and we will design our systems to help them and provide assisted digital support to ensure that people are not excluded when they can't or won't complete tasks online.

The Digital Innovation and Transformation Team (DITT) act as the hub for digital transformation across LLR. The team is committed to the NHS Digital Service Manual's Design Principles[i] and GDS Service Standard[ii].

The DITT Digital Champion is accountable for the co-design process across the responsibilities of the User-Centred Design roles within the Digital, Data, and Technology Profession Capability Framework[iii].

11.2 Access to Information

We will provide our citizens with a range of digital tools and channels which will enable them to be better informed, manage their conditions, access statutory and community services and communicate effectively with the people who support them.

The NHS App provides a simple and secure way for people to access a range of NHS services on their smartphone or tablet device. This is provided at a national level and, locally patients have the opportunity to use supplementary apps and portals, integrated with the NHS App, to provide targeted information and healthcare management.

A key aspect of our ambitions is to realise the opportunities that digital technologies give us to bring our citizens closer to the health and social care services that support them. Providing digital access to information will provide our citizens with relevant and up-to-date service information and advice, the opportunity to manage their conditions, and securely share information with their health and social care team.

In the modern digital age, it is vital that we are able to engage with our citizens / patients and providing public-facing digital services is core to our digital vision and we will look to provide this access across five areas:

- **Active Signposting**

  By combining knowledge of the services available in our area and an understanding of our citizens as individuals, we will be able to provide personalised signposting to local community services and information.

[i] *https://service-manual.nhs.uk/design-system/design-principles*

[ii] *https://www.gov.uk/service-manual/service-standard*

[iii] *https://www.gov.uk/government/collections/digital-data-and-technology-profession-capability-framework*

In some cases, patients are already able to access NHS services without a referral from their GP. Providing greater information through digital channels about the services which support self-referral is expected to remove perceived barriers to receiving appropriate and timely support.

- **NEW TYPES OF CONSULTATION**

  Alongside conventional face-to-face consultations, we will provide online consultations, including online triage and symptom checking.

  We have the technology to deliver remote consultations, including telephone and video.

  Digital channels offer the opportunity to allow shorter, more frequent unscheduled consultations, including through secure messaging or chat.

  We can provide remote monitoring of our patients, through online templates and questionnaires, or ultimately using telecare devices or wearable technology.

- **SELF-CARE AND MANAGEMENT**

  Managing a health condition across multiple organisations can be challenging for patients, parents, and carers. Delivering a joined-up digital solution to bring together patient information, conditions, care plans, medications, and appointments is an important step to providing people with the tools to manage their own health.

  We have, or plan to deliver, tools which can provide:

  - Searchable directory of services
  - Online appointment booking and management
  - Online prescriptions
  - Personalised symptoms checker
  - Access and update personal information, including care plans
  - Access to advice and information via NHS.UK

- **COMMUNITY CONNECTIVITY**

  Support is available from many sources. Giving access to community services and resources is part of our wider ambition to provide the best care and support to our citizens.

  We will provide access to:

  - Personalised signposting for self-care
  - Access to moderated online forums to provide peer support
  - Patient / carer networking
  - Personalised prescribing

- **CONDITION-SPECIFIC DIGITAL TOOLS**

  In addition to digitals tools which support the individual, their health, and their conditions, many standalone tools are available which provide focused support for specific conditions.

11.3 Addressing Digital Exclusion

While providing digital options for delivering health and social care will benefit many, a significant proportion of the population are digitally-excluded, many of whom would receive the greatest benefit.

We are creating the role of Digital Champion to build momentum in supporting the digitally excluded citizens of LLR, helping them gain better access to health and care specifically and public sector agencies in general. Our Research and Design roles will ensure that system design role creates digital systems that people want to use.

We will look to support organisations who promote digital inclusion and ensure that the digital systems we deliver meet modern accessibility standards. We will guarantee that the digitally-excluded will not be disadvantaged from the digital transformation programme.

Digital Inclusion

While a large proportion of the population have become accustomed to digital tools and services, many people are digitally-excluded through skills, cost, or accessibility.

Digital inclusion covers:

Digital skills

Being able to use digital devices (such as computers or smart phones and the internet. This is important, but a lack of digital skills is not necessarily the only, or the biggest, barrier people face.

Connectivity

Access to the internet through broadband, wi-fi and mobile. People need the right infrastructure but that is only the start.

Accessibility

Services need to be designed to meet all users' needs, including those dependent on assistive technology to access digital services.

Barriers to Digital Inclusion

Research for the UK digital strategy suggests that there are a number of important barriers, and more than one may affect individuals at any one time.

They are:

- access - not everyone has the ability to connect to the internet and go online
- skills - not everyone has the ability to use the internet and online services
- confidence - some people fear online crime, lack trust, or don't know where to start online
- motivation - not everyone sees why using the internet could be relevant and helpful

As access, skills and confidence improve, it is increasingly important to tackle other barriers, including:

- design - not all digital services and products are accessible and easy to use

- awareness - not everyone is aware of digital services and products available to them
- staff capability and capacity - not all health and care staff have the skills and knowledge to recommend digital services and products to patients and service users

It is recognised nationally through the Government's Digital Inclusion Strategy and the NHS and wider health care system initiatives that online services have had a huge impact in transforming almost every aspect of the population's lives. Although there has been great progress in internet access and use of online services, there are still a significant number of people who do not make use of digital services to benefit their health and care needs.

11.5m people in the UK lack the basic digital skills they need to use the internet effectively and 4.8m people are believed to have never been online at all. There are also particular cohorts of the population who are more likely to be digitally excluded than others, many of which who could most benefit from digital health services.

Table 1 - Digital Exclusion: Factors and Statistics

older people	51% of digitally excluded are over 65
people in lower income groups	45% of digitally excluded earn less than £11.5k a year
people without a job	19% of digitally excluded are unemployed
people in social housing	37% of digitally excluded are social housing tenants
people with disabilities	56% of digitally excluded have a disability or long-term condition 27% of adults with a disability (3.3m people) have never been online
people with fewer educational qualifications	78% of digitally excluded left school before 16
people living in rural areas	
homeless people	
people whose first language is not English	

Many of the groups on the list above will be disproportionally overrepresented as service users thus acting as a barrier to a complete channel shift to digital.

Each year, Good Things Foundation gathers facts and statistics about digital inclusion and exclusion in the UK. Their 2021 infographic is included in Appendix F - Digital Nation UK 2021 [Page 86].

We will work with partners across LLR to increase the opportunity for the excluded population to engage and establish a dedicated digital engagement workstream.

As part of the establishment of the Digital Innovation and Transformation Team, we are introducing the role of Digital Champion with key responsibilities to:

- identify which citizens that are at most risk of digital exclusion and develop strategies to provide support to those residents of LLR.
- develop a network of supportive organisations that can act as champions, providing essential digital skills to access health and care digital services.

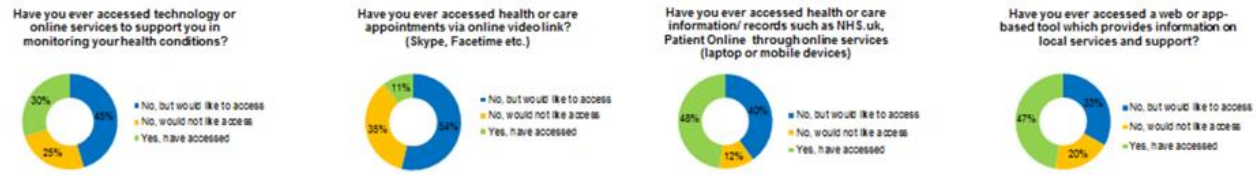
- develop activities and campaigns so that citizens are aware that support is available to them and to encourage adoption of that support.
- develop a digital advocate scheme so that verified individuals can perform online tasks on the behalf of excluded citizens that are unable to transact online with health and care.
- develop a network of digital access points to public services and to ensure that their existence is publicised, branded and easy to obtain.
- Collect monitoring and evaluation information to demonstrate the level of success of the role.
- specifically promote access to personal record sharing, transactional platforms, and condition specific support sites/applications that LLR would wish to promote e.g., NHSApp, TPP Airmid.
- ensure that transformations and projects that are thinking about digital transformations consider on how to provide the best service for all citizens.
- embed patient and public involvement within the digital workstream of the ICS.
- promote digital inclusion as a consideration in the thinking of technical and service design colleagues.
- work across different design and delivery teams so that the end-to-end journey of all patients and service users is considered regardless of their digital literacy

11.4 PUBLIC ADOPTION OF DIGITAL CHANNELS

Figure 8 below is based on a recent survey In Nottinghamshire, who have a similar socio-economic profile to LLR. The survey concluded that, while some people express a reluctance to engage with digital channels, the current digital offer from the NHS to our population is a greater barrier to adopting online services.

It is likely that over 70% of the population would readily adopt digital channels for most activities if provided with the effective tools and clear guidance. However, it must be recognised that delivering digital tools must be supported effectively by aligned ways of working and skilled workforce to deliver the experience benchmark that has been set in online commercial sectors such as retail, banking, and travel.

Figure 8 - Survey of Public attitude to accessing Health Care online



12. The Way Forward

This strategy will deliver the following seven long-term strategic goals:

- We will have a clear and empowered governance structure.
- We will have levelled-up all partners will have a consistent level of digital maturity.
- UHL will have a mature EPR system with tight integration to niche departmental systems, capable of sharing data with the Shared Care Record.
- The ICS will have digital capacity and capability to support future digital needs.
- Data quality will have been improved so it can be used for secondary purposes such as Population Health Management.
- We consolidated duplicated systems into a cohesive digital ecosystem.
- Supported the transformation of care pathways such as Maternity, End of Life and Long Term Conditions with digital enablement.

This strategy will require an additional investment of £24.8M (twenty four point eight million) over three years, which will be subject to NHSE allocation announcements or bidding.

This will require a collaborative system-first approach with the endorsement and support of all partner organisations and the resource capacity to focus on the transformation programme.

12.1 DIGITAL INNOVATION AND TRANSFORMATION TEAM

Within LLR, it is recognised that technology is key to our transformation and the current collaboratives and design groups are supported from within our current technology resources. However, the primary focus of our existing IT teams is the provision of operational IM&T support and project implementation and we have often relied on the use of external consultants to support major change and transformation initiatives.

To move forward and deliver the benefits of digital transformation, we require focused and dedicated roles within the ICS. We therefore plan to establish the Digital Innovation and Transformation Team (DITT) who will act as the digital transformation hub within the ICS, working across our partner organisations.

PURPOSE

- Increase productivity, efficiency, and quality through digital technology and improved ways of working.
- Deliver intuitive digital tools for people to access information and services easily and securely.
- Ensure clinical information can be safely and securely accessed from wherever it is needed.
- Reduce the administrative burden on clinicians and staff, so they can focus on care.
- Improve patient safety across the NHS and Social Care.

CORE RESPONSIBILITIES

- Support LLR ICB by enabling design teams to focus on delivering improvements to front line personnel.
- Act as a champion for patients and their interests and involve the public and patients in the digital transformation plans and decision making of the ICB in LLR.
- Ensure that transformations and projects are thinking about how to provide the best service possible for the patient experience.
- Embed patient and public involvement within the digital workstream of the ICS.
- Promote equality and diversity in the thinking of technical and service design colleagues.
- Support the digitally excluded citizens of LLR, helping them gain better access to services in Health and Social Care and generally raise their confidence in dealing online with public sector agencies.
- Plan and design all aspects of data from its collection, processing, and storage to supporting a range of users to maximise data use and to identify, design and deliver the data and insights strategy.
- Deliver technology requirements that are based on real-user needs, solve the key problems and frictions experienced and are endorsed across the healthcare system.
- Publish standards and specifications that drive interoperability of systems and collections of information to support the management of services.
- Design and lead cyber security policies and provide assurance that will ensure systems are secure and that information is held safely.
- Shape the ICS wide approach, procedures, and culture with regards to information security, data privacy and compliance.
- Deliver a modern architecture for access to local and national services and to support the way local organisations work.

- Deliver proof of concepts using disruptive technology and rapid innovation techniques to create new healthcare opportunities, digital pathways that accelerate the long-term plan and deliver meaningful value to patients quicker.
- Plan and implement transformation programmes for new and existing digital initiatives and identify opportunities for channel shifting how clinical services and corporate functions are delivered through the utilisation of technology and digital solutions.

RELATIONSHIPS

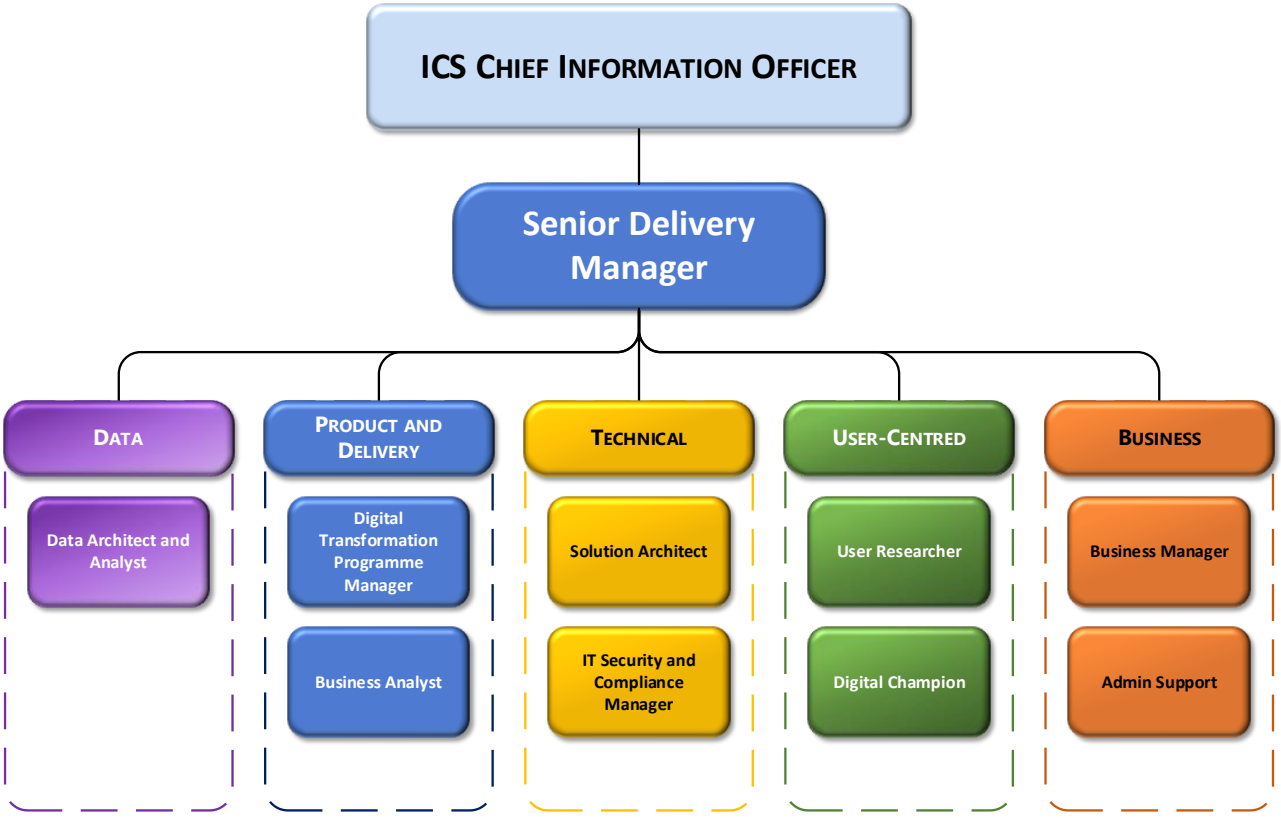
To do this, the DITT will maintain a collaborative working network with:

- CCG/ICS colleagues, Senior Managers, and wider colleagues
- Local system stakeholders including healthcare providers and local authorities
- Other Clinical Commissioning Groups; NHS England / Improvement; Commissioning Support Unit
- Governing Body Members (clinical, managerial, and lay members)
- Executive Team
- GP Portfolio leads
- Primary Care Network Clinical Directors
- Member GP practices and other practice staff
- Public Health England
- ICS stakeholders including Health and Wellbeing Board members
- Patients, carers, and communities
- Local professional committees (LMC, LPC, LOC, LDC)
- Health Education England
- Academic Health Science Networks and Centres
- Voluntary Groups
- Other local and national organisations as required, including Regulatory Bodies.

STRUCTURE

The activities of the Digital Innovation and Transformation Team will be sponsored by the ICS Digital Design Board, and professional accountability will be through the ICS CIO role.

Figure 9 – Digital Innovation and Transformation Team Structure



12.2 DIGITAL ASSET OPTIMISATION

LLR has experienced a significant increase in the adoption of digital technology to support care delivery which has accelerated over the past two years in response to the COVID-19 pandemic.

To ensure that the best solutions are in place across the system, that they align and deliver best value and outcomes for patients, a digital asset assessment has been undertaken. The scope of this assessment related to technical, financial, and cultural aspects as it has been identified that many of the challenges and opportunities relate to how technology is utilised rather than the technology itself.

The assessment found that there is great enthusiasm and a desire to collaborate across LLR which is demonstrated in some of the initiatives across the ICS and the developments within some of the pathways and with partners, e.g., Community Pharmacy.

The digital baseline of LLR is not consistent across the ICS; there are multiple systems in use many of which are duplications of functionality or separate instances, and there is a lack of system-wide alignment of the implementation of new technology across the partners that could compromise or deviate away from the overall joint ambitions for the ICS if left unchecked.

The challenges and opportunities that were identified in achieving the ICS strategic goals include:

- Setting up a clear and empowered governance structure
- Levelling up all partners to a consistent level of digital maturity
- Supporting UHL to deliver the EPR, prioritising the development that will digitally enable pathways across the system, and provide the opportunity to transform and provide better care
- Supporting the ICS to develop the digital capacity and capability to support the digital needs of the ICS

- Establishing and managing data quality
- Converging Systems
- Transforming pathways such as Maternity, End of Life and Long Term Conditions (LTC)

The assessment concluded that "*Access to joined up data is critical to achieve LLR's goals to transform the delivery of care and improve outcomes for its citizens. This needs to be supported by a number of digital capabilities that will then enable the delivery of better outcomes and quality of care for the varying needs of the citizens of Leicester, Leicester, and Rutland.*

In addition to data, the citizen themselves needs to be front and centre in the design of care pathways. Whilst there are known issues to be considered in tackling issues relating to digital inequality, there are often unfounded assumptions related to the digital capabilities of citizens, especially the elderly. Studies show that issues concerning the ability to embrace digital solutions are not a barrier to the elderly."

The assessment made three recommendations for key areas of focus:

- **Shared Care Record**

  The LLR shared care record is a key enabler to deliver and transform the delivery of care across the system.

- **Population Health**

  The wider use of population health data will inform the system how and where to commission services.

- **UHL EPR Programme**

  UHL are a fundamental stakeholder in the delivery of care; it is therefore imperative that this EPR programme is offered the time and support of the ICS to progress and expedite where possible to enable the whole of the health economy to move on the digital journey.

The Digital Asset Optimisation Assessment is included in Appendix D - Digital Asset Optimisation Assessment [Page 77].

12.3 Digital Portfolio

To deliver the vision outlined in this document, we shall define, plan, and implement a portfolio of digital initiatives and actions.

The outline Digital Action Plan from which will define this portfolio is included in Appendix G - Digital Action Plan [Page 87].

12.4 Financial Outline

The outline financial forecast for this strategy and its action plan are included in Appendix H - Financial Forecast [Page 91]. This lists the additional requirements over existing baseline budgets and may be subject to bid funds being successfully agreed.

The annual funding requirements are summarised in Table 2 below.

Table 2 - Funding Requirements Summary

	2022/23	2023/24	2024/25
Revenue Sub Total	**£3,753,000**	**£4,461,116**	**£3,665,116**
Capital Sub Total	**£4,434,000**	**£4,875,000**	**£3,589,000**

APPENDIX A. UHL APPLICATIONS ASSESSMENT

Table 3 – UHL Applications EPR Replacement Roadmap

APPLICATION NAME	FUNCTIONALITY	2022	2023	2024	2025	COMMENTS
HISS / PatientCentre	PAS/ADT/Waiting lists/Clinical Coding/Outpatient appointment management/patient index	**Retained**	**Decommission and replace with EPR**	**Decommissioned**		PAS capability via EPR is planned for December 2022
ICE	GP/ED Order comms/Results Viewing	**Decommission and replace with EPR**		**Decommissioned**		Replacement with EPR for acute inpatients is planned by Autumn 2022
Patient Demographic Service	PAS MPI for pathology only	**Retained**	**Decommissioned**			Will be retired via the EPR PAS upgrade and the LIMS upgrade (due by 2024)
Data Management Portal	PAS MPI	**Retained**	**Decommissioned**			Internal system, very low usage. Will be replaced by EPR
Wristband Application	Inpatient wristbands	**Retained**	**Decommission and replace with EPR**	**Decommissioned**		Planned for replacement in 2023 as part of PAS scope.
ORMIS	Theatres Management	**Retained**	**Decommission and replace with EPR**	**Decommissioned**		
TrackIT	Medical records tracking	**Retained**	**Decommission and replace with EPR**	**Decommissioned**		Plan to decommission following EPR implementation pending confirmation of replacement capabilities.
Dict3	Outpatient letters dictation platform	**Retained**		**Decommission and replace with EPR**	**Decommissioned**	Review the need after EPR outpatient capabilities are in place
Euroking E3	Maternity Information System	**Retained**		**Decommission and replace with EPR**	**Decommissioned**	To be covered by digital maternity strategy in Q1 2022/23. Expect to integrate with EPR and review patient app / community interactions
Medicus	ITU system	**Retained**		**Decommission and replace with EPR**	**Decommissioned**	Specialist ITU system, plan to incorporate into Acute EPR

APPENDIX B. 'WHAT GOOD LOOKS LIKE' MEASURES AND ACTIONS

Table 4 - What Good Looks Like

WGLL SUCCESS MEASURE	ACTION
Success measure 1 - Well led Your ICS has a clear strategy for digital transformation and collaboration. Leaders across the ICS collectively own and drive the digital transformation journey, placing citizens and frontline perspectives at the centre. All leaders promote digitally enabled transformation to efficiently deliver safe, high quality care. Integrated Care Boards (ICBs) build digital and data expertise and accountability into their leadership and governance arrangements and ensure delivery of the system-wide digital and data strategy.	Own an ICS-wide digital and data strategy that drives 'levelling up' across the ICS and is underpinned by a sustainable financial plan
	Establish ICS governance to regularly review and align all organisations' digital and data strategies, ICS-cyber security plan, programmes, procurements, services, delivery capability and risks
	Ensure that your ICS digital and data strategy has had wide input from clinical representatives from across the ICS
	Identify ICS-wide digital and data solutions for improving health and care outcomes by regularly engaging with partners, citizen, and front line groups
	Invest in regular board development sessions to develop digital competence
	Support investment in ICS-wide multidisciplinary CCIO and CNIO functions
Success measure 2 - Ensure smart foundations Digital, data and infrastructure operating environments are reliable, modern, secure, sustainable, and resilient. Across your ICS, all organisations have well-resourced teams who are competent to deliver modern digital and data services.	Have a system-wide strategy for building multidisciplinary teams with clinical, operational, informatics, design, and technical expertise to deliver the ICS digital and data ambitions
	Ensure progress towards net zero carbon, sustainability, and resilience ambitions by meeting the Sustainable ICT and Digital Services Strategy (2020 to 2025) objectives
	Make sure that all projects, programmes, and services meet the Technology Code of Practice and are cyber secure by design
	Oversee across organisation investment in modern infrastructure to retire unsupported systems
	Drive organisations towards 'simplification of the infrastructure' by sharing and considering consolidation of spending, strategies, and contracts
	Ensure levelling up of the use and scope of electronic care record systems, including using greater clinical functionality and links to diagnostic systems and EPMA
	Lead the delivery and development of an ICS-wide shared care record (ShCR) which adheres to the Professional Records Standard Body's (PRSB) Core Information Standard
Success measure 3 - Safe practice Organisations across the ICS maintain standards for safe care, as set out by the Digital Technology Assessment Criteria for health and social care (DTAC). They routinely review system-wide security, sustainability, and resilience.	Have a system-wide plan for maintaining robust cyber security, including development of centralised capabilities to provide support across all organisations
	Establish a process for managing the cyber risk with mitigation plans, investment and progress regularly reviewed at ICS level
	Have an adequately resourced ICS-level cyber security function, including a senior information risk owner and data protection officer (DPO)
	Ensure that you fully use national cyber services provided by NHS Digital
	Ensure the organisations in your ICS are supported to comply with the requirements in the Data Security and Protection Toolkit which incorporates the Cyber Essentials Framework
	Have an adequately resourced clinical safety function, including a named CSO, to oversee ICS-wide digital and data development and deployment

WGLL Success Measure	Action
	Ensure ICS-wide clinical systems meet clinical safety standards as set out by DTAC and DCB0129 and DCB0160
	Establish a clear system-wide process for reviewing and responding to relevant safety recommendations and alerts, including those from NHS Digital (cyber), NHS England and NHS Improvement, the MHRA and the Healthcare Service Investigation Branch (HSIB)
	Ensure compliance with NHS national contract provisions related to technology-enabled delivery, for example, clinical correspondence and electronic discharge summaries
Success measure 4 - Support people Your workforce is digitally literate and are able to work optimally with data and technology. Digital and data tools and systems are fit for purpose and support staff to do their jobs well.	Create and encourage a digital first approach across the ICS and share innovative improvement ideas from frontline health and care staff
	Promote the use of systems and tools to enable frictionless movement of staff across the ICS - allowing staff from different organisations to work flexibly and remotely where appropriate
	Ensure that front-line staff across your ICS have the information they need to do their job safely and efficiently at the point of care, including an ICS shared care record
	Create ICS-wide professional development, front-line skills development, peer support mechanisms and training opportunities
	Pool resources to provide resilient digital support services across your ICS
Success measure 5 - Empower citizens Citizens are at the centre of service design and have access to a standard set of digital services that suit all literacy and digital inclusion needs. Citizens can access and contribute to their healthcare information, taking an active role in their health and well-being.	Develop a single, coherent ICS-wide strategy for citizen engagement and citizen-facing digital services that is led by and has been co-designed with citizens
	Make consistent, ICS-wide use of national tools and services (NHS.uk, NHS login and the NHS App), supplemented by complementary local digital services that provide a consistent and coherent user experience
	Ensure and monitor a consistent citizen offer by ICS organisations
	Ensure a system-wide approach to the use of digital communication tools to enable self-service pathways such as self-triage, referral, condition management, advice, and guidance
	Ensure a system-wide approach for people to access and contribute to their health and care data
	Take an ICS-wide approach to access to care plans, test results, medications, history, correspondence, appointment management, screening alerts and tools
	Have a clear ICS digital inclusion strategy, incorporating initiatives to ensure digitally disempowered communities are better able to access and take advantage of digital opportunities
Success measure 6 - Improve care Your ICS embeds digital and data within their improvement capability to transform care pathways, reduce unwarranted variation and improve health and wellbeing. Digital solutions enhance services for patients and ensure that they get the right care when they need it and in the right place across the whole ICS.	Have an ICS-wide approach to the use of data and digital solutions to redesign care pathways across organisational boundaries to give patients the right care in the most appropriate setting
	Ensure that organisations across your ICS make use of digital tools and technologies that support safer care, such as EPMA and bar coding
	Ensure that organisations across your ICS employ decision support and other tools to help clinicians follow best practice and eliminate quality variation across the entire care pathway
	Ensure that organisations across your ICS provide a consistent and cost-effective approach to remote consultations, monitoring, and care services
	Lead a system-wide approach to collaborative and multidisciplinary care planning using an array of digital tools and services alongside PRSB standards

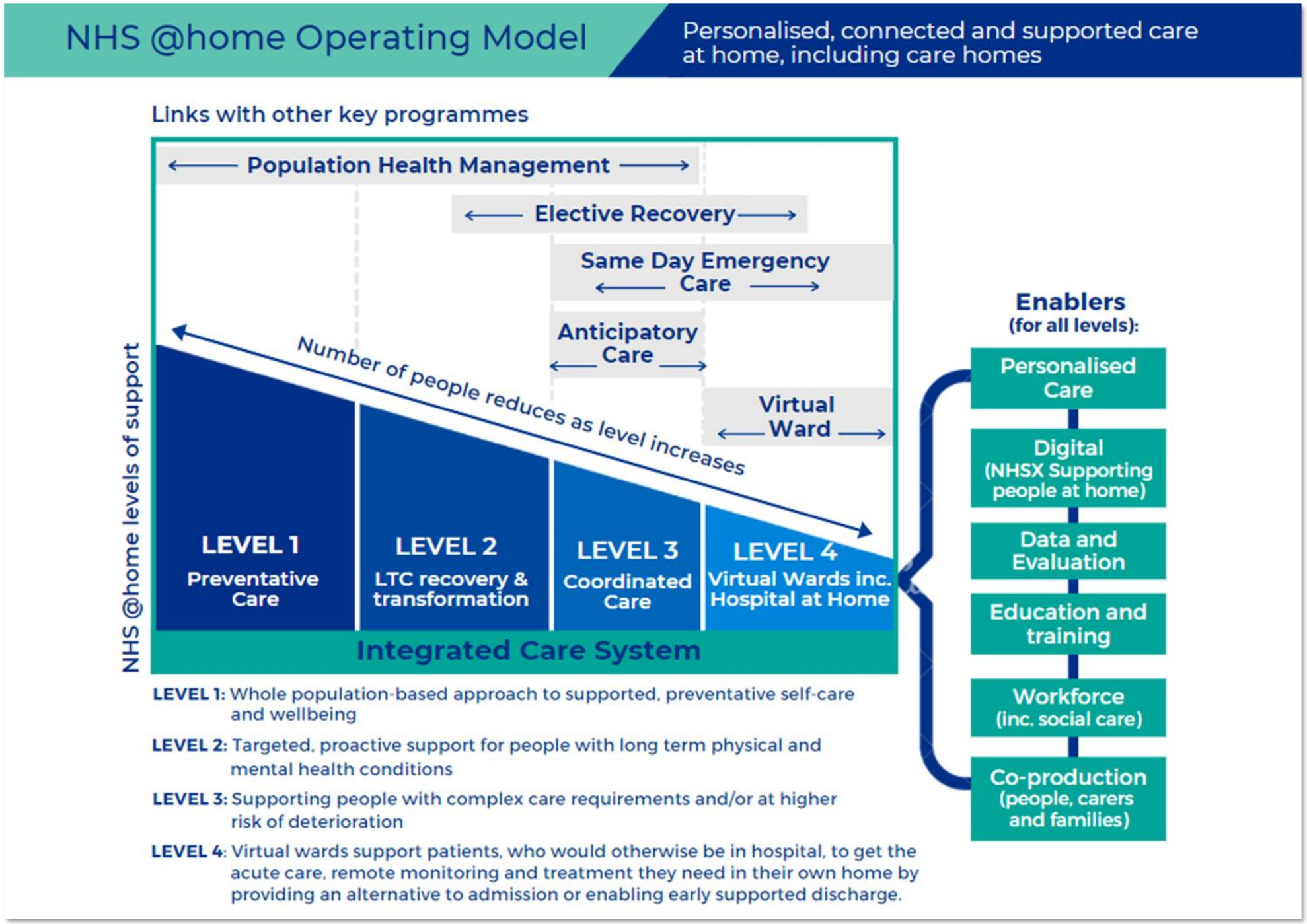
WGLL Success Measure	Action
Success measure 7 - Healthy populations Your ICS uses data to design and deliver improvements to population health and wellbeing, making best use of collective resources. Insights from data are used to improve outcomes and address health inequalities.	Lead the delivery and development of an ICS-wide intelligence platform with a fully linked, longitudinal data-set (including primary, secondary, mental health, social care, and community data) to enable population segmentation, risk stratification and population health management
	Use data and analytics to redesign care pathways and promote wellbeing, prevention, and independence (for example, identifying patients for whom remote monitoring is appropriate)
	Create integrated care models for at risk population groups, using data and analytics to optimise the use of local resources and ensure seamless coordination across care settings
	Ensure that local ICS and place-based decision making forums, including PCN multi-disciplinary teams, have access to timely population health insight and analytical support
	Make data available to support clinical trials, real-world evidencing, and AI tool development
	Drive ICS digital and data innovation through collaborations with academia, industry, and other partners

APPENDIX C. VIRTUAL WARDS AND REMOTE MONITORING

Table 5 - Principles of Virtual Wards

1 SAFETY AND SUSTAINABILITY	**2 CONSENT AND SELF-SUPPORT**
Virtual wards should be developed for a range of conditions, symptoms, and settings, and should track specific metrics that measure appropriate outcomes to demonstrate patient safety and service sustainability.	Virtual ward staff should provide patients (and/or their carers) with adequate information to allow informed consent and understanding of their care, and to support the use of equipment or digital technology such as mobile phones, apps, web-based tools, or wearables.
3 CRITERIA TO ADMIT AND RESIDE	**4 CLINICAL ACCESS TO SUPPORT**
Virtual wards should have clearly defined criteria to admit and reside, supported by daily clinical review, by an MDT if clinically appropriate, to provide a safe and robust service.	Virtual wards should have access to specialty advice, guidance, and diagnostics support equivalent to acute hospital access as appropriate in order to enable timely clinical decision-making by virtual ward staff.
5 TIME-LIMITED INTERVENTIONS	**6 ESCALATION PROCEDURES**
Virtual wards should only be used to deliver time-limited interventions and monitoring based on acute clinical care needs that would otherwise be treated in a hospital.	Virtual ward staff should ensure that patients are given clear information on who to contact if their symptoms worsen, including out-of-hours. There should be clear pathways to recognise deterioration early, with appropriate escalation processes in place to maintain patient safety.
7 CLINICAL GOVERNANCE	**8 INTEGRATED SERVICE PROVISION**
Virtual wards should provide acute clinical care and be delivered by a multi-disciplinary team if clinically appropriate. They should be led by a named consultant practitioner (inc. nurse or AHP consultants, or suitably trained GPs), with clear lines of clinical responsibility and governance.	Virtual wards should be fully aligned or integrated with other service development programmes, including urgent crisis response (UCR), same day emergency care (SDEC) and unscheduled care across their systems, which may require forging future links with system partners.
9 DIGITAL INCLUSION	
Virtual wards should consider the risk of excluding patients through the exclusive use of digital tools and offer alternatives should patients lack the ability to fully use the technology. This includes recognising potential bias in who an offer of technology-enabled support is made to.	

Figure 10 - NHS @Home Operating Model



APPENDIX D. DIGITAL ASSET OPTIMISATION ASSESSMENT

There is great ambition and the appetite for an ambitious digital agenda in a manageably-sized ICS. However, there are some key challenges and dependencies that need to be addressed. These include the need to level up all the organisations to a consistent standard with agreed and shared principles, including an agreed approach to delivering an EPR across the system. Investment is required for the necessary capacity and capability to deliver the digital agenda across the system.

A RAG rating has been applied to illustrate the level of risk against each of the digital asset optimisation criteria independently. A final status of amber has been drawn by aggregating all ratings to give an overall appraisal.

SUMMARY

Table 6 – Digital Asset Optimisation Assessment Summary

ASSESSMENT THEME	DESIRED STATE	RAG STATUS
Digital Ambition	Common objectives and strategic alignment across the ICS	🟢/🟠
Digital Technology	Shared and agreed digital foundations	🟠
Digital Maturity	A digital first culture and the capacity and capability to deliver	🟠/🔴
Digital Transformation	A successful track record in delivering business change and transformation across the ICS	🟠/🔴
Realising Value	An established mechanism to measure and realise benefits across the ICS	🟠/🔴
Governance and Risk	A clear governance structure for centralised decision making and risk management	🔴

Key

- 🟢 No cause for concern
- 🟠 Areas for improvement
- 🔴 Significant action required

ASSESSMENT

Table 7 - Digital Asset Optimisation Assessment

	ASSESSMENT THEME	ASSESSMENT CRITERIA	DESIRED STATE	STATUS
●/●	**Digital Ambition**	A common understanding of the digital vision across all ICS partners	The ICS digital vision is identified, agreed, and shared. All ICS partners see the importance of digital transformation and the associated need for change.	●
		Agreement on key priorities	Key priorities for the ICS digital agenda are established and agreed system-wide.	●
		Alignment on approach	ICS partners agree on the approach.	●
		ICS Digital strategy established and aligned with ICS business/organisational and clinical strategy	The ICS digital strategy is supportive of the ICS's clinical and business priorities.	●
		ICS scope has been confirmed and all partners are fully engaged	A definitive list of all ICS members/participants/partners is established and communicated. All organisations are excited about the potential that ICS digital has to offer.	●
		Executive leadership and sponsorship	Digital leadership as a system	●
●	**Digital Technology**	Culture	Service led.	●
		Delivery track record	The ICS shows a track record of consistent good delivery of digital projects with the desired outcomes achieved and standardised.	●
		Efficiency		●
		Programme approach	There is a central register of technology being implemented, typically coordinated by a PMO function, and is aligned to the overall ICS business and clinical vision.	●
		Principles/standards	Core principles are agreed and adhered to, promoting open standards.	●
		Information governance	Information Governance representation is assigned to the ICS.	●
		Architecture	A documented overview of the overall architecture for the ICS is in place, including all the interfaces to internal and external sources.	●

	Assessment Theme	Assessment Criteria	Desired State	Status
		Infrastructure	Ensure levelling up and use and of digital solutions. The ICS is driven to simplification of the infrastructure by sharing and consolidation of procurement, strategies, and contracts. An asset register is in place with agreed refresh cycle.	🟠
		Network	The network is sufficiently robust for the ICS requirements and all of its users. Performance is assured and will not be impacted- or plans are in place to upgrade the network in accordance with the ICS system-wide requirements.	🟠
		Coding	Common codes agreed and in place.	🔴
		Data Quality	All providers including third sector and independent sector providers are submitting “comprehensive data”.	🟠
		Data warehouse strategy	A firm plan is in place to complete a rationalisation of the data warehouse capability across the ICS.	🔴
		Reporting	Catalogue of reports.	🟠
		Population health data	The ICS has smart digital foundations, connected health and care services, locally joined-up person-level data across health and care partners, and robust analytical capability aligned across system partners.	🟠
		Cyber	A system-wide plan has been agreed for maintaining robust cyber security, including development of centralised capabilities to provide support across all organisations, and regular reviews have been scheduled. ICS CSO, DPO and SIRO functions have been appointed.	🟠
		Business continuity/resilience	ICS wide business continuity plan.	🟠
		Environment	Agenda towards net zero carbon, sustainability and resilience ambitions by meeting the Sustainable ICT and Digital Services Strategy (2020 to 2025) objectives has been agreed and included in the digital strategy.	🟠
🟠/🔴	**Digital Maturity**	Culture	Care without walls philosophy is truly embedded (pathway and building thinking has been replaced with patient thinking).	🟠/🔴
		ICS leadership	The ICS has evidence to confirm that the current leadership team has successfully led an organisation of similar size and complexity.	🟢/🟠
		Digital maturity of user base	The organisation has a clear understanding of how to measure the digital maturity of its user base and supports its workforce in its ability to adopt new solutions and the confidence in how to use those.	🟢/🟠
		Resourcing model	A resourcing model has been agreed across the ICS.	🟠

	Assessment Theme	Assessment Criteria	Desired State	Status
		IM&T capacity and capability	A digitally mature and experienced IM&T function is established to deliver the size and complexity of the ICS.	●/●
		Transformation capacity and capability	The people and resources to deliver are clearly understood and can be allocated. The skills and capabilities required to deliver the transformative aspects of the ICS are identified and available.	●/●
		Customer and user experience	Internal and external customer experience meet good standards.	●
		Continuous improvement	The ICS has an established framework to ensure continuous improvement forms part of the standard digital delivery cycle/model. Optimisation projects are integral to the BAU planning.	●
●/●	**Digital Transformation**	Digital first culture	A digital first approach across the ICS is encouraged and innovative improvement ideas are shared from frontline health and care staff.	●
		Co-design with staff and patients/citizens	Plans to involve all stakeholders as part of the design and assurance of solutions.	●
		Business change		●
		Digital inclusion	A clear ICS digital inclusion strategy has been developed, incorporating initiatives to ensure digitally disempowered communities are better able to access and take advantage of digital opportunities. A single, coherent ICS-wide strategy has been developed for citizen engagement and citizen facing digital services that is led by and has been co-designed with citizens.	●
		Access to health and care data	A system-wide approach has been implemented for people to access and contribute to their health and care data. Take an ICS-wide approach to access to care plans, test results, medications, history, correspondence, appointment management, screening alerts and tools.	●
		Interoperable record	A system-wide approach has been implemented to collaborative and multidisciplinary care planning using an array of digital tools and services alongside PRSB standards. The interoperable record needs to provide a single view per pathway/condition and is used to improve the care given across the system. Data can be extracted (vs. PDF).	●
		Population health	As ICS-wide approach has been established to the collection and use of data and digital solutions to redesign care pathways across organisational boundaries to give patients the right care in the most appropriate setting.	●
		Implementation planning and approach	An established ICS programme framework is embedded, and preferred methodology identified. Staff are experienced and trained in programme methodology to fulfil associated roles.	●
		Standardisation	Agreed set of prioritised pathways that will be standardised.	●
		Digital-enabled transformation		●

	Assessment Theme	Assessment Criteria	Desired State	Status
		Efficiency and effectiveness		●
		New ways of working	There is an agreed digital training strategy and approach in place to embed the new ways of working.	●
		Paperless	Digitised processes and data capture.	●
●/●	**Realising Value**	Benefits identification and management	The ICS has an established approach to successfully ensure the delivery of intended outcomes and benefits. It understands the importance of early benefits identification and clear ownership throughout the realisation cycle of target benefits to deliver against those.	●
		Benefits framework	An established Benefits Delivery Framework is in place and operational.	●
		Benefits realisation track record	There is a clear track record of technology-enabled benefits realisation.	●
		Cost effectiveness and value for money	The ICS understands the non-negotiable agenda for cost effectiveness and Value for Money and the digital supports this.	●
●	**Governance And Risk**	Governance	There is a clearly defined governance structure and processes are established to enable decision making at the appropriate level and regularly review and align all digital and data strategies.	●/●
		Risk	Risk is visible and assessed centrally by the ICS with accountability per organisation.	●
		Procurement	Controlled and managed procurement framework across the ICS. Each initiative is approved by the digital board.	●
		ICS leadership	The ICS leadership team has been established and is joined-up.	●/●
		Collaboration		●
		Trust		●
		Finance	Financial decisions are taken in line with the strategic direction of the ICS.	●/●

APPENDIX E. ARCHITECTURE PRINCIPLES

Table 8 – Architecture Principles

NAME	DESCRIPTION	RATIONALE	IMPLICATION	PRACTICAL STEPS
1. Deliver Sustainable Services	All digital services need to be delivered sustainably.	Digital services need to be 'resilient', that is robust and able to withstand and respond to changes arising out of the Environmental Emergency. The impact of digital services on "embodied emissions" or ecological & social impact from mining and manufacture (that is, the environmental cost of producing and disposing of IT equipment) should be considered. Design principles – • Minimise data retention and resolution • Code efficiently • Avoid duplication • Limit architectural obsolescence • Carefully consider the benefits of utilising and AI / machine learning – ensure benefit outweighs energy requirements.	Architects should consider the impact of climate change in their work from three perspectives in addition to the other principles: **Direct** • Ensure that non-functional requirements are appropriate (do not build in unnecessary duplication and redundancy) • Design services that maximise resource utilisation (i.e., cost and carbon optimisation). **Upstream** • Select suppliers considering their carbon footprint. **Downstream** • Promote the move to environmentally sustainable cloud services. • Promote digital by default as a principle, reducing CO_2 in health and care business processes.	
2. Put our tools in modern browsers	All digital services should be browser based and utilise open web standards.	Provides flexibility for users (and their trusts, CCGs, or any other administrative group) to choose any modern computers and operating systems that meet their needs. Supports move to a mobile-first approach and makes the same digital services easily accessible from mobile phones, tablets, laptops, and assistive technologies like screen readers. Achieves the benefit of the continual security and functionality improvements that come with the continuing evolution of modern browsers and web technologies.	Comply with the Apps and Infrastructure Design Authority's (AIDA) browser standard, designing systems that support modern browsers on a range of device types. Move away from Internet Explorer 11. Evidence for this should be provided via: • Requirements • Technical specifications • User journeys • Architecture • Testing • Operational support. Browser support should be assessed by the Architecture Approval Group.	• Adopt the latest web standards to ensure content is accessible to as many people as possible, including those with disabilities • Ensure that website load times are less than 3 seconds to avoid users dropping off • Use automation to ensure compatibility with all supported browsers and to shorten software test cycles • Only procure tools that are available via modern browsers and adopt a responsive design • Ensure tools are composed as API-facing services for reuse across emerging digital channels such as conversational interfaces
3. Internet First	All digital services should adopt internet standards and protocols including setting the default that	When we adopt internet standards and protocols for our networks and digital services: • We maximise the number of technologies and digital services that will work for us and for those we care for	Digital architectures must demonstrate that they are designed to use the Internet as the default way of accessing information. This has two contexts:	• Design lightweight front-end user interfaces with no business logic • Adopt modern internet protocols for sending and receiving data across the internet

NAME	DESCRIPTION	RATIONALE	IMPLICATION	PRACTICAL STEPS
	services are available over the public Internet.	• We maximise the number of developers and software engineers that can help us transform health and care and meet the needs of our users • We minimise what you need to learn to build software and digital services for health and care • We maximise the amount of distributed data we can handle. Our health and care system will never be a centralised service because it services the citizens of an entire nation, and so too should its infrastructure not be centralised. Appropriate access to our data from any part of the system – like you can access your email from anywhere, as long as you have the right passwords – is an important part of delivering care.	• Internet is preferable to non-digital interactions for most users (letter, phone) • Public Internet is preferable to private networks. This supports sustainability by enabling digital by default. This should be shown in architecture diagrams and assessed by the Architecture Approval Group.	• Use APIs provided on the national API gateway to decouple the application from the underlying infrastructure that provides the service • Systems to have modern network protection as standard ensuring services remain up and secure • Designs must demonstrate robust communication with the end-user despite a loss of connectivity
4. Public Cloud First	Digital services should move to the public cloud unless there is a clear reason not to do so.	Cloud services provide many advantages for NHS Digital, including a reduction in the time to deploy infrastructure and a significant reduction in emissions.	Digital services should be delivered from the public cloud unless there is a reason not to do so, specifically: • Service characteristics (availability, recover time objective, etc) that cannot be met by public cloud. • Cyber or information governance that cannot be met by public cloud. This should be reflected in architecture designs and assessed by the Architecture Approval Group.	• Use cloud native services to reduce the amount of time needed to manage servers and infrastructure • Architect for scale up and down on demand to ensure services can easily meet future needs without huge rework • Demonstrate a shift to devops, containers or serverless, microservices and CI/ CD to increase time to market and reduce risk • Non-production environments should only be running when they are being used to ensure no unnecessary costs are incurred • Empower product teams to “own” their solution and provide a strong security boundary using cloud accounts
5. Build a data layer with registers and APIs	Digital services should only store data once (usually where collected) and make it available via open APIs whilst maintaining privacy and security.	By storing data only once we reduce costs by removing requirements for data replication/propagation when data is changed and we ensure that each individual (patient or clinician) has visibility of the same record. Through storing data once and making it available via APIs, it reduces the requirements for costly large databases of personal health and care data to deliver our services and meet our research aims - and smaller, dispersed datasets mean fewer large attractive targets for hackers.	Implement architectures that reuse platforms and separate out disparate components. APIs should be made publicly available through an API management layer based upon open standards. APIs should be included in the API catalogue APIs should also be consumed internally unless there is a good reason not to do so. Data access designs should be shown in architecture diagrams and assessed by the Architecture Approval Group.	• All data will be validated at the point of entry to improve data quality • All data will be made discoverable • Do not duplicate data • All clinical data stored will be made accessible using APIs published on the national API gateway • APIs will be managed throughout their life cycle making them more discoverable, serviceable, and more easily monitored • Ensure data is digitally signed to an appropriate level
6. Adopt the best cyber security standards	Services must adopt the appropriate cyber security standards subject to risk	It is critical that we maintain public trust in how we hold, share and use data.	Digital Services must demonstrate conformance to cyber security best practice during design, development, operation and maintenance phases as specified by:	• An annual Data Security and Protection Toolkit return must be completed by any organisation handling health data

NAME	DESCRIPTION	RATIONALE	IMPLICATION	PRACTICAL STEPS
	appetite, including keeping all software, networks, and systems up to date.	We need to maintain a safe and secure data infrastructure that protects health and care services, patients, and the public. The digital architecture of the health and care system needs to be underpinned by clear and commonly understood data and cyber security standards, mandated across the NHS, to ensure we are secure by default and that the penalties for data breaches are effective in protecting patients' privacy.	• Cyber Design Authority (CDA) • National Cyber Security Centre • Vendor best practice This should be shown through a statement of conformance to security standards and through non-functional testing. Since cyber security standards change, conformance will need to be regularly assessed and maintained through the lifecycle of the service.	• Services should conform to the technical requirements of Cyber Essentials (for example by not requiring an unpatchable warranted environment). • Services should be assessed against the Digital Technology Assessment Criteria from NHSX which is the baseline criteria for digital health technologies entering into the NHS and social care. • Cyber security expertise to be engaged as a resource to the initiative from the earliest point to ensure good practice is followed and a smooth transition to production.
7. Use Platforms	Digital services should build upon existing platforms to deliver their services.	New digital services should reuse common infrastructure (platforms) and services rather than create their own. This will reduce architecture debt (duplication of digital services and use of non-strategic technologies) which saves money and time for development.	This should be shown in architecture diagrams and assessed by the Architecture Approval Group. The Platforms and Infrastructure Board will oversee the development of future platforms. The EA team will monitor the Digital services portfolio to inform the use of platforms in future releases.	• Design and build using microservices that can be composed to deliver business capability • APIs must be delivered and managed as a product to drive an ecosystem of innovation and new experiences • Use NHS number as the primary identifier to connect patient data • Documentation to be published in the API catalogue so that reusable services and data are human and machine discoverable.
8. Ask what the user need is	Every service must be designed around user needs, whether the needs of the public, clinicians, or other staff. Services designed around users and their needs: • are more likely to be used • help more people get the right outcome for them – and so achieve their intent • cost less to operate by reducing time and money spent on resolving problems.	This is best practice in the development of digital services. Inclusivity is a legal requirement, e.g., the Equalities Act. The NHS Long Term Plan specifies the need to improve healthcare offerings for excluded groups, e.g., patients with learning disabilities & homeless.	Digital Services should: • Comply with all legal requirements, especially around website accessibility • Undertake user needs analysis as part of the design process • Ensure UX design principles are followed • Demonstrate that the architecture supports a range of user interactions, e.g., digital, paper, phone. This can be demonstrated through documented user journeys. Digital services should be developed with progressive enhancement; this will ensure: • Services are more resilient • The service's most basic functionality will work and meet the core needs of its users • Improved accessibility by encouraging best practices like writing semantic mark-up • Users with device or connectivity limitations can use the service.	

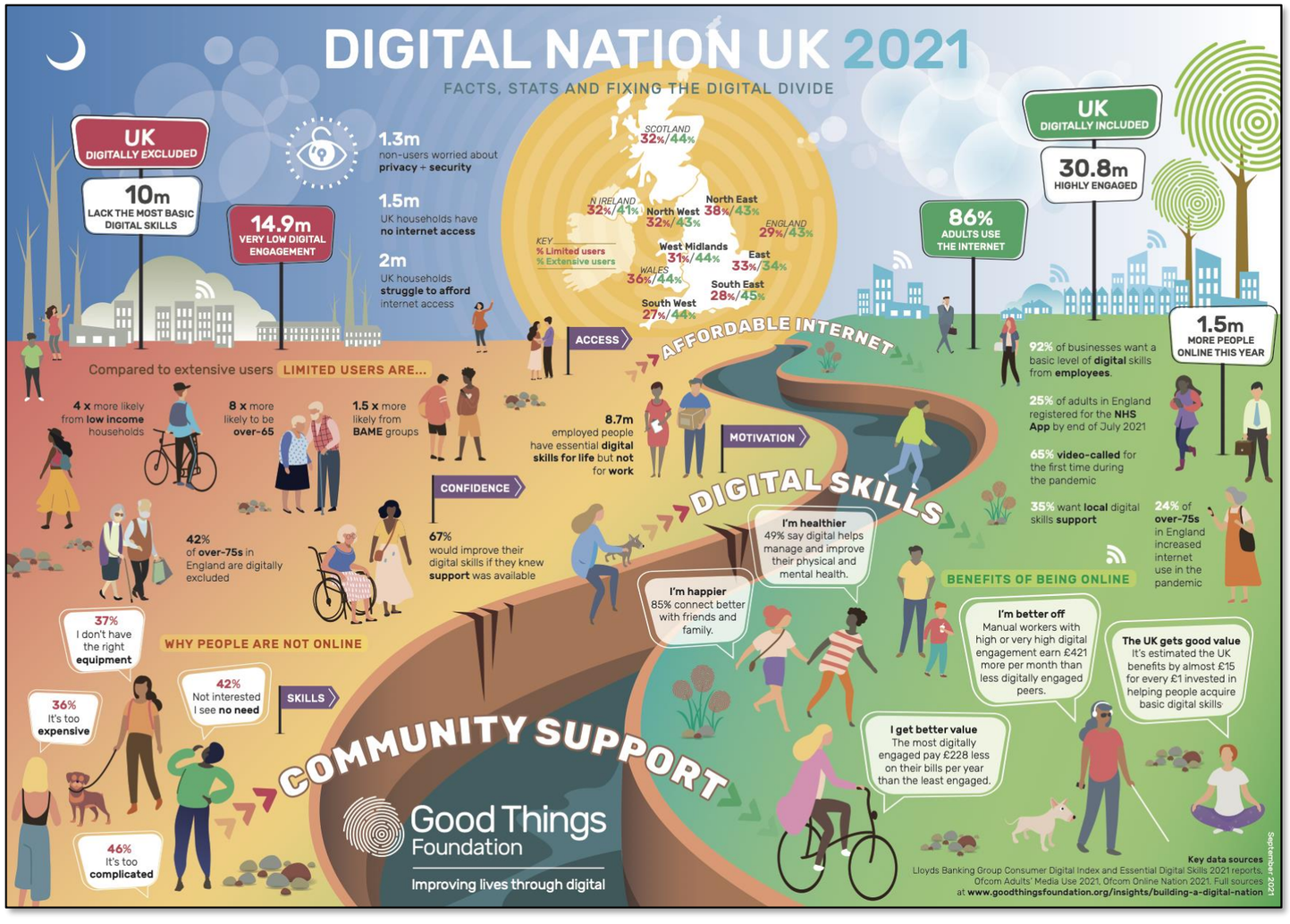
NAME	DESCRIPTION	RATIONALE	IMPLICATION	PRACTICAL STEPS
9. Interoperability with open data and technology standards	Digital services should adopt open data and technology standards.	Open standards permit interoperability between different regions and systems but they also, crucially, permit a modular approach to IT in the NHS, where tools can be replaced with better alternatives as vendors develop better products. This, in turn, will help produce market conditions that drive innovation, in an ecosystem where developers and vendors continuously compete on quality to fill each niche, rather than capturing users.	Digital services should demonstrate conformance to best practice during design, development, operation, and maintenance phases as specified by Design Authorities.	• Avoid data siloes; clinical systems should integrate with key EPR systems and/or Shared Care Record at a data or API layer. .
10. Reuse before Buy/Build	Digital services should demonstrate that they have sought to reuse existing solutions before delivering new ones. Where it is not possible to reuse an existing solution, off-the-shelf (commercial or open source) products should be considered. For open source products there should be an appropriate level of contractual support provided. Only having ruled out the former two options should a new solution be built, either in-house or through third parties.	Cost and time to market. Sustainability and reduction of carbon footprint.	Conformance with approved Technologies List, owned and managed by AIDA. Use of platforms. Evaluation of business case by technical and enterprise architecture. Assessment of high-level solution architecture and risk log by Architecture Approval Group.	

APPENDIX F. DIGITAL NATION UK 2021

Each year, Good Things Foundation create a Digital Nation infographic, gathering together the facts and stats about digital inclusion and exclusion in the UK[i].

The 2021 update gathers together facts and statistics about digital inclusion and exclusion in the UK. It uses new analysis of the latest Ofcom data by Prof. Simeon Yates alongside key sources such as Lloyds Bank UK Consumer Digital Index and Essential Digital Skills 2021, external research, and their own data insights.

Figure 11 - Digital Nation UK 2021 Infographic



[i] *https://www.goodthingsfoundation.org/insights/building-a-digital-nation/*

APPENDIX G. DIGITAL ACTION PLAN

SECTION	ACTION	DELIVERED THROUGH	START DATE	END DATE
5.1 Governance	We will build a governance structure which brings together partner organisations at a system level to share resources, make decisions and plan jointly, with a single person accountable for the delivery of shared outcomes and plans, working with local partners.	Establishment of the ICS Governance Model	Jun-22	Ongoing
5.2 Digital Governance	We will build a model which balances flexibility for clinicians and practitioners to operate effectively within their 'place' with the benefits of consistency across the ICS 'system'.	Establishment of the ICS Digital Governance Model	Jun-22	Ongoing
5.3 Assurance	We will build ICS-wide assurance policies and functions to give confidence that our digital and data solutions meet all appropriate legislation, standards, and best practice.	Establishment of Digital Innovation and Transformation Team in ICS	Jun-22	Ongoing
5.3.1 Clinical Design Authority	In 2022/23, we will establish a Clinical Design Authority Group under the leadership of the ICS CCIO to determine the impact of transformational opportunities presented by ICS Design Groups and major Trust-level transformations on the digital agenda.	Establishment of Clinical Design Authority	Jun-22	Ongoing
5.3.2 Technical Design Authority	In 2022/23, we will establish a Technical Design Authority Group under the leadership of a System CIO to act as assurance of technical architecture across the ICS.	Establishment of Technical Design Authority	Jun-22	Ongoing
5.3.3 System-Level Assurance Function	In 2022/23, we will establish an ICS-wide function who will establish policies for key areas of compliance and provide assurance of functions', programmes', and solutions' adherence.	Establishment of Digital Innovation and Transformation Team in ICS	Jun-22	Ongoing
6.1 Architecture and standards	Greater multi-organisational collaboration and data sharing requires a consistent approach to technology standards. We fully support a standards-based approach to technology implementation, and this will underpin the technology roadmap across our partners.	Ownership of LLR Architectural Standards by LLR ICS Technical Design Authority with active assessment of new proposals against this standard.	Jun-22	Ongoing
6.2 Cyber Security	We are creating the role of Security & Compliance Manager in our Digital Innovation and Transformation Team to define and assure our approach, procedures, and culture with regards to information security, data privacy and compliance.	Establishment of Digital Innovation and Transformation Team in ICS	Jun-22	Ongoing
6.3 Information Governance	The LLR Information Governance Board is embedded into ICS delivery governance and proactively supports and advises our programmes. Early engagement and a solution-focused perspective keeps our citizens' data secure and facilitates the increased collaboration between ICS partner organisations	Through resetting Digital governance in LLR ensuring LLR Information Governance Board is playing an active role in supporting the Digital Delivery Agenda taking asks and returning solution back to the IM&T Delivery Board on a monthly basis.	Jun-22	Ongoing
6.4 Commercial Management	We will use the scale of ICS to support our partners' supplier relationships to provide an over-riding focus on the holistic healthcare needs of the region as a whole and endorse the suppliers who best align with the regional vision.	Establishment of Digital Innovation and Transformation Team in ICS	Jun-22	Ongoing

SECTION	ACTION	DELIVERED THROUGH	START DATE	END DATE
6.5 Financial Management	We will ensure that digital spending is effective across LLR, driving efficiency gains through greater alignment of resources and taking opportunities to review technology consolidation when contractually feasible.	Establishment of Digital Innovation and Transformation Team in ICS	Jun-22	Ongoing
6.6 Business Continuity / Disaster Recovery	The ICS will provide assurance that partner organisations' BC/DR plans are effective as we increase our dependency on digital services and systems.	Establishment of Digital Innovation and Transformation Team in ICS	Jun-22	Ongoing
6.7 Environmental Impact	To support the NHS Net Zero commitment, we will provide and encourage the use of digital alternatives to paper and physical travel for our citizens and staff where this does not reduce the care we provide.	Establishment of Digital Innovation and Transformation Team in ICS	Jun-22	Ongoing
7.1 Front Line Infrastructure	We will provide our workforce with the tools which allow them to work remotely where possible, including internet-facing virtual desktops and supporting the adoption of cloud telephony in primary care.	Through ICS CIO discussion with other ICS partner technical teams to adopt at organisational level as a strategy.	Jul-22	Ongoing
7.2 Cloud Architecture	Where appropriate, we will transition services to cloud-hosted platforms or cloud-based systems to provide resilience, scalability, and wider access.	Through ICS CIO discussion with other ICS partner technical teams to adopt at organisational level as a strategy.	Jul-22	Ongoing
7.3 Strategic Systems Landscape	We will rationalise the number of operational systems in use across the region to simplify support, increase data sharing, and improve training.	Through ICS CIO discussion with other ICS partner technical teams to adopt at organisational level as a strategy.	Jul-22	Dec-24
8.1 Data Quality	We will build an ICS Intelligence function to drive improved use of data and Data Quality Assurance. We will introduce the new responsibility/role of Chief Data Officer who will be accountable for building a culture of data quality across the region.	ICS Deputy Director of Strategy and Planning and Chief Data Officer	Mar-22	Mar-23
8.2 Record Sharing	By March 2023, the LLR Shared Care Record (LLRCR) will support direct care across primary and secondary health organisations as well as the three local authorities within the LLR footprint.	ICS LLR Shared Care Record Programme Manager	Jun-21	Mar-23
8.3 Operational Insights	We want to establish a platform to share real-time operational insights across health and social care partners which will help operational planning at a regional level.	Chief Data Office	Jul-22	Mar-24
8.4 ICS Intelligence Function	We will establish an ICS-wide function to drive improved reactive and pro-active use of data encompassing Population Health Management and Business Intelligence across LLR by March 2023.	Chief Data Office	Mar-22	Mar-23
8.5 Machine Learning / AI / RPA	We aspire to research and adopt modern and emerging technologies such as ML and RPA where there is a clear benefit to doing so.	Horizon scanning through DITT and also membership of the Northamptonshire General exemplar for RPA.	Ongoing	Ongoing
8.6 Digital Communication and Transfer of Data	We will build upon existing initiatives by endorsing a greater availability of digital communication and information sharing for both our citizens and our workforce.	Managed through IM&T Delivery Board to establish paper switch off.	Ongoing	Mar-23
9.1 Digital Culture	We shall co-design our systems with our workforce, ensuring that our solutions are intuitive. We shall streamline the number of different systems our people need to learn and keep working processes and system processes aligned.	Establishment of Digital Innovation and Transformation Team in ICS	Jun-22	Ongoing

SECTION	ACTION	DELIVERED THROUGH	START DATE	END DATE
9.1.1 Digitally Enabled Nursing	We will support our nurses, PAMS, and practitioners by collaborating with them to co-design digital systems which reduce unnecessary administration and allow them to focus on the care they give.	Establishment of Digital Innovation and Transformation Team in ICS	Jun-22	Ongoing
9.2 Digitally Enabled Workforce	We will promote an environment where intuitive digital tools support flexible working models and we will work with our people to give them the digital skills they need.	Establishment of Digital Innovation and Transformation Team in ICS	Jun-22	Ongoing
9.3 Digital Workforce Tools	Through our Digital Workforce Programme, we will build a workforce intelligence system which will digitise workflows, integrate core systems such as e-rostering and Electronic Staff Record within 18 months. This will reduce administration, improve staff experience, and release time for care.	Digital Innovation and Transformation Team working with People Programme Delivery Board	Jun-22	Dec-23
9.4 Digital Skills	We will support our people through ICS-wide professional development in digital skills.	CIOs, Digital Innovation and Transformation Team working with People Programme Delivery Board	Jun-22	Mar-23
9.5 IM&T capability	We will work together with our technical personnel to establish an initiative to improve how we can best recruit and retain the best people to deliver and support our digital solutions.	CIOs, Digital Innovation and Transformation Team working with People Programme Delivery Board	Jun-22	Mar-23
10.1 Improved Care	Currently, we have 132 virtual wards beds with concrete plans for 287 beds to support patients receiving acute care in their own homes.	Virtual Wards Delivery Group	Ongoing	Dec-23
10.2 Remote Patient Monitoring	We will expand the capability of existing pathways through remote monitoring to maximise the prevention of avoidable admissions, improve patient readiness for surgery through prehabilitation, and support in-home monitoring patients being discharged.	Home First Delivery Group	Ongoing	Ongoing
10.3 Digital Primary Care	We will continue to support our GP practices with their provision of video and online consultations through dedicated business change support, move e-referrals to a more robust and resilient platform, and support practices with their adoption of cloud telephony to support flexible working.	GP IM&T Steering Group	Jun-22	Mar-23
10.4 Community Pharmacy	We will continue to include community pharmacy in our digital initiatives to provide a truly joined-up patient experience.	IM&T Delivery Board	Ongoing	Ongoing
10.5 Integration with Voluntary Sector	We will identify how we can collaborate and communicate digitally with the voluntary sector on a case-by-case basis.	IM&T Delivery Board	Jun-22	Ongoing
10.6.1 Social care	We will support digital services and tools in social care to provide citizens with access to the same levels of information and advice as the NHS services.	IM&T Delivery Board	Jul-22	Mar-24
	We will continually review the opportunities of remote monitoring and assistive technologies to support service users in their own homes.	IM&T Delivery Board	Jul-22	Mar-24

SECTION	ACTION	DELIVERED THROUGH	START DATE	END DATE
	We will ensure that our social care workforce is able to access and use modern technologies and share information to improve productivity and service quality.	IM&T Delivery Board	Jul-22	Mar-24
10.7 Care Homes	We remain on target to achieve our target of digitally-enabling 80% of our care homes by March 2024 and we are working to ensure that there is a financially-sustainable model to continually support the homes.	Care Homes Project Board	Ongoing	Mar-24
10.8 Mental Health	We will provide digital tools and services to increase access to mental health services, work with voluntary and community partners, broaden the range of information and advice to our citizens, make better use of data, and align our ways of working with the digital tools and channels we have to simplify the mental health journey and help people meet their goals effectively, including through new digital models of care.	LPT IM&T Committee	Jun-22	Mar-24
11.1 Service and System Co-Design	We will put the needs of patients, family, carers, and staff at the heart of our system and service design processes by having dedicated roles with clear responsibility for understanding and meeting their emotional, physical, and technical needs.	Establishment of Digital Innovation and Transformation Team in ICS	Jun-22	Ongoing
11.2 Access to Information	We will provide our citizens with a range of digital tools and channels which will enable them to be better informed, manage their conditions, access statutory and community services and communicate effectively with the people who support them.	Establishment of Digital Innovation and Transformation Team in ICS	Jun-22	Ongoing
11.3 Addressing Digital Exclusion	We are creating the role of Digital Champion to build momentum in supporting the digitally excluded citizens of LLR, helping them gain better access to health and care specifically and public sector agencies in general. Our Research and Design roles will ensure that system design role creates digital systems that people want to use.	Establishment of Digital Innovation and Transformation Team in ICS	Jun-22	Ongoing
	We will look to support organisations who promote digital inclusion and ensure that the digital systems we deliver meet modern accessibility standards. We will guarantee that the digitally-excluded will not be disadvantaged from the digital transformation programme.	Establishment of Digital Innovation and Transformation Team in ICS	Jun-22	Ongoing

APPENDIX H. FINANCIAL FORECAST

Table 9 - Additional Technology Funding Capital and Revenue Requirements for Three Years

	2022/23	2023/24	2024/25
Implementation Capital UHL EPR	£2,129,000	-	-
Implementation Revenue UHL EPR	£1,485,000	-	-
Post Implementation Capital UHL EPR	-	2,570,000	1,284,000
Post Implementation Revenue UHL EPR	-	2,002,000	1,270,000
Levelling Up digital Maturity Capital (NHSE Allocation)	£2,133,000	2,133,000	2,133,000
Critical Cyber Security Capital (NHSE allocation)	£172,000	172,000	172,000
Digital Implementation Teams Revenue (NHSE allocation)	£492,000	492,000	492,000
Tech enabled Remote Monitoring Revenue (NHSE allocation)	£351,000	351,000	351,000
ShCR Revenue (PDC 21/22)	£1,425,000	1,352,000	1,288,000
Elective Recovery (Virtual Wards / Remote Monitoring) (PDC 22/23)	-	264,116	264,116

Revenue Sub Total	**£3,753,000**	**£4,461,116**	**£3,665,116**
Capital Sub Total	**£4,434,000**	**£4,875,000**	**£3,589,000**

4

Leicester, Leicestershire and Rutland Integrated Care Board

Governance Handbook

Reference number:	LLR Corporate xxx
Title:	Governance Handbook
Version number:	Version 1
Approved by:	NHS LLR Integrated Care Board
Approved date:	
Date Issued:	
Review Date:	
Document Author:	Daljit Bains, Head of Corporate Governance
Director:	Nicci Briggs, Executive Director of Finance, Contracting and Corporate Governance

Version Control

Version number	Approval / Amendments made	Date (Month Year)
Version 1	Governance Handbook compiled for the LLR Integrated Care Board (ICB) incorporating the relevant documents as approved by the ICB. Aimed at ICB staff and board members.	July 2022

DOCUMENT STATUS:
This is a controlled document. Whilst this document may be printed, the electronic version posted on the shared drive/intranet is the controlled copy. Any printed copies of the document are not controlled.

RELATED DOCUMENTS:
This document will reference additional policies and procedures which will provide additional information

Contents

Purpose and Introduction

1. The purpose of this document is to bring together a range of corporate statutory documents in one place and is described as the "Governance Handbook" for NHS Leicester, Leicestershire and Rutland Integrated Care Board (hereafter "the ICB" or "LLR ICB"). This document will aim to ICB employees and ICB Board members to navigate through our governance systems and processes across the ICB and build a consistent corporate approach to implementing governance arrangements.

2. Effective governance enables clarity about decisions that have been made, by whom, when and why; transparent accountability; provides clear escalation routes for staff to safely report risks and concerns; and promotes values and behaviours we can embrace as an organisation. This may also be of interest to members of the public and therefore the Governance Handbook will be published on the ICB's public website at XXXX.

3. The content of the Governance Handbook will be updated regularly as a routine reference guide for staff and the public. Where there are any changes to the Constitution and Standing Orders these shall be endorsed by NHS England.

Principles of Good Governance

4. Corporate governance is the means by which the Board of the ICB lead and direct the organisation, so decision making is effective.

5. The Board will ensure that it complies with the full range of regulations and legislation to ensure the ICB is governed appropriately. Whether it is statutory requirements or NHS guidance, the ICB is legally accountable for meeting these obligations acting in the best interests of the organisation, patients, their carers and the wider community.

6. The ICB advocates adherence with the *Good Governance Standard for Public Services* as the guidance for best practice. It builds on the Nolan Principles for the conduct of individuals in public life, by setting out six core principles of good governance for public service organisations as illustrated below.

7. The 'Nolan Principles' set out the ways in which holders of public office should behave in discharging their duties. The seven principles are:

    a) **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

    b) **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

    c) **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

d) **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

e) **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

f) **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

g) **Leadership** – Holders of public office should promote and support these principles by leadership and example.

Source: *The First Report of the Committee on Standards in Public Life* (1995)

Decision Making: the governance structure

Role of the ICB

8. 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.

9. The LLR ICB is a statutory body responsible for the commissioning of healthcare services across the Leicester, Leicestershire and Rutland Integrated Care System area, bringing the NHS together locally to improve population health and care. It replaces NHS East Leicestershire and Rutland Clinical Commissioning Group, NHS Leicester City Clinical Commissioning Group and NHS West Leicestershire Clinical Commissioning Group. The statutory functions of these organisations will transfer to the ICB.

10. The LLR ICB will be part of the LLR Integrated Care System, a partnership involving the local NHS, Local Government organisations, the third sector and other relevant bodies with an active interest in the health, care and wellbeing of the residents of Leicester, Leicestershire and Rutland. Together they will collaborate to address health and care inequalities, enhance integrated working, ensure optimal use of available resources and contribute to broader societal priorities.

11. The LLR ICB will be specifically responsible for a range of planning, commissioning, financial and oversight functions which will be discharged with the aims of improving the health of the local population and ensuring the efficient and effective delivery of NHS services.

The Constitution and Standing Orders

12. The ICB is responsible for determining the governing arrangements for their organisations, which they are required to set out in a Constitution. The Constitution set outs the arrangements made by the CCGs to meet their responsibilities for commissioning health and care services. It describes the governing principles, rules and procedures that the

CCG will establish to ensure probity and accountability in the day-to-day running of the CCG to ensure that decisions are taken in an open and transparent way and that the interests of the local population remain central to what the CCG does.

13. The CCG's Standing Orders set out the statutory framework and status upon which the CCG should carry out its business, the composition of the Membership, key roles and appointment process, calling meetings of the CCG and how these are managed through clear internal control processes, appointments of Committees and Sub-Committees, duty to report non-compliance with Standing Orders and Delegated Financial Authority Limits, use of seal and authorisation documents and overlap with other CCGs policy statements/procedures and regulations. The Standing Orders are detailed in Appendix 3 of the CCG Constitution.

Scheme of Reservation and Delegation

14. The ICB's Scheme of Reservation and Delegation (SoRD) (as at Appendix B) focuses on delegations within the ICB in the first instance whilst secondary legislation and statutory guidance is awaited.

15. The SoRD sets out clearly which functions and powers of the ICB are:

    a. reserved to the board itself, so that only the board may make those decisions
    b. delegated to individuals (board members or employees)
    c. delegated to committees and sub-committees of the organisation that have been established by the board
    d. delegated to other statutory bodies using the boards legal powers (to become section 65z5 and 65z6 of the 2006 Act) to delegate functions to another organisation or to a joint committee with another organisation
    e. any functions that have been delegated to the ICB by other bodies, e.g. NHS England's functions relating to the commissioning of primary medical services.

Functions and decisions map

16. The functions and decisions map is a visual representation at a high-level setting out where key decisions are delegated and taken by which part(s) of the system and specifically in relation to the internal governance arrangements for the ICB. The functions and decisions map is appended to this Governance Handbook at Appendix C.

Standing Financial Instructions (SFIs)

17. 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. These can be found at Appendix D.

Detailed Financial Policies and Operational Scheme of Delegations

18. The detailed financial policies and operational scheme of delegations underpin the SFIs and the SORD respectively and should be adhered to by all staff. These can be found at Appendix E.

Committees and Groups of the ICB

19. The following are committees established by the ICB and the terms of reference for each is appended to this document:

    a. Audit Committee (terms of reference as at Appendix F)
    b. Remuneration Committee (terms of reference as at Appendix G)
    c. System Executive (terms of reference as at Appendix H)
    d. Finance Committee (terms of reference as at Appendix I)
    e. Quality and Safety Committee (terms of reference as at Appendix J)
    f. Health Equity Committee (tbc)

Meetings

20. The functions and decisions map provides an overarching visual representation of the governance architecture and corporate meetings as at Appendix C. The schedule of meeting dates and frequency of meetings is available and held by the Corporate Governance Team.

Standards of Business Conduct

21. Employees, members, committee and sub-committee members of the ICB and its committees will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the ICB and should follow the *Seven Principles of Public Life*; set out by the Committee on Standards in Public Life (the Nolan Principles).

22. They must comply with the ICB's policy on standards of business conduct and declaration of interest, including the requirements set out in the policy for managing conflicts of interest. The Conflicts of Interest Policy (which incorporates standards of business conduct) will be available on the ICB's website.

Appendices

Appendix A – The Constitution and Standing Orders

NHS Leicester, Leicestershire and Rutland Integrated Care Board

CONSTITUTION

Version	Date approved by the ICB	Effective date
V1.0	Approved by NHS England	1st July 2022

CONTENTS

1. Introduction

1.1 Background/ Foreword

NHS England has set out the following as the four core purposes of ICSs:

a) Improve outcomes in population health and healthcare
b) Tackle inequalities in outcomes, experience and access
c) Enhance productivity and value for money
d) Help the NHS support broader social and economic development.

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

- Improving the health of children and young people
- Supporting people to stay well and independent
- Acting sooner to help those with preventable conditions
- Supporting those with long-term conditions or mental health issues
- Caring for those with multiple needs as populations age
- Getting the best from collective resources so people get care as quickly as possible.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Leicester, Leicestershire and Rutland ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is Leicester, Leicestershire and Rutland with the following districts:

a) Blaby District
b) Charnwood Borough
c) Harborough District
d) Hinckley and Bosworth Borough
e) Leicester City District
f) Melton Borough
g) North West Leicestershire District
h) Oadby and Wigston Borough
i) Rutland District

1.3.2 The ICB will replace NHS East Leicestershire and Rutland Clinical Commissioning Group, NHS Leicester City Clinical Commissioning Group and NHS West Leicestershire Clinical Commissioning Group. The statutory functions of these organisation will transfer to the ICB

1.3.3 The ICB will be part of the Leicester, Leicestershire and Rutland Integrated Care System, a partnership involving the local NHS, Local Government organisations, the third sector and other relevant bodies with an active interest in the health, care and wellbeing of the residents of Leicester,

Leicestershire and Rutland. Together they will collaborate to address health and care inequalities, enhance integrated working, ensure optimal use of available resources and contribute to broader societal priorities.

1.3.4 The ICB will be specifically responsible for a range of planning, commissioning, financial and oversight functions which will be discharged with the aims of improving the health of the local population and ensuring the efficient and effective delivery of NHS services

1.4 Statutory Framework

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

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

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

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

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

a) having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
b) exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) duties in relation to children, including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014);
d) adult safeguarding and carers (the Care Act 2014);
e) equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35);

f) information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000); and
g) provisions of the Civil Contingencies Act 2004.

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

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

a) section 14Z34 (improvement in quality of services),
b) section 14Z35 (reducing inequalities),
c) section 14Z38 (obtaining appropriate advice),
d) section 14Z40 (duty in respect of research),
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z44 (public involvement and consultation),
g) sections 223GB to 223N (financial duties), and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z58 of the 2006 Act), and to intervene where it is satisfied that the ICB is failing or has failed to discharge any of its functions, or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 July 2022 by [*name and reference of establishment order*], which made provision for its constitution by reference to this document.

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

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

1.6 Variation of this Constitution

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

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

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

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

a) The ICB Executive Management Team may propose amendments to the Constitution for consideration by the board subject to appropriate engagement process(es). The board will review and consider the proposals and subsequently will propose a variation to the Constitution and make an application to NHS England.

b) Proposed amendments to this constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

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

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

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

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

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

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

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

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

- The above documents a) – c)
- Terms of reference for all committees and sub-committees of the board that exercise ICB functions.

- 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.
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
- The up-to-date list of eligible providers of primary medical services under clause 3.6.2.
- Handbook may also include other documents relating to the ICB more generally.

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

- Standards of Business Conduct Policy
- Conflicts of interest policy and procedures
- Policy for public involvement and engagement.

2. Composition of the Board of the ICB

2.1 Background

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

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

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

a) a Chair
b) a Chief Executive
c) at least three Ordinary members

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

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

a) three executive members, namely:

- Director of Finance
- Medical Director
- Director of Nursing

b) At least two non-executive members.

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

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description;
- the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description;
- the local authorities which are responsible for providing social care and whose areas coincide with or include the whole or any part of the ICB's area.

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

2.2 Board Membership

2.2.1 The ICB has six Partner Members.

a) Acute Trust sector (Executive level) representative
b) Community / mental health sector (Executive level) representative
c) Primary Care Provider Representative
d) Three Executive level members from local authority to provide sectoral perspective on adult and children's social care, and public health

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

a) ICB Director of Strategy
b) Non-Executive Member – Audit Committee Chair
c) Non-Executive Member – Health Inequalities, Public Engagement, Third Sector and Carers
d) Non-Executive Member – People and Remuneration
e) Non-Executive Member – Quality, Safety and Transformation
f) Clinical Executive Lead

2.2.3 The board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) Two Partner member(s) NHS and Foundation Trusts
d) One Partner member(s) Primary medical services
e) Three Partner member(s) Local Authorities
f) Four Non executive members
g) Director of Finance
h) Medical Director
i) Director of Nursing
j) Director of Strategy
k) Clinical Executive Lead

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

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

2.3 Regular Participants and Observers at Board Meetings

2.3.1 The board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision making and the discharge of its functions as it sees fit.

2.3.2 Participant will receive advance copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting, by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions, address the meeting and fully participate in the meeting but may not vote.

a) Representative from Healthwatch Leicester and Leicestershire (non-voting)
b) Representative from Healthwatch Rutland (non-voting)
c) Representative from the Ambulance Trust (non-voting)
d) ICB Director of Transformation (non-voting)
e) ICB Director of People (non-voting)

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

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

3. Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test"
b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles)
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification Criteria for Board Membership

3.2.1 A Member of Parliament.

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

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—
a) in the United Kingdom of any offence, or
b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, sections 56A to 56K of the Bankruptcy (Scotland) Act 1985 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

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

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

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office
b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings,

c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
d) of misbehaviour, misconduct or failure to carry out the person's duties.

3.2.7 A health care professional (within the meaning of section 14N of the 2006 Act) or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was—
a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to—
a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

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

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

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

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

3.3 Chair

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

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

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area.
b) Any of the disqualification criteria set out in 3.2 apply.

3.3.4 The term of office for the Chair will be three years and the total number of terms a Chair may serve is three terms.

3.4 Chief Executive

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

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

3.4.3 The Chief executive must fulfil the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Meets the requirements as set out in the Chief Executive Person Specification

3.4.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Subject to clause 3.4.3(a), they hold any other employment or executive role.

3.5 Partner Members - NHS Trusts and Foundation Trusts

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

a) University of Hospitals of Leicester NHS Trust
b) Leicestershire Partnership NHS Trust
c) East Midlands Ambulance Service

3.5.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be an Executive Director of one of the NHS Trusts or FTs within the ICB's area
b) One shall have specific knowledge, skills and experience of the provision of acute services, and.

c) The other member shall have specific knowledge, skills and experience of the provision of community and mental health services. This member may also fulfil the requirements of an Ordinary Member with knowledge and experience of service relating to the prevention, diagnosis and treatment of mental illness.

3.5.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) A conflict of interest is evident, as determined by the Chair or an ICB Board appointment panel, which results in the individual being unable to fulfil the role

3.5.4 These members will be appointed by a panel subject to the approval of the ICB Chair.

3.5.5 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation listed at 3.5.1. will be invited to make one nomination.
- The nomination of an individual must be seconded by one other eligible organisations.
- Eligible organisations may nominate individuals from their own organisation or another organisation listed at 3.5.1
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

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

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

c) Chair's approval

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

d) The Chair of the ICB will report the appointed Partner Member(s) to the next meeting of the ICB board.

e) Any re-appointment including at the end of a term will follow the process as described in section 3.5.5 a) to d).

f) A Trust Executive paid for a full-time role by their Trust should not expect to be paid again by the ICB.

3.5.6 The term of office for these Partner Members will be three years and there will be a re-appointment process which will commence before the term comes to an end.

3.6 Partner Member - Providers of Primary Medical Services.

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

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

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

a) Be a registered General Practitioner (registered with the General Medical Council).

b) Be a current provider of general medical services, working in a primary care setting in the ICB area.

c) Have experience of leadership role(s) in primary care.

3.6.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply

b) A conflict of interest is evident, as determined by the Chair or an ICB Board appointment panel, which results in the individual being unable to fulfil the role

3.6.5 This member will be appointed by a panel subject to the approval of the ICB Chair

3.6.6 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make one nomination.

- The nomination of an individual must be seconded by one other eligible organisations.
- Eligible organisations may nominate individuals from their own organisation or another organisation as described at 3.6.1
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

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

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

c) Chair's approval

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

d) The Chair of the ICB will report the appointed Partner Members to the next meeting of the ICB Board.

e) Any re-appointment at the end of a term will follow the process as described in section 3.6.5 a) to d).

f) Legislation may also allow for this Partner Member to be remunerated where relevant or appropriate, as may vary for different members and depending on their circumstances.

3.6.7 The term of office for this Partner Member will be two years and there will be a re-appointment process which will commence before the term comes to an end.

3.7 Partner Member(s) - local authorities

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

a) Leicester City Council
b) Leicestershire County Council
c) Rutland County Council

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

a) Be the Chief Executive or hold a relevant Executive level role or be an elected member (i.e. councillor) of one of the bodies listed at 3.7.1

b) members will bring experience of Adult Social care, Children's Social Care and Public Health.

3.7.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply.
b) A conflict of interest is evident, as determined by the Chair or an ICB Board appointment panel, which results in the individual being unable to fulfil the role

3.7.4 This member will be appointed by a panel subject to the approval of the ICB Chair.

3.7.5 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation listed at 3.7.1.a will be invited to make one nomination.
- The nomination of an individual must be seconded by one other eligible organisations.
- Eligible organisations may nominate individuals from their own organisation or another organisation at 3.7.1
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they do not, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

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

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

c) Chair's approval

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

d) The Chair of the ICB will report the appointed Partner Member(s) to the next meeting of the ICB Board.

e) Any re-appointment at the end of a term will follow the process as described in section 3.7.5 a) to d).

f) A Local Authority Executive paid for full-time role by their Local Authority should not be paid again by the ICB.

3.7.6 The term of office for this Partner Member will be three years and there will be a re-appointment process which will commence before the term comes to an end.

3.8 Medical Director

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Medical Practitioner
c) Meets the requirements as set out in the Medical Director role description and person specification.

3.8.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply

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

3.9 Director of Nursing

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Nurse.
c) Meets the requirements as set out in the Director of Nursing role description and person specification.

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply

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

3.10 Director of Finance

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

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

b) Be a qualified accountant (CCAB) with full membership and evidence of up-to-date continuing professional development

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

3.10.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply

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

3.11 Four Non-Executive Members

3.11.1 The ICB will appoint four Non-Executive Members

3.11.2 These members will be appointed by a panel and approved by ICB Chair.

3.11.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Not be employee of the ICB or a person seconded to the ICB
b) Not hold a role in another health and care organisation in the ICS area
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee
d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee
e) third member should have knowledge, skills and experience in quality, safety and performance;
f) the fourth member should have knowledge, skills and experience in health inequalities and public engagement.

3.11.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) They hold a role in another health and care organisation within the ICB area
c) A conflict of interest is evident, as determined by the Chair or an ICB Board appointment panel, which results in the individual being unable to fulfil the role.

3.11.5 The term of office for a Non-Executive Member will be three years and the total number of terms an individual may serve is three terms. after which they will no longer be eligible for re-appointment.

3.11.6 Initial appointments to the ICB Board may be for a shorter period in order to avoid all non-executive members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity. This will allow future appointments to be staggered and support continuity of membership on the Board.

3.11.7 Subject to satisfactory performance assessed through appraisal the Chair may approve the re-appointment of a non-executive member up to the maximum number of terms permitted for their role.

3.12 Other Board Members

3.12.1 ICB Director of Strategy

3.12.1.1 This member will be appointed by the ICB Chief Executive or an ICB Board appointment panel and approved by the Chair.

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act
b) Meets the requirements as set out in the ICB Director of Strategy role description and person specification.

3.12.1.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) A conflict of interest is evident, as determined by the Chair or an ICB Board appointment panel, which results in the individual being unable to fulfil the role.

3.12.2 Clinical Executive Lead

3.12.2.1 This member will be appointed by the ICB Chair or an ICB Board appointment Panel and approved by the Chair.

3.12.2.2 The appointment process will be as follows:

a) Nomination:

- The ICB will create a role description for the Clinical Executive Lead, which will set out the requirements associated with the role, the expected skills, knowledge and expertise that is necessary, and the term of office.
- The ICB will issue the role description to the Clinical Executive Group together with a timeline for a nomination and selection process.
- The Clinical Executive Group will be invited to make one nomination for the Clinical Executive Lead role. The nomination will be made by the members of the Clinical Executive Group from within its membership.
- The nomination of an individual will be seconded by one other member of the Clinical Executive Group.

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

- The nomination from the Clinical Executive Group will be considered by a panel convened by the Chief Executive taking into account the ability of the nomination(s) to fulfil the role description; and ensuring they have meet the criteria under 3.1.1 and taking consideration of paragraph 3.2.

- The panel will select a suitable appointment.

c) Chair's approval

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

d) The Chair of the ICB will report the appointed Member to the next meeting of the ICB Board.

e) Any re-appointment including at the end of a term will follow the process as described in section 3.12.4.2 a) to d).

f) Whether this role is remunerated or not will be determined by local policy.

3.12.2.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) A conflict of interest is evident, as determined by the Chair or an ICB Board appointment panel, which results in the individual being unable to fulfil the role.

3.13 Board Members: Removal from Office.

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

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

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance.
b) If they fail to attend a minimum of 75% of the meetings to which they are invited over a six-month period unless agreed with the Chair in extenuating circumstances.
c) If they are deemed to not meet the expected standards of performance at their annual appraisal.
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.
e) If they are deemed to have failed to uphold the Nolan Principles of Public Life.
f) If they are subject to disciplinary action by a regulator or professional body.

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

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

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

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

a) terminate the appointment of the ICB's chief executive; and
b) direct the chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.14 Terms of Appointment of Board Members

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

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

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

3.15 Specific arrangements for appointment of Ordinary members made at establishment

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

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

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

3.15.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and [one other] will appoint the ordinary members who are expected to be all individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments.

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

4. Arrangements for the Exercise of our Functions.

4.1 Good Governance

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

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

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws, including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) comply with directions issued by the Secretary of State for Health and Social Care;
c) comply with directions issued by NHS England;
d) have regard to statutory guidance, including that issued by NHS England;
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England; and
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

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

4.3 Authority to Act

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

a) any of its members or employees;
b) a committee or sub-committee of the ICB.

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

arrangements with a local authority under which the local authority exercises specified ICB functions. or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act, the Board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full on the ICB website.

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

4.4.3 The SoRD sets out:

a) those functions that are reserved to the Board;
b) those functions that have been delegated to an individual or to committees and sub committees;
c) those functions delegated to another body, or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

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

4.5 Functions and Decision Map

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

4.5.2 The Functions and Decision Map is published on the ICB website.

4.5.3 The map includes:

a) Key functions reserved to the Board of the ICB;

b) Commissioning functions delegated to committees and individuals;

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

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

4.6 Committees and Sub-Committees

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

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

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

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

a) Ensure membership of committees be specified by the Board.
b) Present a summary report highlighting decisions and / or assurances to the Board
c) Ensure compliance with internal audit findings.
d) Undertake annual committee effectiveness reviews.
e) Conduct meetings in line with the Standing Orders.
f) Ensure terms of reference align with the Scheme of Reservation and Delegation.
g) Submit terms of reference for approval by the Board (or by the parent committee for sub-committees where the Board has delegated the power to establish sub-committees).

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

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

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

4.6.8 The following committees will be maintained:

a) **Audit Committee**: This committee is accountable to the board and provides an independent and objective view of the ICB's compliance with

its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

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

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

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

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

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

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2, the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

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

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

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

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

5. Procedures for Making Decisions

5.1 Standing Orders

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

- conducting the business of the ICB;
- the procedures to be followed during meetings; and
- the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB, unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and forms part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of SFIs which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs published on the ICB website.

6. Arrangements for Conflicts of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest, and do not (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the ICB website.

6.1.3 All board, committee and sub-committee members, and employees of the ICB will comply with the ICB policy on conflicts of interest in line with their terms of office and/or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts, in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision making of the ICB and not otherwise covered by one of the categories above, has an interest or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of interest and Standards of Business Conduct Policy.

6.1.6 The Integrated Care Board has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
b) be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) support the rigorous application of conflicts of interest principles and policies;
d) provide independent advice and judgement to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
e) provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions, the ICB will abide by the following principles:

a) To comply with this Constitution
b) To act in good faith and in the interests of the ICB.
c) To adhere to the *Seven Principles of Public Life*, set out by the Committee on Standards in Public Life (i.e. the Nolan Principles).
d) To comply with the ICB policy on standards of business conduct and declaration of interest as set out in the Conflicts of Interest Policy.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) members of the ICB;
b) members of the board's committees and sub-committees;
c) its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act, registers of interest are published on the ICB website.

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1.

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business, such as sponsored events, posts and research will be managed in accordance with the ICB Conflicts of Interest Policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) act in good faith and in the interests of the ICB;

b) follow the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles);

c) comply with the ICB Standards of Business Conduct Policy and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB, or otherwise providing services or facilities to the ICB, will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct Policy.

7. Arrangements for ensuring Accountability and Transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 11(2) of Schedule 1B to the 2006 Act.

7.2 Principles

7.2.1 Key principles will be as follows:

a) The ICB will be open and transparent in the way it makes decisions, providing information that is clear and easy to understand.

b) Meetings will be held in public and papers will be published.

c) The ICB will ensure that the voice of the people is heard by involving non-executive members and Healthwatch representatives.

d) The ICB will explain how public views have been sought and the impact and difference this has made.

7.3 Meetings and publications

7.3.1 Board meetings, and committees composed entirely of board members or which included all board members will be held in public, except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.3.2 Papers and minutes of all meetings held in public will be published.

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

7.3.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.3.6 Information will be provided to NHS England as required.

7.3.7 The Constitution and governance handbook will be published as well as other key documents, including but not limited to:

- Conflicts of interest policy and procedures
- Registers of interests

7.3.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

- sections 14Z34 to 14Z45 (general duties of integrated care boards), and
- sections 223GB and 223N (financial duties).

and

a) proposed steps to implement the Leicester, Leicestershire and Rutland joint local health and wellbeing strategy(ies).

7.4 Scrutiny and Decision Making

7.4.1 At least three Non-Executive Members will be appointed to the Board, including the Chair; and all of the Board and committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.4.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.4.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including: complying with existing procurement rules until the provider selection regime comes into effect.

7.4.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.5 Annual Report

7.5.1 The ICB will publish an annual report, in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)
b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)
c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and

d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007

8. Arrangements for Determining the Terms and Conditions of Employees.

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines, and appoint staff on such terms and conditions as it determines.

8.1.2 The board has established a Remuneration Committee, which is chaired by a Non-Executive Member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration Committee is determined by the board. No employees may be a member of the Remuneration Committee, but the board ensures that the Remuneration Committee has access to appropriate advice by:

a) Associate Director of People or a HR adviser being in attendance or appointment of independent HR advice to the Remuneration Committee.

b) Head of Corporate Governance.

8.1.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the Board.

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the Board are published in the Governance Handbook.

8.1.6 The duties of the Remuneration Committee include:

a) Setting the ICB pay policy (or equivalent) and standard terms and conditions
b) Making arrangements to pay employees such remuneration and allowances as it may determine
c) Set remuneration and allowances for members of the Board
d) Set any allowances for members of committees or sub-committees of the ICB who are not members of the Board
e) Any other relevant duties in line with its terms of reference.

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9. Arrangements for Public Involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the Integrated Care Board

b) the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them

c) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

a) In line with the Involvement and Engagement Strategy / People and Communities Strategy.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities:

a) Put the voices of people and communities at the centre of decision making and governance, at every level of the ICS;
b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions;
c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect;
d) Build relationships with excluded groups – especially those affected by inequalities;
e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners;
f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust;
g) Use community development approaches that empower people and communities, making connections to social action;
h) Use co-production, insight and engagement to achieve accountable health and care services;
i) Co-produce and redesign services and tackle system priorities in partnership with people and communities; and

j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 In addition, the ICB has agreed the following:

a) To build on the engagement capability and capacity in our workforce and empower out staff;

b) To embed business intelligence and insights from people and communities into the heart of the ICS,

c) To harness the power of equality impact assessments to support the eradication of health inequalities.

9.1.5 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.6 These arrangements will be in line with the Involvement and Engagement Strategy / People and Communities Strategy.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
ICB board	Members of the ICB.
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this Constitution.
Committee	A committee created and appointed by the ICB board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following**:** • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description

	• the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.

Appendix 2: Standing Orders

1. Introduction

1.1 These Standing Orders have been drawn up to regulate the proceedings of NHS Leicester, Leicestershire and Rutland Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. Amendment and review

2.1 The Standing Orders are effective from 1 July 2022.

2.2 Standing Orders will be reviewed on an annual basis or sooner if required.

2.3 Amendments to these Standing Orders will be made in line with section 1.6 of the Constitution.

2.4 All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application and compliance

3.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2 These Standing Orders apply to all meetings of the board, including its committees and sub-committees unless otherwise stated. All references to board are inclusive of committees and sub-committees unless otherwise stated.

3.3 All members of the board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from Head of Corporate Governance will provide a settled view which shall be final.

3.5 All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6 If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the board for action or ratification and the Audit Committee for review.

4. Meetings of the Integrated Care Board

4.1 Calling Board Meetings

4.1.1 Meetings of the board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2 In normal circumstances, each member of the board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.

b) One third of the members of the board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.

c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3 A public notice of the time and place of the meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the board.

4.2.2 If the Chair is absent or is disqualified from participating by a conflict of interest, the deputy chair will chair the meetings of the Board. Where the Chair and the deputy chair are both absent or are disqualified from participating by a conflict of interest the assembled members would be required to appoint a deputy to chair the meeting of the Board.

4.2.3 The board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website.

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the board in accordance with the ICB policy as published in the Governance Handbook.

4.5 Nominated Deputies

4.5.1 With the permission of the person presiding over the meeting, the Executive Director members and the Partner Members of the Board may nominate an appropriate deputy to attend a meeting of the Board that they are unable to attend. The deputy may speak and vote on their behalf. The ICB Chair will appoint a Non-Executive Director to act as deputy in their absence.

4.5.2 The decision of person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6 Virtual attendance at meetings

4.6.1 The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

4.7 Quorum

4.7.1 The quorum for meetings of the board will be a simple majority members of the Board, including:

a) Chair or Deputy Chair; and

b) the Chief Executive or nominated deputy; and

c) Director of Finance or nominated deputy; and

d) either The Medical Director or the Director of Nursing; and

e) at least one non-executive independent member; and

f) at least three Partner Members representing at least two different sectors between them.

4.7.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8 Vacancies and defects in appointments

4.8.1 The validity of any of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

a) Chair or Deputy Chair

b) the Chief Executive or nominated deputy; and

c) Director of Finance or nominated deputy; and

d) either The Medical Director or the Director of Nursing; and

e) at least one non-executive independent member; and

f) at least three Partner Members representing at least two different sectors between them.

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the board who are present at the meeting will be eligible to cast one vote each.

b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

c) For the sake of clarity, any additional Participants and Observers (as detailed within paragraph 2.3 of the Constitution) will not have voting rights.

d) A resolution will be passed if more votes are cast for the resolution than against it.

e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.

f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3 Where helpful, the board may draw on third party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Urgent decisions

4.9.4 In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply.

4.9.5 The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having been made to consult with as many members as possible in the given circumstances.

4.9.6 The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit Committee for oversight.

4.10 Minutes

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 Admission of public and the press

4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960, all meetings of the board and all meetings of committees which are comprised of entirely board members or all board members, at which public functions are exercised will be open to the public.

4.11.2 The board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.

4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 (as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the board.

5. Suspension of Standing Orders

5.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members.

5.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents.

6.1 The ICB may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

- the Chief Executive
- the Director of Finance
- the Director of Nursing
- the Medical Director
- Other Executive Directors

6.2 The following individuals are authorised to execute a document on behalf of the ICB by their signature:

- the Chief Executive
- the Director of Finance
- the Director of Nursing
- the Medical Director
- Other Executive Directors

6.3 **Register of seal:** will be maintained by the Head of Corporate Governance on behalf of the Chief Executive and the contents of the register will be reported to the Board on at least an annual basis.

Appendix B – Scheme of Reservation and Delegation

Leicester, Leicestershire and Rutland Integrated Care Board

SCHEME OF RESERVATION AND DELEGATION (v1, July 2022)

Matters Reserved to the Board and Decisions Delegated to the Committees, Chief Executive and Officers.

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
REGULATION AND CONTROL	Determine the arrangements by which the Board approves decisions that are reserved for the Board.	✓								
REGULATION AND CONTROL (Constitution 1.6)	Consideration and approval of applications to the NHS England on changes to the Board's constitution and standing orders.	✓								
REGULATION AND CONTROL	**Prepare** the Board's scheme of reservation and delegation and standing financial instructions.									**Head of Corporate Governance**
REGULATION AND CONTROL (Constitution 4.4)	Approval of the Board's scheme of reservation and delegation and standing financial instructions.	✓								
REGULATION AND CONTROL (Constitution 4.6)	Establish and approve terms of reference and membership for ICB Committees.	✓								
REGULATION AND CONTROL (Constitution 1.4)	Approve the arrangements for discharging the ICB's functions including but not limited to a) Having regard to and acting in a way that promotes the NHS	✓								

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
	Constitution b) Exercising its functions effectively, efficiently and economically. c) Duties in relation to children including safeguarding and promoting welfare. d) Adult safeguarding and carers (the Care Act 2014) e) Equality, including the public-sector equality duty f) Information law g) Provisions of the Civil Contingencies Act 2004. h) Improvement in quality of services. i) Reducing inequalities. j) Obtaining appropriate advice. k) Duty to have regard to effect of decisions. l) Public involvement and consultation. m) Financial duties. Having regard to assessments and strategies									
REGULATION AND CONTROL	Exercise or delegation of those functions of the Board which have not been retained as reserved by						✓			

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
	the Board, delegated to a committee or sub-committee or employee.									
REGULATION AND CONTROL	Prepare the operational scheme of delegation, which sets out those key operational decisions delegated to individual employees of the ICB, not for inclusion in the Board's constitution.									**Head of Corporate Governance**
REGULATION AND CONTROL	Approval of the ICB's operational scheme of delegation that underpins the Board's overarching scheme of reservation and delegation as set out in its constitution.						✓			
REGULATION AND CONTROL	Prepare detailed financial policies that underpin the ICB's Standing Financial Instructions.									**Head of Corporate Governance / Deputy Director of Finance**
REGULATION AND CONTROL	Approve detailed financial policies.						✓			**Supported by the Executive Director of Finance**
REGULATION AND CONTROL	Approve arrangements for managing exceptional funding requests within delegated limits.				✓					
REGULATION AND CONTROL	Set out who can execute a document by signature / use of the seal.	✓								

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
REGULATION AND CONTROL	Carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, except those relating to individual GP performance management, which have been reserved to NHS England. This includes the following activities:									**System Executive**
	• GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);									**Strategic Commissioning Group (Group reporting to System Executive)**
	• Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");									**Strategic Commissioning Group (Group reporting to System Executive)**
	• Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);									**Strategic Commissioning Group (Group reporting to System Executive)**

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
	• Decision making on whether to establish new GP practices in an area;									**Strategic Commissioning Group (Group reporting to System Executive)**
	• Approving practice mergers;									**Strategic Commissioning Group (Group reporting to System Executive)**
	• Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).									**Strategic Commissioning Group (Group reporting to System Executive)**
	The ICB will also carry out the following activities in relation to its delegated primary care commissioning functions: • To plan, including needs assessment, primary care services in LLR (including Pharmacy, Optometry and Dentistry (PODs));									**Strategic Commissioning Group (Group reporting to System Executive)**
	• To undertake reviews of primary medical care services;									**Strategic Commissioning Group (Group reporting to System Executive)**
	• To co-ordinate a common approach to the commissioning of primary care services generally;									**Strategic Commissioning Group (Group reporting to System Executive)**

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
	• To manage the budget for commissioning of primary medical care services.									**Strategic Commissioning Group (Group reporting to System Executive)**
MEMBERS OF THE BOARD	Approve the arrangements for nominations and selection process for partner members on the Board.	✓								
	Approve the appointment of non-executive members and partner members on the Board (subject to any regulatory requirements).					✓				
	Approve arrangements for identifying the ICB proposed accountable officer (subject to any regulatory / national requirements).			✓						
STRATEGY AND PLANNING	Agree the vision, values and overall strategic direction of the ICB.	✓								
	Approval of the Board's operating structure.	✓								
	Approval of the ICB commissioning and financial plan.	✓								
	Agree a plan to meet the health and healthcare needs of the population within LLR, having regard to the Partnership integrated care strategy	✓								

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
	and place health and wellbeing strategies.									
FINANCE	Approval of the ICB's corporate budgets that meet the financial duties as set out in the constitution.				✓					
	Approval of variations to the approved corporate budget where variation would have a significant impact on the overall approved levels of income and expenditure or the Board's ability to achieve its agreed strategic aims.				✓					
	Approve investment of LLR wide non-recurrent funding provided nationally outside of core allocation, within limits of delegated authority.									**System Executive**
ANNUAL REPORTS AND ACCOUNTS	Approve the Annual Accounts, and the Letter of Representation.		✓							
	Approval of the ICB's Annual Report.		✓							
	Approval of Internal Audit and External Audit Arrangements.		✓							

Leicester, Leicestershire and Rutland Integrated Care Board

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
	Approval of the arrangements for discharging the ICB's statutory financial duties.	✓								
HUMAN RESOURCES	Approve the terms and conditions, remuneration and travelling or other allowances for governing body members, including pensions and gratuities.			✓						
	Approve the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) excluding the Chair.			✓						
	For CEO, Directors and VSMs determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars.			✓						
	For CEO, Directors and VSMs Determine arrangements for termination of employment and other contractual terms and non-contractual terms.			✓						

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
	For all staff: • Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change); • 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.			✓						
	Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the ICB.			✓						
	Approve disciplinary arrangements for employees, where he/she is an employee of the ICB and for other persons working on behalf of the ICB.				✓					
	Review disciplinary arrangements where the accountable officer is an employee.			✓						

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
	Approval of the arrangements for discharging the ICB's statutory duties as an employer.				✓					
	Approve human resources policies for employees and for other persons working on behalf of the ICB.				✓					
QUALITY AND SAFETY	Scrutinise arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.									**Quality and Safety Committee**
	Approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.									**Quality and Safety Committee**
OPERATIONAL AND RISK MANAGEMENT	**Prepare** and recommend an operational scheme of delegation that sets out who has responsibility for operational decisions within the ICB.									**Head of Corporate Governance**
	Approve the ICB's counter fraud and security management arrangements.		✓							

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
	Approve the counter fraud policies.		✓							
	Approve the security management policies.				✓					
	Approval of the ICB's risk management arrangements.	✓								**Supported by Executive Management Team**
	Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other bodies as permitted or pooled budget arrangements under section 75 of the NHS Act 2006).									**System Executive**
	Approval of a comprehensive system of internal control, including budgetary control, that underpin the effective, efficient and economic operation of the ICB.		✓							
	Approve proposals for action on litigation against or on behalf of the ICB.							✓		**Supported by Head of Corporate Governance**
	Approve the ICB's arrangements for business continuity and emergency planning.	✓								

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
	Consider and approve policy proposals for clinical policies where policies apply to the ICB and / or LLR system.									**Quality and Safety Committee**
INFORMATION GOVERNANCE	Approve the ICB's arrangements for handling complaints.				✓					
	Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.				✓					
	Approve the Data Security and Protection Toolkit submission				✓					
	Approve information governance and information security policies.				✓					
TENDERING AND CONTRACTING	Approval of the ICB's contracts for commissioning support unit.				✓					
	Approval of the ICB's contracts for corporate / infrastructure support (for example finance provision, non-healthcare related contracts e.g. infrastructure, HR, payroll, back office support services).				✓					

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
	Approval of the ICB's contracts for corporate / infrastructure support (for example finance provision, non-healthcare related contracts) above delegated limit.	✓								
PARTNERSHIP WORKING	Approve decisions that individual members or 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 to be delegated to joint committees established under section 75 of the 2006 Act.	✓								**Supported by System Executive**
	Approval of collaborative commissioning arrangements and agreements (above delegated limits to committees)	✓								
	Approval for making decisions within delegated limits pertaining to coordinating commissioner arrangements on behalf of the ICB.	✓								**Supported by System Executive**
COMMISSIONING AND CONTRACTING	Approval of the arrangements for discharging the ICB's statutory duties associated with its	✓								

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
FOR CLINICAL SERVICES	commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.									
	Approve arrangements for co-ordinating the commissioning of services with other ICBs and or with the local authority(ies), where appropriate**.**	✓								
	Approval of system level clinical pathway changes.									**Quality and Safety Committee**
	Approval of business cases (for commissioning or decommissioning and/or investment or disinvestment) in line with financial scheme of delegation.									**System Executive**
	Approval of business cases for commissioning or decommissioning and / or investment or disinvestment above delegated limit to Committee(s).	✓								

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
	Approve service specification for procurement of health care services.									**System Executive**
	Consider options to procure LLR wide healthcare services.									**System Executive**
	Approve business cases for healthcare services to be developed or delivered (for commissioning or decommissioning and/or investment or disinvestment) with a total financial value up to £20,000,000 over the period of the contract (or three years if the investment is not time limited) following approval of the Operational / Financial Plan by the board.									**System Executive**
	Approve preferred bidder and contract award for services above Committee level delegated authority.	✓								
	Approval of contract variation to contracts for services, including any change in funding arrangements (up to a value in line with financial delegations)									**System Executive**

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
COMMISSIONING AND CONTRACTING FOR NON-HEALTHCARE / INFRASTRUCTURE SERVICES	Approval of business cases (for commissioning or decommissioning and/or investment or disinvestment) in line with financial scheme of delegation – non-healthcare procurement (e.g. infrastructure, HR, payroll, back office support services from commissioning support unit etc). With total financial value up to £10,000,000 in total over the period of the contract (or three years if the investment is not time limited).				✓					
	Approval of business cases for commissioning or decommissioning and / or investment or disinvestment (for non-healthcare / infrastructure) above delegated limit to Committee(s).	✓								
	Approval of contract award for non-healthcare procurements and infrastructure above individual delegations for day-to-day non-healthcare / infrastructure contracts for a total financial value up to £10,000,000 in total over the period of the contract (or three years if the investment is not time limited).				✓					

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
	Approval of any contract variation to non-health care / infrastructure contracts, including any changes to funding arrangements subject to the overall contract value not exceeding £10,000,000 in total.				✓					
COMMISSIONING SUPPORT ARRANGEMENTS	Agreement of service specification for commissioning support services – healthcare commissioning.				✓					
	Agreement of service specification for commissioning support services – non-healthcare / infrastructure commissioning.				✓					
	Procurement: preferred bidder award of contract – healthcare commissioning (up to the value of £10,000,000 over the period of the contract).				✓					
	Procurement: preferred bidder award of contract – non-healthcare commissioning.				✓					
COMMUNICATIONS	Approving arrangements for handling Freedom of Information requests.				✓					

Policy Area	Decision	Reserved to the ICB Board	Delegated to:							
			Audit Committee	Remuneration Committee	Executive Management Team	Chair	Chief Executive	Director of Finance	Director of Quality	Other officer, Committee or sub-committee
	Determining arrangements for handling Freedom of Information requests.									**Head of Corporate Governance**
	Public Engagement Strategy	✓								
	Approval of consultation materials and process for system wide proposals following review by Board.									**System Executive Team**
Other:	Approvals for research projects within financial delegated limits.								✓	

Appendix C – Functions and Decisions Map

Leicester, Leicestershire and Rutland Integrated Care System (ICS): Functions and Decisions Map

(v1, 1 July 2022)

LLR Integrated Care System: planning, partnerships and delivery (key functions and roles)

Residents and local population

Statutory Body

Health and Wellbeing Boards

- Joint Strategic Needs Assessments and development of Joint Health and Wellbeing Strategies for each respective area.
- Population health management at place.
- Planning and improvement of health and care.
- Develop strong connection with place(s).
- Operates at place level, can also operate at system level.

Statutory Committee

LLR Health and Wellbeing Partnership

(i.e. the Integrated Care Partnership)

- Develop an integrated care strategy covering health and social care needs of population informed by JSNA. Does not commission services.
- Champion inclusion and transparency and demonstrate progress in reducing inequalities and improving outcomes.
- Agree collective objectives and outputs at system level.
- Influence wider determinants of health including creating healthier environments and inclusive and sustainable economies
- Bring the statutory and non-statutory interests of places together.
- Promote mobilisation of resources and assets in the community and system and across place-based partnerships.
- Support the Triple Aim (better health for everyone, better care for all and efficient use of NHS resources).

Two-way communication /interface and influence

Statutory ICS

Statutory Body

NHS LLR Integrated Care Board

- Develop plan to meet health and healthcare needs of population informed by partnership's strategy and by JSNA.
- Secure collaboration within the NHS and at the interface of health and local government.
- Responsible for NHS resource allocation to deliver the plan across the system.
- Arrange provision of health services in line with allocated resources across the ICS.
- Establish joint working arrangements with partners.
- Ensures appropriate accountability arrangements for NHS bodies within LLR.
- Fulfil functions delegated from NHS E/I.
- Lead system implementation of:
  - people priorities including delivery of the People Plan
  - Data and digital.
  - Estates, procurement, supply chain and commercial strategies to maximise value for money
  - Emergency Preparedness, Resilience and Response
- Population Health intelligence
- Economic development and environmental sustainability

Locally established

Collaboratives

- Partnership arrangements involving NHS providers working at scale across system and / or across multiple places with a shared purpose.
- Build broader coalitions with community partners to transform, promote health and wellbeing and reduce unwarranted variation and inequality in health outcomes, access to services and experience.

Accountability

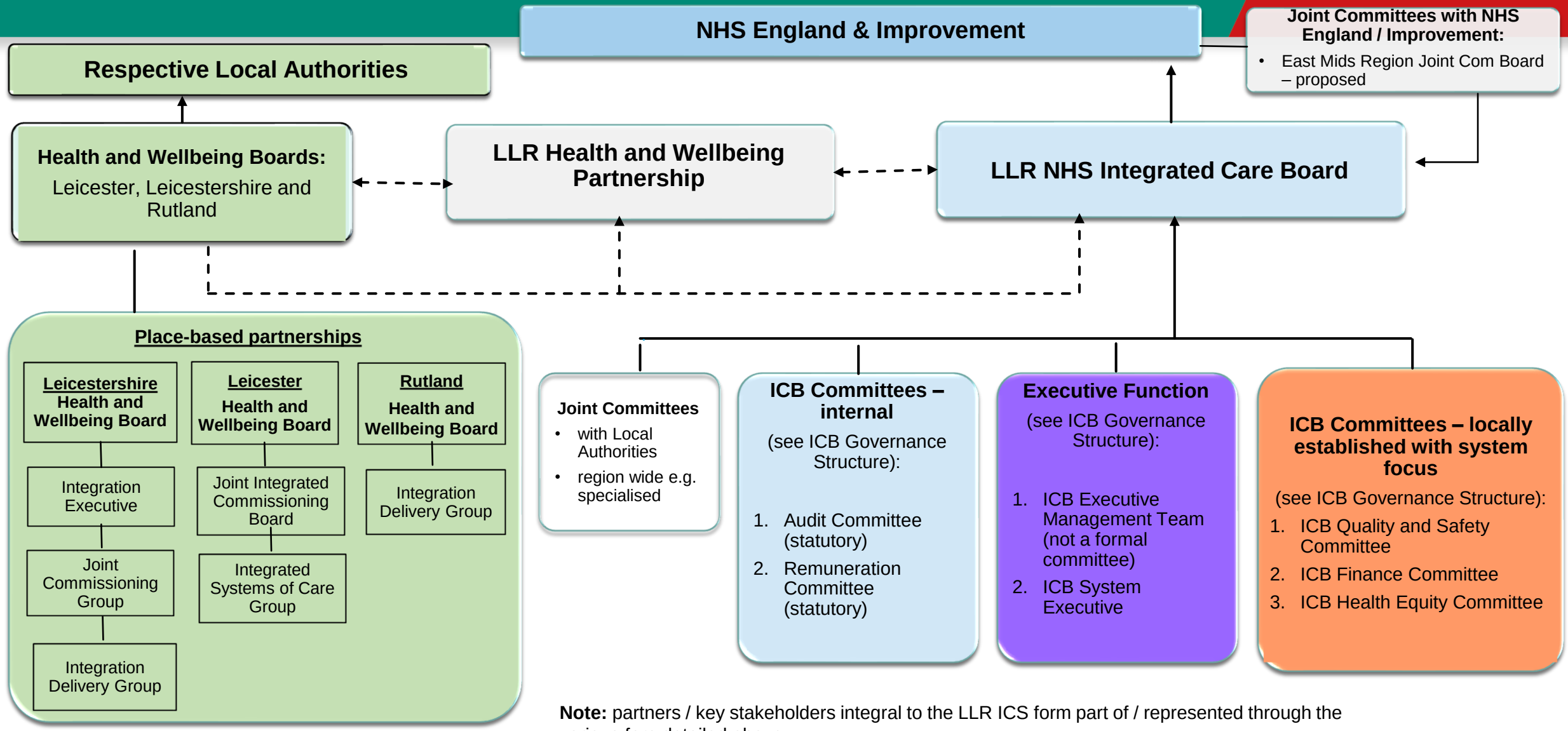
Place-based partnerships

- Delivery at place.

Accountability

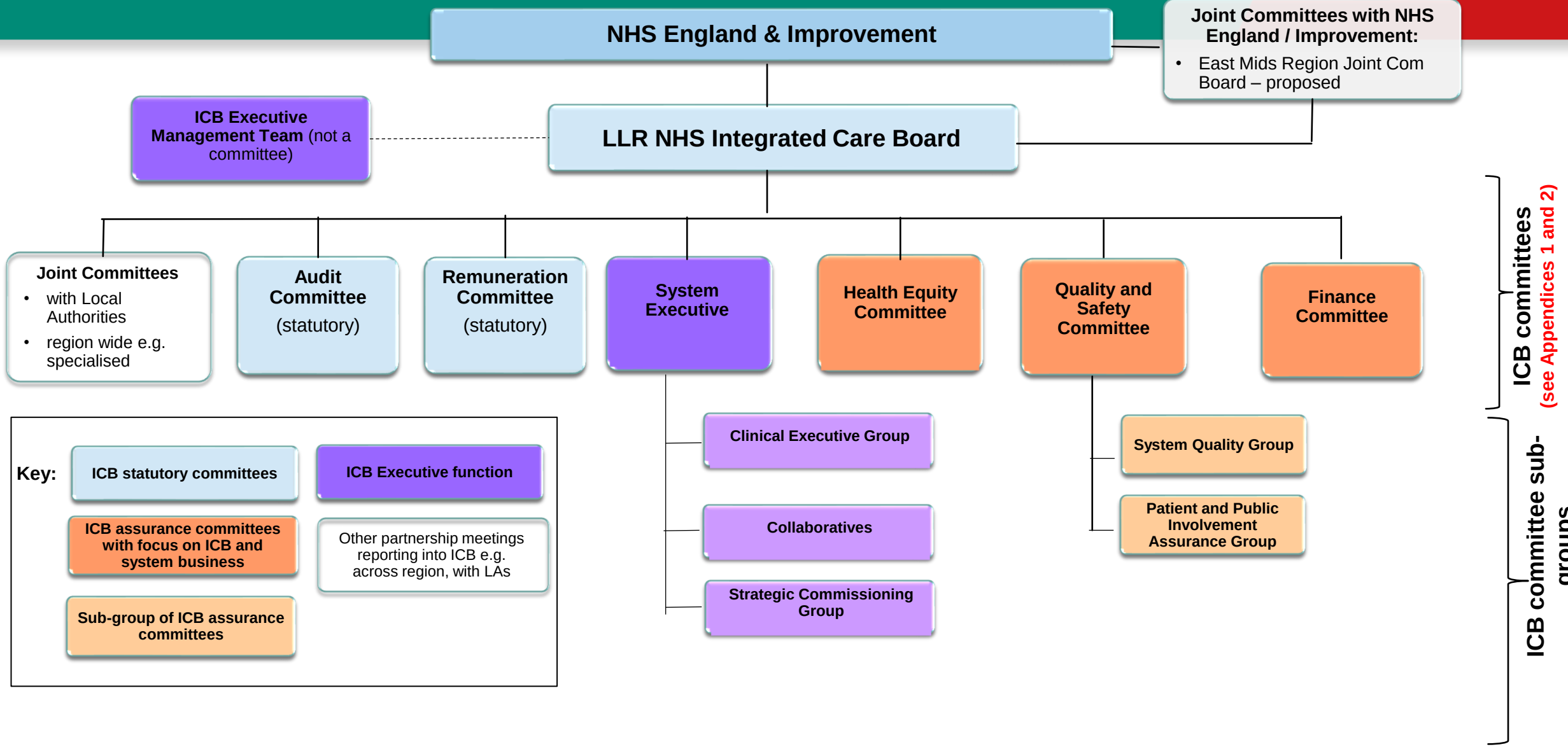
Defining need for place → Aggregating need at system level → Defining healthcare needs and responsibility for commissioning health care → Delivery

LLR Integrated Care System: interface and accountability



Note: partners / key stakeholders integral to the LLR ICS form part of / represented through the various fora detailed above.

LLR Integrated Care Board governance structure



Appendices

APPENDIX 1: SUMMARY OF STATUTORY AND INTERNAL COMMITTEES

Committee / group	Responsible for…
Integrated Care Board (Board of the statutory Body)	• Responsible for developing a plan and allocating resource to meet the health and healthcare needs of the population. • Establishing joint working arrangements with partners that embed collaboration for delivery. • Establishing governance arrangements to support collective accountability for whole-system delivery and performance. • Arranging for the health provision of services including contracting arrangements, transformation, working with local authority and partners to put in place personalised care for people. Leading system implementation of people priorities including delivery of the People Plan and People Promise. • Leading system-wide action on data and digital. • Oversight and approval of the Scheme of Reservation and Delegation. • Discharging duties in line with delegations from NHS England.
Audit Committee (Statutory)	• Providing ICB with independent and objective review of adequacy and effectiveness of internal control systems including financial information and compliance with laws, guidance and regulations governing the NHS. • Approval of the Annual Report and Accounts and governance related policies in line with SoRD.
Remuneration Committee (Statutory)	• Approving the pay policy, terms of service and remuneration. • Review of the remuneration for the CEO, executive directors and clinical leads (outside of pay arrangements set at a national level). • Approving remuneration for executive members (except Chief Executive) and clinical leads.

APPENDIX 2: SUMMARY OF COMMITTEES WITH SYSTEM FOCUS

Committee/Group	Responsible for…
System Executive Team	• Executive and management responsibilities at system level (membership will include: ICB Executive Management Team, UHL and LPT CEOs, and senior responsible officers for each of the Collaboratives). • Developing a system strategy, planning and finance. • Oversight of system performance and managing the day-to-day delivery of NHS services at system level with support from Collaboratives, Clinical Executive and the Strategic Commissioning Group for primary medical services. • Carrying out its functions in line with delegated financial authority (up **to £20m** for approval of healthcare services related procurement and contracts over term of contract following approval of the Operational and Financial Plan by the Board).
Finance Committee	• Scrutiny of the delivery of a robust, viable and sustainable system financial strategy and plan. • Oversight of payment policy reform and oversight of reporting of placed based allocations and provider collaborations. • Providing assurance on the system's current and forecast financial position and recovery plans to address any challenges. • Oversight of system capital plans and monitoring and forecasting for onward assurance.
Quality and Safety Committee	• Development of system quality, performance improvement and assurance strategy. • Providing assurance on quality, safety, performance improvement, patient engagement, patient experience, patient and public involvement, and the personalisation of care. • Monitoring quality, safety and performance risks at and receive assurance in relation to mitigations and improvement plans. • Approval of clinical pathways and clinical policies. • Oversight of the nationally mandated sub-group, the System Quality Group (requirement set out by the National Quality Board).
Health Equity Committee	• Seeking assurance that the ICB is delivering its statutory functions and making decisions to enable inclusion, improve health outcomes for patients and service users, and reduce unwarranted health inequality. • Scrutinising the robustness of, and gain and provide assurance to the ICB, that there is an effective and sustainable system of monitoring our progress in reducing health inequalities that supports effective deliver of the ICB's strategic objectives and provides sustainable, high quality care.

Appendix D – Standing Financial Instructions

Leicester, Leicestershire and Rutland Integrated Care Board
Standing Financial Instructions

Version Control

Version number	Approval / Amendments made	Date (Month Year)
Version 1	NHS England model documentation used and localised for the ICB.	April 2022
Version 2	Adopted updated model documentation published by NHS England on 30 May 2022.	June 2022

Contents

1. Purpose and statutory framework

1.1.1 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.

1.1.2 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.

1.1.3 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.

1.1.4 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.

1.1.5 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.

1.1.6 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.

1.1.7 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.

1.1.8 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.

1.1.9 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.

2. Scope

2.1.1 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.

2.1.2 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.

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

2.1.4 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.

3. Roles and Responsibilities

3.1 Staff

3.1.1 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

3.2 Accountable Officer

3.2.1 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.

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

3.2.3 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.

3.3 Audit and risk assurance committee

3.3.1 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.

4. Management accounting and business management

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

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

4.1.3 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.

4.1.4 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.

4.1.5 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.

5. Income, banking arrangements and debt recovery

5.1 Income

5.1.1 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.

5.1.2 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 standardized 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.

5.2 Banking

5.2.1 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.

5.2.2 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.

5.3 Debt management

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

5.3.2 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.

6. Financial systems and processes

6.1 Provision of finance systems

6.1.1 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.

6.1.2 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.

6.1.3 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.

6.1.4 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.

7. Procurement and purchasing

7.1 Principles

7.1.1 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.

7.1.2 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.

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

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

7.1.5 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.

7.1.6 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.

7.1.7 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.

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

7.1.9 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.

8. Staff costs and staff related non pay expenditure

8.1 Chief People Officer

8.1.1 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.

8.1.2 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.

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

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

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

9. Annual reporting and Accounts

9.1.1 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;

9.1.2 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.

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

9.1.4 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.

9.2 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.

9.3 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.

10. Losses and special payments

10.1.1 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.

10.1.2 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.

10.1.3 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.

10.1.4 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

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

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

11. Fraud, bribery and corruption (Economic crime)

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

11.1.2 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.

11.1.3 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.

12. Capital Investments & security of assets and Grants

12.1.1 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.

12.1.2 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.

12.1.3 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.

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

12.1.5 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

12.1.6 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.

12.2 Grants

12.2.1 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.

12.2.2 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.

13. Legal and insurance

13.1.1 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.

13.1.2 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.

Appendix E – Detailed Financial Policies and Operational Scheme of delegation

Leicester, Leicestershire and Rutland Integrated Care Board

Detailed Financial Policies and Operational Scheme of Delegation

July 2022

Reference number:	LLR CORPORATE XXX
Title:	Detailed Financial Policies and Operational Scheme of Delegation
Version number:	Version 1, July 2022
Document Approved by:	Chief Executive and the Executive Management Team
Date of Approval:	
Date Issued:	
Review Date:	
Document Author:	Daljit K. Bains, Head of Corporate Governance In conjunction with Michelle Iliffe, Deputy Director of Finance and Nicci Briggs, Executive Director of Finance, Contracting and Corporate Governance
Executive Lead:	Andy Williams, Chief Executive

Version control

Version	Date	Amendment
Version 1	July 2022	Document produced for the Integrated Care Board.

Contents

Introduction

1. The Detailed Financial Policies and Operational Scheme of Delegation (OSoD) set out in this document, shall have effect as if incorporated in the Constitution of NHS Leicester, Leicestershire and Rutland Integrated Care Board (hereafter referred to as "the LLR ICB" or the "ICB". The Chief Executive (Accountable Officer) for the LLR ICB has responsibility for the OSoD. The roles and responsibilities that are outlined in this document as applicable to the Accountable Officer, apply also to those with delegated authority as given in the operational scheme of delegation.

2. The OSoD are part of the ICB's control environment for managing the ICB's financial affairs and corporate governance. They contribute to good corporate governance, internal control and risk management. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. They also help the Accountable Officer and the Executive Director of Finance, Contracting and Corporate Governance to effectively perform their responsibilities.

3. The Standing Financial Instructions are re-enforced with the detailed financial policies within this document that have been approved by the Executive Director of Finance, Contracting and Corporate Governance and the OSoD approved by the Accountable Officer provide procedural advice in financial and corporate governance.

4. This document should be read in conjunction with the Constitution and Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation. This document is aimed at supporting the Accountable Officer, Executive Director of Finance, Contracting and Corporate Governance or any other authorised officer, member or person working on behalf of the group in discharging their responsibilities on a day to day basis.

5. Should any difficulties arise regarding the interpretation or application of any of the detailed financial policies and OSoD, then the advice of the Executive Director of Finance, Contracting and Corporate Governance must be sought before acting.

6. The user of this document should also be familiar with and comply with the provisions of ICB Constitution, Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions. Failure to comply with these governance documents, the detailed financial policies and the OSoD may in certain circumstances be regarded as operating 'ultra vires' of the ICB and may be a disciplinary matter.

PART ONE: Detailed Financial Policies

Internal Control

7. Overall responsibility for the ICB' system of internal control lies with the ICB' Board. Responsibility for ensuring that there are arrangements to review, evaluate and report on the effectiveness of the internal controls, including the establishment of an effective Internal Audit function, lies with the Executive Director of Finance, Contracting and Corporate Governance. The ICB will establish Audit Committee to follow best practice including guidance provided within the *NHS Audit Committee Handbook*.

8. Where the Audit Committee consider there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board of the ICB. Exceptionally, the matter may need to be referred to NHS England.

9. The Executive Director of Finance, Contracting and Corporate Governance will ensure:

   (a) Relevant policies are considered for review and updated annually by the Board or committee with delegated authority.

   (b) All breaches of financial policies will be reported to the Executive Director of Finance, Contracting and Corporate Governance and subsequently to the Finance and Activity Committee and the Board on a risk-based assessment. A written system should be in place for the checking, reviewing and reporting of all breaches of financial policies.

   (c) The procedure for checking the adequacy and effectiveness of the control environment forms part of financial monitoring and is outlined in the Budgetary Control Manual and assurance on the effectiveness of the internal control system is given as part of a planned Internal Audit programme as outlined below.

Audit

Internal Audit

10. The full extent of the Audit Committee's responsibilities is detailed in the ICB Audit Committee' terms of reference (a copy of the terms of reference can be obtained from the Head of Corporate Governance). The procedure for alerting and escalating unresolved management issues, fraud and serious irregularity is outlined in the Service Level Agreement (SLA) with Internal Audit. The monitoring system is outlined in the SLA.

11. The system of selecting the Internal Audit service provider will ensure that ICB has a professional and technically competent internal audit function. This will be detailed in procurement process and service specifications.

12. The Internal Audit plan will be founded on a risk based methodology and refers to the Board Assurance Framework to enable Internal Auditors to give an annual opinion regarding internal controls. The Audit Committee' terms of reference will detail the functions and tasks of the Audit Committee. The Board will approve the terms of reference.

External Audit

13. The external auditor is appointed by the Board and paid for by the ICB.
14. It is the duty of the Audit Committee to ensure that the external auditor provides a cost effective service. Any problems arising with this service will be discussed and resolved with the provider, and referred to the Audit Committee if resolution is not immediately possible.

Fraud and Corruption

15. NHS England requires the ICB to ensure appropriate anti-fraud, bribery and corruption arrangements are in place within their organisations, as specified within NHS Counter Fraud Authority Standards for Commissioners. In line with their responsibilities, the ICB' Accountable Officer and Executive Director of Finance, Contracting and Corporate Governance shall monitor and ensure compliance with the required standards.

16. In order to demonstrate compliance, NHS Counter Fraud Authority quality inspectors require ICB to submit an annual self-review of anti-fraud, bribery and corruption activity undertaken within their organisations this is achieved via the Self-Assessment Review toolkit (SRT). The definition, responsibilities, objectives, detection, prevention and resolution relating to fraud is set out clearly in the Counter Fraud, Bribery and Corruption Policy.

17. The LCFS shall report to the Executive Director of Finance, Contracting and Corporate Governance and shall work with NHS Protect to ensure the ICB discharges its responsibilities regarding anti-fraud, bribery and corruption. The LCFS will provide a written report at least annually on the counter fraud work carried out within the ICB. The Audit Committee will review this report.

Expenditure Control

18. The ICB will ensure that effective expenditure control is in place and that expenditure is within the allotments and allocations from the NHS England and other legally received sums by the use of effective processes outlined in the Budgetary Control Manual. The Budgetary Control Manual will:

    (a) outline the procedures which ensure that the ICB complies with Codes of Practice and guidance issued by the Department of Health and the NHS England.

    (b) outline the procedures that ensure that it exercises its functions effectively, efficiently and economically and in a way which provides good value for

money.

(c) outline a control framework to ensure that only approved expenditure is drawn down at the time of need and to illustrate an adequate system of monitoring financial performance.

(d) illustrate the procedure for ensuring compliance that expenditure limits that are not automatically controlled by ledger system are monitored and controlled.

Allotments

19. The preparation of an annual Financial Plan for the application of the resources allotted lies with the Executive Director of Finance, Contracting and Corporate Governance. The Executive Director of Finance, Contracting and Corporate Governance will

(a) lead in the budget setting process
(b) submit the annual budget to the Board for approval.

20. The Budgetary Control Manual will outline the process for periodic reporting and escalation to the Board.

Commissioning strategy, budgets, budgetary control and monitoring

Commissioning Strategy

21. The ICB's Commissioning Strategy, submitted to the Board before the start of the financial year, takes into account financial targets and forecast limits of available resources, and contains a statement of all significant assumptions upon which the Strategy is based and gives details of the major changes in workload and delivery of services or resources required to achieve the Strategy.

Budgets

22. It is the responsibility of the Executive Director of Finance, Contracting and Corporate Governance, prior to the start of the financial year, to prepare and submit budgets for approval by the Board. These budgets will:

(a) be in accordance with the aims and objectives set out in the Commissioning Strategy;

(b) be in accordance with workload and manpower plans;

(c) be produced following discussions with appropriate budget holders;

(d) be prepared within the limits of available funds; and

(e) identify potential risks and procedures for these in the Budgetary Control Manual.

23. The Executive Director of Finance, Contracting and Corporate Governance shall monitor the ICB's financial performance and periodically report to the Finance and Activity Committee and onwards to the Board, providing explanations for significant variances. The Executive Director of Finance, Contracting and Corporate Governance is allowed to delegate the management of individual budgets; the procedures covering this delegation and management are laid out in the Budgetary Control Manual and the Operational Scheme of Delegation.

24. Virements are permissible within the budget holder's approved budget providing that NHS best practice is followed. The procedure for virements is detailed in the Budgetary Control Manual and should allow for authorisation, accuracy and availability of budget.

Budgetary Control

25. The Executive Director of Finance, Contracting and Corporate Governance will devise and maintain systems of budgetary control, which will include the following:

    (a) Monthly and annual financial reports to the Board in a form agreed by the Finance and Activity Committee and approved by the Board.

    (b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder.

    (c) Investigation and reporting of variances from financial, workload and manpower budgets.

    (d) The monitoring of management action to correct variances

    (e) Arrangements for the authorisation of budget transfers

    (f) The Budgetary Control Manual will outline the frequency and points of escalation for budget monitoring and variance analysis.

Monitoring

26. The Accountable Officer is responsible for ensuring that the appropriate monitoring forms and returns are submitted to the requisite monitoring organisations in accordance with statutory and locally agreed timetables.

Annual Accounts and Reports

27. Compliance with Statutory requirements of the production of Annual Accounts will be the responsibility of the Executive Director of Finance, Contracting and Corporate Governance and will be managed by the employment of staff members with adequate skills, knowledge and experience.

28. The Executive Director of Finance, Contracting and Corporate Governance is responsible for the following:

(a) Arranging for the audit of the Accounts by an auditor appointed by the ICB' Board.

(b) Presenting the audited Accounts to a public meeting and making the Accounts available to the public.

(c) Publishing the Annual Report and presenting it to a public meeting.

29. The annual timetable for the production of accounts will outline the process to address and report issues identified in the external auditors management letter according to risk.

Information technology

30. The SLA with the Finance and Accounting IT services provider will outline the controls to ensure that there is an effective and secure system to ensure data security and security of hardware.

31. The joint procedures issued by the IT service provider and ICB for data processing and entry will ensure that adequate controls as required by the Prime Financial Policies are in operation. These procedures will also ensure effective audit trails are in operation.

32. The Executive Director of Finance, Contracting and Corporate Governance will ensure that computer audits are undertaken as identified by the risk based process referred to above.

33. Where external contractors are engaged to make amendments to the current system the Executive Director of Finance, Contracting and Corporate Governance will ensure that there are adequate contracts/SLAs to support this.

Accounting Systems

34. The Executive Director of Finance, Contracting and Corporate Governance will ensure that any arrangements with other service providers for the provision of accounting services is underpinned with a robust SLA/contract outlining the monitoring process and those points identified in the Standing Financial Instructions.

Bank and Government Banking Services (GBS) Accounts

35. The Executive Director of Finance, Contracting and Corporate Governance is responsible for managing ICB's banking arrangements and for advising the Board on the provision of banking services and operation of bank accounts. In accordance with Department of Health/NHS England guidelines and best practice ICB should minimise the use of commercial bank accounts and consider using Government Banking Services (GBS) accounts for all banking services.

36. The Executive Director of Finance, Contracting and Corporate Governance is

responsible for:

(a) bank accounts and GBS accounts;
(b) establishing separate bank accounts for ICB's non-exchequer funds;
(c) the operation, monitoring, reporting and compliance of Banking processes is outlined in the Budgetary Control Manual.

Banking Procedures

37. The Executive Director of Finance, Contracting and Corporate Governance will prepare detailed procedures on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the ICB' accounts.

38. The Executive Director of Finance, Contracting and Corporate Governance must advise the ICB's bankers in writing of the conditions under which each account will be operated.

Tendering and Review of GBS Accounts

39. The Executive Director of Finance, Contracting and Corporate Governance will review the banking arrangements of the ICB at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the ICB's banking business.

40. Where GBS accounts have not been used, competitive tenders should be sought at least every 5 years. Competitive tender review is not necessary for GBS accounts. The results of the tendering exercise should be reported to the Audit Committee.

Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments

Income Systems

41. The ICB will operate a secure system of collecting all monies due by implementing the following.

42. The Budgetary Control Manual will outline

(a) The system for designing, maintaining and ensuring compliance with proper recording, invoicing, collection, recovery, communication, accounting and coding of all monies due.

(b) the prompt banking of all monies received.

(c) the appraisal process for making secure grants and loans.

Fees and Charges

43. The ICB shall follow the Department of Health's advice in the "Costing" Manual in setting prices for NHS service agreements.

44. The Executive Director of Finance, Contracting and Corporate Governance is responsible for and will outline in the Budgetary Control Manual the process for

(a) establishing and maintaining systems and procedures for the secure handling of cash, debt recovery and other negotiable instruments.

(b) incorporating a risk based methodology in the raising of additional revenue as permitted by respective regulations and guidance.

Debt Recovery

45. The Executive Director of Finance, Contracting and Corporate Governance is responsible for

(a) the appropriate recovery action on all outstanding debts.

(b) Prevention, detection and initiation of recovery action of overpayments.

46. Income not received should be dealt with in accordance with Losses and Special Payments Policy.

Security of Cash, Cheques and other Negotiable Instruments

47. The Executive Director of Finance, Contracting and Corporate Governance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities, systems and processes for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the ICB.

48. The holders of safe keys shall not accept unofficial funds for depositing in their safes.

Petty Cash

49. The Executive Director of Finance, Contracting and Corporate Governance is responsible for:
    (a) Developing and maintaining a controlled, secure system for petty cash records, disbursements and replenishment specified in the Budgetary Control Manual.

    (b) Ensuring all holders of petty cash floats are aware of and comply with any such system.

Tendering and Contract procedure

Duty to comply with Standing Orders, Prime Financial Policies and Standing Financial Instructions

50. The procedure for making all contracts by or on behalf of ICB shall comply with these Standing Orders and SFIs to ensure value for money and transparency.

51. The ICB shall have regard to all relevant guidance issued by the Department of Health, and NHS England in relation to the conduct of procurement practice and the commissioning of healthcare services.

Legislation Governing Public Procurement

52. The ICB shall comply with Public Contract Regulations 2015 ("the Regulations") and any successor legislation, EU Directives relating to EU procurement law having direct effect in England (the "Directives"). In addition, these procedures must comply with the EU Treaty ("Treaty Obligations") of Fairness, Transparency, Equality and Non-Discriminatory, and any duties derived from the UK common law ("Common Law Duties") (the Regulations, Directives, Treaty Obligations and Common Law Duties together are referred to elsewhere in these SFIs as "Procurement Legislation") and any other duties and guidance issued by the Department of Health. The procurement legislation shall have effect as if incorporated in these SFIs.

53. The ICB shall comply with guidance documents issued.

54. The EU procurement limits are available at the following http://www.ojec.com/Threshholds.aspx and must be applied.

Decision to Tender and Exceptions to requirement to Tender

Presumption to Tender

54. Where:
    (a) a contract opportunity is required to be tendered under the Regulations (i.e. the contract opportunity is governed by the Regulations and the value of the contract opportunity as calculated pursuant to the Regulations exceeds the relevant financial threshold for the requirement to run a formal tender process);

or

(b) the contract opportunity would be subject to competition following assessment of the market, however it shall be assumed there is no cross border interest (and requirement to advertise in the OJEU) if the contract value is below threshold.

(c) the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 applies to contract opportunities that are not governed by "the Regulations".

Equality of Treatment

55. The ICB shall ensure that no sector of any market (public, private, third sector/social enterprise) is given an unfair advantage in the design or conduct of any tender process.

(a) The subject matter and the scope of the contract opportunity should be described in a non-discriminatory manner. The ICB should utilise generic and/or descriptive terms, rather than the trade names of particular products or processes or their manufacturers or their suppliers.

(b) All participants in a tender process should be treated equally and all rules governing a tender process must apply equally to all participants.

(c) Any providers used in testing of services (such as rapid cycle testing) will be named in the tender process and any learning shared with potential bidders during the tender process.

(d) Any learning from previous contract activity, unless developed in to the revised service specification / requirements, will be shared with potential bidders during the tender process to mitigate against any potential incumbent provider advantage.

56. ***Commissioning Health Care Services: Decision to Tender*** - health care services are named as being incorporated in to the "Light Touch Regime" under 'the Regulations'. All contract opportunities equal to and greater than the threshold named in the Regulations will be advertised, in accordance with the Regulations requirements'. Opportunities below threshold will be evaluated for requirement to advertise in line with the above and seeking advice from Commissioning Support Unit (CSU) procurement.

57. Recommendations for route to market will be presented to the Competition and Procurement Group (CPG) which is supported by the three ICB and CSU procurement. The CPG will then advise their recommendation or support for the proposed route to market before approval through the remainder of the ICB' governance process.

58. ***In-House Services: Decision to Tender Services*** - the Accountable Officer shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. ICB may also determine from time to time

that in-house services should be market tested by competitive tendering. Where the decision to market-test is made, then this should be undertaken in accordance with the tendering levels. In some circumstances, where a consortium / collaborative arrangement is in place and a lead organisation has been appointed, the lead organisation will carry out the tendering activity on behalf of the consortium / collaborative members.

59. Exceptions and instances where formal tendering need not be applied. Formal tendering procedures need not be applied where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000 (including VAT); or

(b) where the supply is proposed under special arrangements negotiated by the Department of Health (DH) or NHS England in which event the said special arrangements must be complied with.

(c) Regarding disposals as set out in paragraph relating to disposals below.

60. Formal tendering procedures **may be waived** in the following circumstances:

(a) in very exceptional circumstances where the Accountable Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate ICB record. The decision will be published in conjunction with advice from the CSU Procurement Team;

(b) where the requirement is covered by an existing contract subject to Regulation no. 72 of "the Regulations";

(c) where the timescale genuinely precludes competitive tendering for reasons of extreme urgency brought about by events unforeseeable by the ICB (it is not justifiable to waiver competitive tendering where attributable to the ICB' failure to plan work properly).

(d) where specialist expertise is required and is available from **only** one source (competition would be deemed to be absent for technical reasons, not limiting or restricting the market);

(e) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(f) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the ICB is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Head of Corporate Governance will ensure that any fees paid are reasonable and within commonly accepted

rates for the costing of such work.

(g) where allowed and provided for in the arrangements for capital procurement, the waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure. Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate ICB record and reported to the Audit Committee at each meeting.

61. The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through competitive procedure.

62. The decision to waive the tendering procedures should be approved by the Accountable Officer or the Executive Director of Finance, Contracting and Corporate Governance. Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate ICB records and reported to Audit Committee and the Board.

63. Items estimated to be below the limits set in the SFIs for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Accountable Officer, and be recorded in an appropriate ICB record.

Use of Framework Agreements, Existing Contracts and Agreements.

64. Contracts already available to the ICB must be used wherever available i.e. CCS contracts, locally tendered contracts and agreements and any other relevant contracts used by other authorities e.g. Health Trust Europe.

65. The ICB may utilise any available contract or framework agreement to satisfy its requirements for works, services or goods but only if it complies with the requirements of Procurement Legislation in doing so, which include (but are not limited to) ensuring that:

(a) the framework agreement was procured on its behalf. The ICB should satisfy themselves that the original procurement process included ICB within its scope;

(b) the framework agreement includes ICB requirements within its scope, the ICB should satisfy itself that this is the case;

(c) where the framework agreement is a multi-operator framework agreement, the process for the selection of providers to be awarded call-off contracts under the framework agreement is followed; and

(d) the call-off contract entered into with the provider contains the contractual terms set out by the framework agreement.

Contracting/Tendering/ Quotations Procedure

66. Guidance documents, standard operating procedures and procedures relating to contracting/tendering/ e-procurement must be followed.

67. The ICB' Contracting and Tendering Procedure is laid out in separate documents:

    (a) Non-healthcare procurement: the applicable document / procedure is available via the provider of non-healthcare related c ontracting and tendering procedure.

    (b) Healthcare procurement: the applicable documents and support are provided for in the Service level Agreement (SLA) with CSU.

68. Where a formal tender process is required under section "Authorisation of Business Cases, Tenders and Competitive Quotations" below then:

    (a) where a contract opportunity falls within "the Regulations" and a process compliant with the Regulations is required, an OJEU Notice should be utilised; or

    (b) where a contract opportunity does not fall within "the Regulations" the ICB shall utilise a form of advertising for such contract opportunity that is sufficient to enable potential providers (including providers in member states of the EU other than the UK) to access appropriate information about the contract opportunity so as to be in a position to express an interest, as a minimum to be advertised on Contracts Finder for clinical services; and

    (c) in relation to any contract opportunity for health care services the ICB shall as a minimum advertise on Contracts Finder, and where appropriate the procurement portal operated by CSU.

69. Choice of Procedure

    (a) Where a contract opportunity falls within "the Regulations" and a process compliant with "the Regulations" is required then ICB shall utilise an appropriate tender procedure as allowed under "the Regulations".

    (b) In all other cases ICB shall utilise a quotation/tender procedure proportionate to the value, complexity and risk of the contract opportunity and shall ensure that invitations to tender are sent to a sufficient number of providers to provide fair and adequate competition (in any event no less than two) as identified within these DFPs and any guidance documents produced.

Receipt and safe custody of tenders

70. Tenders should be received in electronic format as far as possible. The Accountable Officer or his/her nominated representative will designate and agree a list of officers who will be able to access the electronic tenders and release them once the time and date for opening has passed.

71. Tenders should be received and retained securely and according to the correct process until such time that they are required to be opened.

72. Where paper based tenders are received a process outlining the secure receipt, retention, opening and awarding should be in place and will be outlined in the Procurement Guidance.

Authorisation of Business Cases, Tenders and Competitive Quotations

73. Providing all the conditions and circumstances set out in these SFIs have been fully complied with, the following limits apply to the awarding of contracts, invoice approval and procurement of goods and services (all values are inclusive of VAT irrespective of whether this is reclaimable or not except the EU limits which are net of VAT). The financial threshold for EU tendering is in accordance with "the Regulations".

74. Each individual authorising officer must ensure that where separate authorising limits are allowed by these SFIs, that the correct limit is applied in authorising spend as detailed in this document under "Part Two Operational Scheme of Delegations".

75. Capital (if applicable) – to be authorised in line with the Operational Scheme of Delegation or escalated to for authorisation by the Board in line with the Scheme of Reservation and Delegation.

Compliance requirements for all contracts

76. The Board may only enter into contracts on behalf of the ICB within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The ICB's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual and guidance on the Procurement and Management of Consultants;

(d) Such of the NHS Standard Contract Conditions as are applicable;

(e) Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;

(f) Where appropriate contracts shall be in or embody the same terms and

conditions of contract as was the basis on which tenders or quotations were invited;

(g) In all contracts made by the ICB, the Board shall endeavour to obtain best value for money by use of all systems in place. The Accountable Officer shall nominate an officer who shall oversee and manage each contract on behalf of the ICB.

77. The Accountable Officer shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts as per the scheme of delegation and reservation, the operational scheme of delegation and any such nominations, limits and delegation given in the SFIs.

Healthcare Services Agreements

78. Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the ICB. Service agreements are not contracts in law and are not enforceable by the courts. However, a contract with a Foundation Trust is a legal document and is enforceable in law. The Accountable Officer shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

Disposals

79. Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Accountable Officer or his/her nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the Disposals Policy of the ICB;

(c) items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

80. Where the assets are held on behalf of the ICB, the holding organisation must ensure that value for money is obtained, rules are followed and this should be detailed within the SLA governing the contract.

Tendering In-house Services

81. In all cases where the Board or appropriate Board Committee determines that in-house services should be subject to competitive tendering the following groups

shall be set up:

(a) Specification group, comprising the Accountable Officer or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Accountable Officer and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Executive Director of Finance, Contracting and Corporate Governance representative. For detail regarding financial delegations see Operational Scheme of Delegation (Part Two of this document).

(d) All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

82. The evaluation team shall make recommendations to the Board.

83. The Accountable Officer shall nominate an officer to oversee and manage the contract on behalf of the ICB.

Commissioning

Role of the ICB in Commissioning Secondary Services

84. The ICB have responsibilities for commissioning secondary services on behalf of the resident population. This will require the ICB to work in partnership with NHS England, local NHS Trusts, and FTs, other commissioning groups, Health and Wellbeing Boards, Local Authorities, patients / users, carers and the voluntary sector to develop robust commissioning plans.

Role of the Accountable Officer

85. The Accountable Officer as the Accountable Officer has responsibility for ensuring secondary services are commissioned in accordance with the priorities agreed in the Commissioning Strategy and Commissioning Intentions. This will involve ensuring SLAs are put in place with the relevant providers, based upon integrated care pathways.

86. SLAs will be the key means of delivering service requirements and therefore they need to have a wider scope. The ICB's Accountable Officer will need to ensure that all SLAs;

(a) Meet the standards of service quality expected;

(b) Fit the relevant national service framework (if any);

(c) Enable the provision of reliable information on cost and volume of services;

(d) Fit the NHS National Performance Assessment Framework;

(e) that SLAs build where appropriate on existing Joint Investment Plans;

(f)) that SLAs are based upon cost-effective services;

(g)) that SLAs are based on integrated care pathways.

87. The Accountable Officer, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing risk, relevant actual and forecast expenditure and activity for each SLA.

88. Where the ICB make arrangements for the provision of services by non-NHS providers it is the Accountable Officer, as the Accountable Officer, who is responsible for ensuring that the agreements put in place have due regard to the quality and cost effectiveness of services provided. Before making any agreement with non-NHS providers, the ICB should explore fully the scope to make maximum cost effective use of NHS facilities.

Role of Executive Director of Finance, Contracting and Corporate Governance

89. The Executive Director of Finance, Contracting and Corporate Governance must account for Out of Area Treatments/Non Contract Activity financial adjustments in accordance with national guidelines.

Risk management and Insurance

Systems of Risk Management

90. The Executive Director of Finance, Contracting and Corporate Governance, in conjunction with the Head of Corporate Governance, shall ensure that the ICB have a programme of risk management, in accordance with national Board Assurance Framework requirements, which must be approved and monitored by the Board. The programme of risk management shall include.

(a) engendering among all levels of staff a positive attitude towards the control of risk;

(b) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(c) contingency plans to offset the impact of adverse events;

(d) audit arrangements including; internal audit, clinical audit, health and safety review;

(e) a clear indication of which risks shall be insured;

(f)) arrangements to review the risk management programme.

91. **The Executive Director of Finance, Contracting and Corporate Governance will ensure that** the existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of internal control within the Annual Report and Accounts as required by current Department of Health guidance.

92. **The Director of Finance is also the Senior Information Risk Officer (SIRO)** for the ICB and will have oversight of information governance and information security risks across the ICB.

93. **The Director of Nursing is also the Caldicott Guardian** for the ICB and has the responsibility for protecting the confidentiality of people's health and care information and making sure it is used appropriately.

Insurance: Risk Pooling Schemes administered by NHS Resolution

94. The Board shall decide if ICB will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

Insurance arrangements with commercial insurers

95. There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when the ICB may enter into insurance arrangements with commercial insurers. The exceptions are:

    (a) for insuring motor vehicles owned by the ICB including insuring third party liability arising from their use;

    (b) where the ICB are involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into;

    (c) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by ICB for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the NHS Resolution. In any case of doubt concerning the ICB' powers to enter into commercial insurance arrangements the Executive Director of Finance, Contracting and Corporate Governance should consult the Department of Health / NHS England.

Arrangements to be followed by the Board in agreeing Insurance cover

96. Where the Board decide to use the risk pooling schemes administered by the NHS Resolution the Executive Director of Finance, Contracting and Corporate

Governance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Executive Director of Finance, Contracting and Corporate Governance shall ensure that documented procedures cover these arrangements.

97. Where the Board decide not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Executive Director of Finance, Contracting and Corporate Governance shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision.

98. The Executive Director of Finance, Contracting and Corporate Governance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed. The procedure for this will be outlined in the Losses and Special Payments Policy.

99. All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the 'deductible'). The Executive Director of Finance, Contracting and Corporate Governance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Payroll

Remuneration and Terms of Service

100. In accordance with Standing Orders the Board shall establish a Remuneration Committee; with clearly defined terms of reference, specifying which posts are within its area of responsibility, its composition and the arrangements for reporting.

Funded Establishment

101. The manpower plans incorporated within the annual budget will form the funded establishment.

102. The funded establishment of any department may not be varied without the approval of the Accountable Officer and Executive Director of Finance, Contracting and Corporate Governance.

Staff Appointments

103. An officer or Member of the Board' Committee, or Member of the ICB' Board or employee may only engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration if:

(a) authorised to do so by the Accountable Officer, or delegated Executive Director; and.

(b) within the limit of their approved budget and funded establishment.

104. The Board will approve procedures presented by the Accountable Officer for the determination of commencing pay rates, condition of service, etc., for employees.

Processing Payroll

105. The Executive Director of Finance, Contracting and Corporate Governance will ensure that there is an adequate SLA supported by terms and conditions for the provision of a Payroll Function and reference to adequate internal controls, and audit review processes. This should be reviewed on a regular basis to ensure value for money and transparency.

Contracts of Employment

106. The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

Non-Pay Expenditure

107. The Board will approve the level of non-pay expenditure on an annual basis and the Accountable Officer will determine the level of delegation to budget managers.

Delegation of Authority

108. The delegation of authority and financial limits will be as stated within the Operational Scheme of Delegation and as per the authorised signatories list are applicable in all non-pay procurement.

Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

109. ***Requisitioning*** - the requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for ICB. In so doing, the advice of the ICB' adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Executive Director of Finance, Contracting and Corporate Governance (and/or the Accountable Officer), shall be consulted.

110. ***System of Payment and Payment Verification*** - the Executive Director of Finance, Contracting and Corporate Governance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be

in accordance with contract terms, or otherwise, in accordance with national guidance.

111. The Executive Director of Finance, Contracting and Corporate Governance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SFIs and the Operational Scheme of Delegations and regularly reviewed;

(b) be responsible for the prompt payment of all properly authorised accounts and claims;

(c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Governing Body members, employees and delegated officers (including specimens of their signatures) authorised to certify invoices.

(ii) Certification to ensure accuracy and bona-fide payment of the invoice as outlined in the Budgetary Control Manual.

112. ***Prepayments*** - prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages.
(b) The appropriate officer member must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the ICB if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

(c) The Executive Director of Finance, Contracting and Corporate Governance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Executive Director or Accountable Officer if problems are encountered.

Official Purchase orders

113. Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Executive Director of Finance, Contracting and Corporate Governance;

(c) state the ICB' terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Accountable Officer;

(e) be used wherever possible.

114. The Accountable Officer and Executive Director of Finance, Contracting and Corporate Governance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with relevant guidance as outlined in the respective SLA with the organisation holding the assets on behalf of the ICB.

115. The technical audit of these contracts shall be the responsibility of the relevant Director, who will arrange for appropriate audits to be undertaken periodically.

Joint Finance Arrangements with Local Authorities and Voluntary Bodies

116. Payments to local authorities and voluntary organisations made under the powers of section 256 of the NHS Act 2006 shall comply with procedures laid down by the Executive Director of Finance, Contracting and Corporate Governance which shall be in accordance with that Act or any other subsequent Act.

Capital Investment, private Financing, Fixed Asset Registers and Security of Assets

Capital Investment

117. For every capital expenditure proposal the Accountable Officer shall ensure that there is compliance with the Capital approval and appraisal process.

118. For capital schemes where the contracts stipulate stage payments, the Accountable Officer will issue procedures for their management. The Executive Director of Finance, Contracting and Corporate Governance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

119. The approval of a capital programme shall not constitute approval for expenditure on any scheme.

120. The Accountable Officer and Executive Director of Finance, Contracting and Corporate Governance shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender; and

(c) approval to accept a successful tender.

121. The Accountable Officer will issue a scheme of delegation for capital investment management in accordance with the ICB' Standing Orders and Operational Scheme of Delegation.

122. The Executive Director of Finance, Contracting and Corporate Governance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes included in Annex C of HSC (1999) 246 and any other subsequent legislation or guidance.

Asset Registers

123. The Executive Director of Finance, Contracting and Corporate Governance is responsible for the maintenance of registers of assets and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

124. The ICB shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual as issued by the Department of Health. This should correspond where applicable to records held by and on behalf of any organisation holding assets on behalf of ICB. The details of additions, deletions and maintenance of fixed assets shall be outlined in the Budgetary Control Policy.

125. Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to an asset register number.

126. Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

127. The value of each asset shall be indexed to current values in accordance with methods specified in the Capital Accounting Manual issued by the Department of Health.

128. The value of each asset shall be depreciated using methods and rates as specified in the Capital Accounting Manual issued by the Department of Health.

129. The Executive Director of Finance, Contracting and Corporate Governance of the ICB shall calculate and incur capital charges as specified in the Capital Accounting Manual issued by the Department of Health.

Security of Assets

130. The Executive Director of Finance, Contracting and Corporate Governance shall be responsible for the security and control of Assets. The recording, identification and verification of assets will be detailed in the Budgetary Control Manual.

NHS LIFT

131. The ICB' planning involvement with LIFT projects should access guidance from the joint DH and Partnerships UK website at www.partnershipsforhealth.co.uk and NHS England.

Retention of Records

132. The Accountable Officer and Executive Director of Finance, Contracting and Corporate Governance shall be responsible for maintaining a disposal procedure.
133. The records held in archives shall be capable of retrieval by authorised persons and there is a disposal process to outline authority, retrieval and access.

134. Records held in accordance with NHS Code of Practice - Records Management 2016, shall only be destroyed at the express instigation of the Accountable Officer or his / her nominated Chief Officer. Detail shall be maintained of records so destroyed as outlined in the disposal process referred to above.

135. A procedure for Freedom of Information (FOI) requests and a FOI publication scheme, as required by the Information Commissioner's Office, will be in place.

Trust Funds and Trustees

136. Where trust funds are held by the group the Executive Director of Finance, Contracting and Corporate Governance will ensure that these are managed appropriately with regard to the purpose and requirements.

PART TWO: Operational Scheme of Delegation

Introduction

1. This section contains the Operational Scheme of Delegation of the ICB that together with the Standing Financial Instructions and the detailed financial policies (as above) has effect as if incorporated into the groups' Constitution.

2. The arrangements made by the ICB as set out in the overarching Scheme of Reservation and Delegation of decisions shall have effect as if incorporated in the ICB Constitution.

3. The ICB remains accountable for all its functions, including those that it has delegated.

4. The Scheme of Reservation and Delegation and details the arrangements made by the ICB for discharging its functions.

5. The Schedule below details the Operational Scheme of Delegation (and financial authority limits). These should be read in conjunction with the Standing Financial Instructions and the Detailed Financial Policies detailed in Part One of this document above.

6. The Operational Scheme of Delegation is prepared by the Accountable Officer (i.e. the Chief Executive Officer) and identifies which functions the Accountable Officer shall perform personally and which have been delegated to other Executive Directors or officers.

7. The approval of the ICB's Operational Scheme of Delegation that underpins the ICB' "Scheme of Reservation and Delegation" is reserved to the Accountable Officer.

Purpose and scope

8. The purpose of this document is to define the control framework for committing the resources of the ICB. The Scheme of Delegation identifies which functions the Accountable Officer shall perform personally and which have been delegated to other Executive Directors or officers.

9. To ensure that all staff, particularly budget holders and authorised signatories are aware of their authorities and responsibilities for compliance with the relevant procedures.

10. The OSoD is consistent with the NHS Code of Conduct and Accountability. Executive Directors and officers are reminded that powers are delegated to them on the understanding that they would not exercise delegated powers in a manner in which their judgement was likely to be a cause for public concern. The Code of Conduct of Accountability in the NHS sets out the core standards of conduct expected of NHS managers.

11. To provide details of delegated limits to all officers holding responsibilities. Budget Holders agree to operate within the delegated limits as outlined in this document. It is their responsibility to manage within their budget and to identify any changes to the budget assumptions surrounding activity, timing and staffing issues which may result in changes to financial risk. If a proposed transaction is beyond their authority, it should be referred to their manager. Failure to do so may result in disciplinary action.

12. This document forms part of the ICB's corporate governance framework which is the regulatory framework for the business conduct of the ICB to which its officers are expected to comply. The aim is not to create a bureaucracy but to protect the ICB's interests and to protect staff from any accusation that they have acted less than properly. It does this by ensuring that all staff, particularly budget managers and authorised signatories are aware of their authorities and responsibilities for compliance with the relevant procedures.

13. Delegated matters in respect of decisions will need to be agreed or reported to other groups and Committee. This policy does not override these but sets out individual powers for committing resources. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Accountable Officer who will, before authorising such delegation, consult with other Executive Directors and senior officers as appropriate.

ICB' Operational Scheme of Delegation (June 2022)

	DELEGATED MATTER	AUTHORITY DELEGATED TO:
1.	***Management of Budgets*** Responsibility of keeping pay and non-pay expenditure within approved budgets and retaining income levels. Authority to spend is only extended where approved budget is available. Approval of financial plan and ICB's overall budgets resides with the ICB's Board in line with the Scheme of Reservation and Delegation.	
(a)	Responsibility of maintaining expenditure within approved budgets at individual budget level (Pay and Non Pay)	Authorised Budget Holders
(b)	For the totality of services covered by the Integrated Care Board (ICB)	In order of authority to make allowances for absence: (1) EDF (2) AO/DAO. The EDF remains accountable for all decisions under this authority.
(c)	For all other areas e.g. Reserves	EDF or Appropriate Delegated Manager
(d)	Approval to spend.	Budget holder is permitted to incur costs in accordance with their budgets and authorisation limits.
(e)	Monitoring of financial performance.	EDF.
(f)	Devise and maintain systems of budgetary control.	EDF.
(g)	Ensure that: a) No overspend or reduction of income that cannot be met from virement is incurred without prior consent of the Executive Director of Finance or Accountable Officer or the Board where delegated limits are exceeded. b) Approved budget is not used for any other purpose subject to rules of virement c) No permanent employees are appointed without the approval of the Accountable Officer (or via Executive Management Team meetings as delegated by the Board) other than those provided for within the available resources and manpower establishment.	a) Budget holder b) Budget holder c) Budget holder
(h)	Approval of Financial Policies (other than those that are reserved to the Board).	EDF
(i)	Advice on interpretation and application of the SFIs.	EDF
(j)	Staff establishment changes.	Accountable Officer and EDF
(k)	Have a duty to disclose any non-compliance with the SFIs to the EDF as soon as possible.	Members of the Board and employees (including office-holders, contractors etc).

	DELEGATED MATTER	AUTHORITY DELEGATED TO
(l)	Responsibility to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Controls.	Accountable Officer
(m)	Accountable for the Financial Control but will as far as possible delegate their detailed responsibilities.	EDF
(n)	To ensure the Board members, officers and employees present and future are notified of and understand the SFIs.	Accountable Officer
(o)	Responsible for: a) implementing ICB financial policies and co-ordinating correction action; b) maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented. c) ensuring that sufficient records are maintained to explain the ICB' transactions and financial position; d) providing financial advice to members of the Board, staff and ICB' Board' Committee; e) maintaining such accounts, certificates etc as are required to carry out its statutory duties.	 EDF EDF EDF EDF EDF
(p)	Identify and implement cost improvements and income generation activities in line with the plan.	Accountable Officer and Executive Directors
(q)	Preparation of Annual Accounts and Reports	EDF
2.	***Resources***	
(a)	Responsible for security of the ICB's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, SFIs and financial procedures.	Members of the Board and employees (including office-holders, contractors etc).
(b)	Ensure that any contractor or employee of a contractor who is empowered by the ICB to commit expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.	Accountable Officer and Executive Directors
3.	***Virements -*** See the Budget Manual and virement rules.	
	DELEGATED MATTER	**AUTHORITY DELEGATED TO**
4.	***Maintenance / Operation of Bank Accounts -*** EDF / Deputy EDF with the Head of Corporate Finance	

(a)	**Bank Accounts** Opening of new (Government Banking Services) Bank Accounts Notification of changes to banking arrangements, with the exception of changes in signatories Banking procedures a) review the banking arrangements of ICB at regular intervals to ensure they reflect best practice and represent best value for money. b) ensure competitive tenders are sought at least every 5 years where non GBS bank is used.	 Approved by the EDF and reported to the next meeting of the Board. Approved by the EDF and reported to the next meeting of the Board. EDF EDF
(b)	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding.	EDF
(c)	Duty to inform Executive Director of Finance, Contracting and Corporate Governance of money due from transactions which they initiate/deal.	All employees
	DELEGATED MATTER	**AUTHORITY DELEGATED TO**
5	***Non-Pay Revenue and Capital Expenditure Requisitioning/Ordering/Payment of Goods and Services***	
a)	Non Pay expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement.	In order of authority to make allowances for absence: (1) EDF (2) AO/DAO. The EDF remains accountable for all decisions.
b)	Orders exceeding 12 month period (other than under contract).	In order of authority to make allowances for absence: (1) EDF (2) AO/DAO. The EDF remains accountable for all decisions.
	DELEGATED MATTER	**AUTHORITY DELEGATED TO**
6	***Quotation, Tendering & Contract Procedures***	

(a)	Limits for quotes, tenders and EU procurement for all Budget Holders (all values are inclusive of VAT irrespective of whether this is reclaimable or not): (a) up to £15,000 (b) from £15,000 up to £50,000 obtaining at least 3 written competitive quotations for goods/services. (c) £50,000 and above (d) The EU limits are given at: http://www.ojec.com/Threshholds.aspx You must check to ensure you have the correct limits. (e) Responsibilities in the Tendering Process: i) Issuing of tender documentation ii) Receipt and custody of tender documentation iii) Opening of Tenders iv) Post tender negotiation	(a) Delegated Budget Holder responsibility (b) Head of Department (Band 8c) / Assistant Directors (Band 8d) /Deputy Directors (Band 9) (c) Formal tendering process (d) EU tendering limit: OJEC procurement process to be applied (e) i) Per authorised limits ii) Accountable Officer or Assistant Director of Contracting. iii) 2 Executive Directors or 2 Deputy Directors (Band 9), or 1 Executive Director and either 1 Head of Department (band 8c) or Assistant Director (band 8d) as designated by the Accountable Officer and not from the originating department. An Executive Director should be one of the two, where the tender is estimated to be in excess of £100,000. iv) At least three of the lowest (highest if sale) tenders shall be informed that the Board wishes to enter into post offer negotiations. Each of the offerors shall be invited to attend a separate meeting with the ICB. Negotiation with each offeror may continue over a series of meetings.

	DELEGATED MATTER	AUTHORITY DELEGATED TO:
(b)	Authorisation of payments to public partnership schemes under existing contracts • May relate to Section 106 (1990 Town & Country Planning Act) private agreements made between local authorities and developers, which can be attached to a planning permission to make acceptable development which would otherwise be unacceptable in planning terms. • May be applied where ICB is asked to endorse Section 106 agreement where one or member practices (and therefore ICB members) are financial beneficiaries of payments under Section 106 in supporting development of primary care estate. The ICB itself would not be a financial beneficiary. • May be applied where there is an existing contract (GMS, PMS, APMS) between the ICB and the practice or practices concerned.	In order of authority to make allowances for absence (1) EDF (2) Deputy Director of Finance / Assistant Director of Contracting. The EDF remains accountable for all decisions.
(c)	Waiver formal tendering procedures.	EDF with the Head of Corporate Governance.
(d)	Report waivers of tendering procedure to the Audit Committee.	In order of authority to make allowances for absence (1) EDF (2) Head of Corporate Governance.
(e)	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the officer / committee with delegated authority.	EDF and Accountable Officer
(f)	Shall maintain a register to show each set of competitive tender invitations despatched.	EDF
(g)	Responsible for treatment of 'late tenders'.	Accountable Officer and Executive Directors
(h)	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by ICB and which is not in accordance with these Instructions except with the authorisation of the Officer with delegated authority.	Accountable Officer
(i)	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.	EDF
(j)	The Accountable Officer or their nominated officer should evaluate the quotation and select the quote which gives the best value for money.	In order of authority to make allowances for absence (1) if within budget holder delegated authority (2)if above budget holder delegation Deputy Director of Finance / Assistant Director of Contracting (3) EDF
(k)	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the ICB and which is not in accordance with these Instructions except with the authorisation of the Officer with delegated authority.	Accountable Officer and EDF
(l)	The Accountable Officer shall nominate an officer who shall oversee and manage each contract on behalf of the ICB.	EDF

(m)	The Accountable Officer shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.	Executive Directors, Deputy Directors, Assistant Directors and Heads of Departments.
(n)	Procurement of professional services: a) Legal advice and services	Head of Corporate Governance or EDF
(o)	Acceptance of tender other than lowest.	Accountable Officer (report to the Board) reasons for acceptance set out in a permanent record.
(p)	Single Quote Authorisations	Accountable Officer or EDF. Where only one quote is sought/received the ICB shall as far as practical, determine that the price to be paid is fair and reasonable and details of the investigation recorded.
(q)	Single Tender Authorisations	Accountable Officer or EDF. Where only one tender is sought/received the ICB shall as far as practical, determine that the price to be paid is fair.
(r)	Waiving of quotations/tenders subject to Standing Orders.	EDF to report to the Audit Committee.
(s)	Capital schemes (a) Appointment of architects, quantity surveyors, consultant engineers and other professional advisors within EU regulations. (b) Granting, terminating or extending leases with an annual charge of: (i) up to £99,999 (ii) £250,000 and above	 (a) Accountable Officer or Executive Director as designated by the Accountable Officer. (b) subject to prior approval from NHS England / PropCo as required (i) EDF (ii) Accountable Officer and EDF

	DELEGATED MATTER		AUTHORITY DELEGATED TO:
7	***Commissioning Expenditure***		
	For information to note: *financial delegation to Committees of the Integrated Care Board are provided below for completeness, the detail is available in the Scheme of Reservation and Delegation (SORD).*		
	Up to	£20,000,000	ICB System Executive collectively have a financial delegation to procure / award contract / approve contract variation of up to £20,000,000 for **healthcare commissioning** / healthcare contracts over the total term of the contract. Above this delegated limit will be approved by the ICB.
	Up to	£32,000,000	ICB Executive Management Team collectively have a financial delegation to procure / award contract / approve contract variation of up to £32,000,000 for **non-healthcare commissioning** and commissioning support unit related contracts / SLA. The figure quoted is over the total term of the contract. Above this delegated limit will be approved by the ICB.
	Up to		Strategic Commissioning Group as a sub-group of the ICB System Executive Management Team to xxxx (yet to be determined) Above this delegated limit will be approved by the ICB System Executive Team up to its delegated limit.
a)	***Limits for Invoice and requisition / purchase order approval of administrative / infrastructure / non-healthcare related spend on Goods and Services*** (figures quoted inclusive of VAT)		
	up to	£15,000	Delegated budget holder
	up to	£50,000	Head of Department (Band 8C) / Assistant Directors (Band 8d)
	up to	£100,000	Deputy Director (Band 9)
	up to	£500,000	Executive Directors
	up to	£3,000,000	Accountable Officer and EDF
	over	£3,000,000	Accountable Officer and EDF to approve following approval from ICB' Board.
b)	***Approval of s117 and Continuing Healthcare and other personalised care packages such as joint packages of care with the local authority (Healthcare spend / Commissioning Programme cost invoices*** (NHS and non-NHS)		
	up to	£100,000	Budget holder for personalised care (Band 8b / Band 8c)
	above	£100,000	Assistant Director of Nursing
c)	***Limits for Invoice approval of Healthcare spend / Commissioning Programme cost invoices*** (NHS and non-NHS) e.g. personalised care invoices.		
	up to	£200,000	Delegated budget holder
	up to	£400,000	Designated senior manager (Band 8b)

	up to	£2,000,000	Head of Department (Band 8C) / Assistant Directors (Band 8d)
	up to	£10,000,000	Deputy Director (Band 9)
	up to	£20,000,000	Executive Director
	over	£20,000,000	Accountable Officer or EDF
d)	***Limits for signing Agreement of NHS Service Level (SLAs), NHS Contracts and non-NHS Contracts and contract variations*** (where SLAs and contracts have been approved, including grant agreements, s256 / s75 agreements (unless s75 agreement needs to be executed by a seal in which case this must be signed by an Executive Director)). Values quoted are over the term of the contract and not annual payments.		
	NHS SLAs / NHS Contracts	**non-NHS**	
	up to £2,000,000	up to £200,000	Head of Department (Band 8C) / Assistant Directors (Band 8d)
	up to £10,000,000	up to £2,000,000	Deputy Director (Band 9)
	over £10,000,000	over £2,000,000	Accountable Officer or Executive Director
e)	***Signing of NHS Contracts, Agreement of NHS Service Level and contract variations*** *(*where contracts and agreements have been approved, where there is no financial impact and the contract variation is of a non-financial nature).		
	GMS, PMS and APMS - non-financial contract variations, for example: - update to terms or specification - changes to boundaries, - change in partnership - lease agreements		In order of authority to make allowances for absence (1) Assistant Director of Contracting and Procurement (2) Head of Contracting and Procurement
	As lead or associate for acute, mental health, community, community based services non-financial contract variations, for example: - update to national / local terms or specification.		In order of authority to make allowances for absence (1) Assistant Director of Contracting (2) Head of Contracting and Procurement
f)	***Other aspects of commissioning expenditure***		
	Further reimbursement of expenditure within approved allocation		Budget holders or Executive Directors
8	**Setting of Fees and Charges (Income generation)**		EDF
9	***Agreements / Licences***		
a)	Preparation and signature of all tenancy agreements/licences for all staff.		In order of authority to make allowances for absence: (1) EDF (2) AO/DAO. The EDF remains accountable for all decisions under this authority.
b)	Extensions to existing leases		In order of authority to make allowances for absence: (1) EDF (2) AO/DAO. The EDF remains accountable for all decisions under this authority.

c)	Letting of Premises to/from outside organisations	In order of authority to make allowances for absence: (1) EDF (2) AO/DAO. The EDF remains accountable for all decisions under this authority.
d)	Approval of rent calculation based on professional assessment	EDF
10	***Condemning & Disposal***	
a)	Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively (e.g. corporate furniture and fittings, IT and other hardware, and intangible assets):	
	i) With current/estimated purchase price <£500	Budget Holder or Deputy Director of Finance
	ii) With current/estimated purchase price >£500	In order of authority to make allowances for absence: (1) Deputy Director of Finance (2) EDF. The EDF remains accountable for all decisions under this authority.
	iii) Community hospital assets on the ICB' Fixed Asset Register	EDF
	DELEGATED MATTER	**AUTHORITY DELEGATED TO**:
11	***Losses, Write-off & Compensation*** Assurance presented to Audit Committee.	
a)	Losses and cash due to theft, fraud, overpayment and others >£50,000	EDF and in line with the Losses and Special Payments Policy.
b)	Fruitless Payments (including abandoned Capital Schemes)	Liaison with the ICB' Local Counter Fraud Specialist and Police as required and in line with the ICB' Corruption, Fraud and Bribery Policy.
	i) <£100,000	Deputy Director of Finance
	ii) >£100,000 and <£250,000	EDF
c)	Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors & Other >£50,000	EDF
d)	Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to : Culpable causes (e.g. fraud, theft, arson) or other >£50,000	EDF
e)	Compensation payments made under legal obligation	EDF in line with the Losses and Special Payments Policy.
f)	Extra contractual payments made to contractors up to £50,000	EDF in line with the Losses and Special Payments Policy.
g)	Extra statutory or exit regulatory payments	EDF in line with the Losses and Special Payments Policy.
h)	***Ex Gratia Payments***	

	Patients and staff for loss of personal effects : i) <£500 ii) >£500 and <£5,000 iii) >£5,000 and £50,000 Any ex Gratia payment relating to termination of employment or termination of employment deemed in excess of or outside of statutory or contractual entitlements would be presented to the Remuneration Committee for review and the Remuneration Committee would make recommendation to the Governing Body. It will also be subject to an application with Business Case to NHS England, where appropriate. This would also include novel, contentious or repercussive cases i.e. Severance payments.	i) ICB Budget Managers ii) Deputy Director of Finance iii) EDF
i)	For clinical negligence and for personal injury claims involving negligence where legal advice has been obtained and guidance applied a) up to £50,000 (negotiated settlements) b) > £100,000 (negotiated settlements)	a) Head of Corporate Governance b) In order of authority to make allowances for absence: (1) Deputy Director of Finance (2) EDF.
j)	Write off of NHS Debtors : i) <£250,000	EDF – reported to Audit Committee for information and assurance.
k)	Write off of Non-NHS Debtors : i) <£250,000	EDF – reported to Audit Committee for information and assurance.
	DELEGATED MATTER	**AUTHORITY DELEGATED TO[11]**
12.	***Reporting of Incidents to the Police***	
a)	Where a criminal offence is suspected : i) Criminal Offence of a violent nature ii) Theft iii) Other	Budget holders or Executive Directors Executive Directors Executive Directors
b)	Where a fraud is involved (following referral to the Counter Fraud Service)	EDF
c)	Where an incident occurs out of normal working hours	On Call Director
13.	***Receiving Hospitality***	

a)	You must ensure that the best interests of public and patients are upheld in decision making and that any decisions are not improperly influenced by gifts or inducements (as set out in the code of conduct for NHS Managers). In the exceptional circumstances that a gift or hospitality is accepted, both individual and collective hospitality receipt items in excess of £25 per item received must be declared. (If this is in conflict with the Conflicts of Interest, Gifts and Hospitality and Sponsorship Policy, then the Policy should take precedence).	Declarations required in line with ICB' Conflicts of Interest, Sponsorship and Gifts and Hospitality Policy.
b)	Register of Gifts and Hospitality to be maintained, monitored and updated.	Head of Corporate Governance.
14.	***Implementation of Internal and External Audit Recommendations***	EDF
15.	***Maintenance & Update of ICB Financial Procedures***	EDF
	DELEGATED MATTER	**AUTHORITY DELEGATED TO[11]**
16.	***Investment of Funds***	EDF
17.	***Personnel & Pay***	
a)	Authority to fill funded post on the establishment with permanent staff (within budget)	Authorised Budget Holders and ICB Budget Managers
b)	Authority to appoint staff not on the formal establishment	Accountable Officer and EDF
c)	*Upgrading & Regrading* : i) All requests for upgrading/re-grading shall be dealt with in accordance with ICB HR policy and procedure	In line with HR Policy.

d)	*Pay:* i) Authority to complete standing data forms effecting pay, new starters, variations and leavers, up to a maximum annual equivalent of £150,000 per annum. ii) Authority to complete standing data forms effecting pay, new starters, variations and leavers, over an annual equivalent of £150,000 per annum iii) Authority to complete and authorise positive reporting forms iv) Authority to authorise overtime (only where HR Policy permits) v) Authority to authorise travel and subsistence expenses vi) Approval of Performance Related Pay Assessment in line with Agenda for Change Framework	i) Executive Directors, EDF and Deputy Director of Finance (relevant to staff function and subject to Remuneration Committee recommendation/decision where applicable). ii) Executive Directors, EDF and Deputy Director of Finance commend the case before seeking Ministerial support via NHS England In order of authority to make allowances for absence: (1) EDF (2) AO/DAO. The EDF remains accountable for all decisions under this authority (relevant to staff function and subject to Remuneration Committee recommendation/decision where applicable). iii) Line/Departmental Managers, Deputy Director of Finance or Executive Directors. iv) and v) Line/Departmental Managers, Deputy Director of Finance or Executive Directors (in line with HR policy). vi) In order of authority to make allowances for absence: (1) EDF (2) AO/DAO or Remuneration Committee to make a recommendation for Very Senior Managers. The EDF remains accountable for all decisions under this authority (except where relating to the EDF).

	DELEGATED MATTER	AUTHORITY DELEGATED TO
e)	*Payroll Deductions*: i) PAYE, NIC & Pension Payments <£500k ii) Payment requests <£100,000	EDF EDF
f)	*Leave:* i) Approval of Annual Leave ii) Annual Leave – approval of carry forward up to a maximum of 5 days iii) Annual Leave – approval of carry forward > 5 days iv) Compassionate Leave v) Special Leave arrangements: • Paternity Leave • Carers Leave	 i) Line / Departmental Manager ii) Executive Directors iii) Executive Directors iv) Line / Departmental Manager (in line with HR Policy) v) Line / Departmental Manager (in line with HR Policy)
g)	viii) Unpaid Leave ix) Maternity Leave – Paid and Unpaid	Line Manager / Departmental Manager (in line with HR Policy) Automatic approval within Executive Directors (subject to HR guidance)
h)	*Sick Leave*: i) Extension of sick leave on half pay ii) Return to work part time on full pay to assist recovery iii) Extension of sick leave on full pay	Executive Directors Executive Directors Executive Directors
i)	*Study Leave:* i) in line with HR Policy	in line with HR Policy
j)	Grievance Procedure : All grievances must be dealt with strictly in accordance with the Grievance Procedure and the advice of HR must be sought.	Line Manager/Departmental Manager
k)	Discipline Procedure : All grievances must be dealt with strictly in accordance with the Discipline Procedure and the advice of HR must be sought .	Line Manager/Departmental Manager
l)	Authorised Car & Mobile Phone Users: i) Requests for car usage, ii) mobile telephone users, I-Phone and VPN access	i) Budget holders, Deputy Director of Finance or Executive Directors ii) Head of Corporate Governance or Executive Directors
m)	Renewal of Fixed Term Contract	Executive Directors or AO or DAO
	DELEGATED MATTER	**AUTHORITY DELEGATED TO**

n)	*Redundancy :* i) <£50,000 ii) >£50,000 to £95,000 (up to maximum allowable under NHS England rules)	In line with policy, EDF and AO (in conjunction with Board)
o)	*Ill Health Retirement :* Decision to pursue retirement on the grounds of ill-health	In order of authority to make allowances for absence: (1) EDF (2) AO/DAO, in conjunction with Occupational Health. The EDF remains accountable for all decisions under this authority
p)	*Dismissal:*	In order of authority to make allowances for absence: (1) EDF (2) AO/DAO. The EDF remains accountable for all decisions under this authority
18.	***Authorisation of Sponsorship Deals***	Refer to Conflicts of Interest, Sponsoring and Gifts and Hospitality Policy
19.	***Authorisation of Research Projects***	Executive Directors
20.	***Insurance Policies and Risk Management***	In order of authority to make allowances for absence: (1) EDF (2) AO/DAO. The EDF remains accountable for all decisions under this authority
21.	***Complaints****:* i) Overall responsibility for ensuring all complaints are dealt with effectively ii) Responsibility for ensuring complaints relating to the ICB are investigated thoroughly iii) Clinical quality and clinical safety related complaints – oversight	EDF in conjunction with Head of Corporate Governance and the Corporate Governance Team Executive Director of Nursing, Quality and Performance
22.	***Relationships with media***	In order of authority to make allowances for absence: (1) AO/DAO (2) Executive Directors.
23.	***Review of all statutory compliance legislation and Health & Safety requirements***	EDF in conjunction with the Head of Corporate Governance.
24.	***Review of ICB's compliance with the Data Protection Act and associated legislation***	In order of authority to make allowances for absence: (1) EDF in conjunction with the Head of Corporate Governance (2) AO/DAO or Appropriate Delegated ICB Management Director
25.	***The Keeping of a Declaration of Interests Register***	Head of Corporate Governance
26.	***Attestation of Sealings in accordance with Standing Orders***	EDF with support from Head of Corporate Governance
27.	***The Keeping of a register of Sealings***	Head of Corporate Governance
28.	***The Keeping of the Hospitality Register***	Head of Corporate Governance
29.	**Senior Information Risk Owner responsibilities**	EDF with support from Head of Corporate Governance
GLOSSARY OF TERMS		

AO – Accountable Officer	***EDF –*** Executive Director of Finance, Contracting and Corporate Governance
DAO – Deputy Accountable Officer	
Executive Directors Where referred to in this document, this will relate to: · The Chief Executive (Accountable Officer) · The Executive Director of Finance, Contracting and Corporate Governance · The Executive Director of Nursing, Quality and Performance and Deputy Accountable Officer (DAO) · The Executive Director of People and Innovation · The Executive Director of Strategy and Planning · The Executive Director of Integration and Transformation	***Budget Manager / Budget holder –*** e.g. Deputy Directors, Heads of Department, Assistant Directors

Appendix F – Audit Committee terms of reference

Leicester, Leicestershire and Rutland Integrated Care Board
Audit Committee
Terms of Reference

1. Constitution

The Audit Committee (the Committee) is established by the NHS Leicester, Leicestershire and Rutland Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR) 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 will be chaired by a non-executive director, it is a 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. 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 Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

3. Authority

The Audit 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.

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 four members of the Committee including two who are Independent 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 shall be the independent Non-Executive Directors of the ICB:

- Non-Executive Director – Audit
- Non-Executive Director – Remuneration
- Non-Executive Director – Quality, Safety, Performance and Transformation
- Non-Executive Director – Health Inequalities, Public Engagement, Third Sector and Carers

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.

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 from one of the other independent Non-Executive Directors of the ICB.

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;
- and other relevant attendees

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.

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 Committee.

5. Meetings Quoracy and Decisions

The Audit 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 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 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. 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.

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 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 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 Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners; Fraud, Bribery and Corruption.

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 and 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 and 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 and 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.

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.

Conflicts of Interest
The chair of the Audit 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. 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 and submitted to the Board in accordance with the Standing Orders.

The Chair will provide 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 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.

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 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 provided by the Head of Corporate Governance 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.

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.

Date of approval:

Date of review:

Appendix G – Remuneration Committee terms of reference

Leicester, Leicestershire and Rutland Integrated Care Board
Remuneration Committee
Terms of Reference

1. Constitution

The Remuneration 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. 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 senior managers/directors (including board members) and non-executive directors excluding the Chair.

As the Committee will consist of Non-Executive Directors, the remuneration for the non-executive members will therefore be determined by the Chair and the Chief Executive, and approved by the Chair in line with the Constitution.

The Board has also delegated the following functions to the Committee:
This might include functions such as:

- Elements of the nominations and appointments process for Board members;
- Oversight of executive board member performance.

3. Authority

The Remuneration 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.

4. Membership and attendance

Membership
The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint four non-executive members of the Board as members of the Committee. Other members of the Committee need not be members of the board, but they may be.

The Chair of the Audit Committee may not be a member of the Remuneration Committee.

The Chair of the Board may be a member of the Committee but may not be appointed as the Chair.

When determining the membership of the Committee, active consideration will be made to diversity and equality.

Members of the Committee shall be the Non-Executive Directors of the ICB:

- Non-Executive Director – Remuneration (Chair of Committee)
- Non-Executive Director – Health Inequalities, Public Engagement, Third Sector and Carers
- Non-Executive Director – Quality, Safety, Performance and Transformation
- Chair 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.

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 terms of reference.

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 Head of Corporate Governance
- Chief Executive

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 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 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's duties are as follows:

For the Chief Executive, Directors and other Very Senior Managers:

- Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars;
- 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.

Additional functions of the Committee include:

- Functions in relation to nomination and appointment of (some or all) Board members;
- Functions in relation to performance review/ oversight for directors/senior managers (i.e. for the Chief Executive, Directors and other Very Senior Managers);
- Succession planning via a skills review / audit 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).

7. 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 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 B of the Board. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.
The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

8. 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.

9. Declarations of interest

All 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 provided by the Head of Corporate Governance, 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.

11. 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 H – System Executive terms of reference

NHS Leicester, Leicestershire and Rutland Integrated Care Board

System Executive
Terms of Reference (v1, July 2022)

1. CONSTITUTION

The System Executive ("SE" or "the Committee") is established by the NHS Leicester, Leicestershire and Rutland Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These terms of reference 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 will be chaired by the Chief Executive, it 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 LLR System Operational Plan. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective and sustainable system of operational planning, resilience and robust performance monitoring, and internal control that supports it to effectively deliver its strategic objectives and provide sustainable and transformational, 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

Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than seven members of the Committee (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.

Members

- ICB Chief Executive Officer (Chair)
- ICB Director of Nursing and Quality (vice Chair) or nominated deputy
- ICB Director of Finance or nominated deputy
- ICB Medical Director or nominated deputy
- ICB Director of Strategy and Planning or nominated deputy
- ICB Director of People or nominated deputy
- ICB Director of Transformation o nominated deputy
- Chief Executive Officer from University Hospitals of Leicester NHS Trust or nominated deputy
- Chief Executive Officer from Leicestershire Partnership NHS Trust or nominated deputy
- Senior Responsible Officers (SROs) for each of the Collaboratives

Only members of the Committee have the right to attend committee meetings. Other individuals may be invited to attend all or part of any meeting as and when appropriate. Attendees do not have voting rights:

Chair and vice chair

In accordance with the Constitution, this meeting will be chaired by the Chief Executive of the ICB and their nominated deputy will be the vice Chair of the Committee.

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 the Committee Chair has a conflict of interest then the vice chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

5. MEETING QUORACY AND DECISIONS

The Committee shall meet on a monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

For a meeting to be quorate a minimum of six members will be required with the following being present: committee Chair or vice chair, plus three ICB Directors, and at least two other members.

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.

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.

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. 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.

6. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

- Have oversight of the development of the development of the system wide financial strategic and strategic plan. Recommend the strategic plan to the ICB for approval.

- Ensure operational plan including capacity and workforce are developed to support the delivery of the strategic plan, providing assurance to the Board of delivery.

- Oversee performance and resilience at system level.

- Oversee and monitor delivery of the ICB key statutory requirements and national performance standards.

- Provide the Board with an accurate understanding of the system's current and forecast performance position. Develop and oversee the system's recovery plans to address and mitigate any risks.

- Oversee the primary care delegated function and seek assurance from the Strategic Commissioning Group.

- Receive assurance from the Collaboratives that transformation programmes are delivering, and any identified risks have associated mitigations in place.

- To approve business cases for healthcare procurement (for commissioning or decommissioning and/or investment or disinvestment) with a total financial value up to £20,000,000 in total over the period of the contract (or three years if the investment is not time limited) for the ICB.

- Develop final proposals for the procurement process and approve these proposals in line with delegated authority.

- Monitor progress of procurement processes for healthcare services within the remit of the System Executive and provide assurance and recommendations to the Board as appropriate.

- Subject to the delegated authority, make recommendations to the Board on the outcome of the procurement evaluation or approve the award of contracts to the preferred bidder, if within the level of authority delegated to the System Executive.

- Keep under review progress made with commissioning and procurement activity, and other activity which should inform commissioning plans including finance and performance. Where necessary, report to the Board any such information which they should be aware of, particularly where it suggests that plans should be amended and escalation of risks identified.

- To approve contract award for healthcare procurements for a total financial value up to £20,000,000 in total over the period of the contract (or three years if the investment is not time limited) for the ICB.

- In accordance with the authority delegated to the System Executive, to receive recommendations and assurance on performance of healthcare service provision.

- Where required, approve any contract variation to health care contracts for the ICB, including any changes to funding arrangements subject to the overall contract value not exceeding £20,000,000 in total for the ICB.

- Ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements.
- Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Committee.

7. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The System Executive 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 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.

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 / Conflicts of Interest Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. DECLARATIONS OF INTEREST

All 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 by the Corporate Governance Team and / or the Executive Assistant to the Chief Executive this 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.

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 – Finance Committee terms of reference

NHS Leicester, Leicestershire and Rutland Integrated Care Board

Finance Committee
Terms of Reference (v1, July 2022)

1. CONSTITUTION

The Finance Committee (the Committee) is established by the NHS Leicester, Leicestershire and Rutland Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These terms of reference 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 will be chaired by a Non-Executive Director from either the ICB or from a NHS partner organisation, it 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 statutory functions in relation to financial planning and management. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective and sustainable system of financial planning and management 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.

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

Membership

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.

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.

Members

- Non-Executive Director (from NHS partner organisation) – Non-Executive Director from Leicestershire Partnership Trust (Chair)
- ICB Non-Executive Director – tbc (vice Chair)
- Executive Director of Finance, Contracting and Corporate Governance or nominated deputy
- Another Executive Director
- Chief Finance Officer from University Hospitals of Leicester NHS Trust (UHL) or nominated deputy
- Chief Finance Officer from Leicestershire Partnership NHS Trust (LPT) or nominated deputy
- Chief Finance Officer from or nominated deputy
- Clinical lead - primary care

Only members of the Committee have the right to attend committee meetings. Other individuals may be invited to attend all or part of any meeting as and when appropriate. The following individuals may be asked to attend on a regular basis, however they would not form part of the membership and therefore do not have voting rights:

- Deputy Director of Finance (for system)
- Representative from East Midlands Ambulance Service
- Non-Executive Directors from UHL and LPT
- NHS England / Improvement representative

Chair and vice chair

In accordance with the Constitution, the Committee will be chaired by a Non-Executive Member of the Board and the second Non-Executive Member will be the vice Chair of the Committee.

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 the Committee Chair has a conflict of interest then the vice chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

5. MEETING QUORACY AND DECISIONS

The Finance Committee shall meet on a monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

For a meeting to be quorate a minimum of four members will be required with one Non-Executive Director, plus the Director of Finance, Contracting and Corporate Governance or deputy, and two other members.

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.

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.

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. 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.

6. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

- Gain assurance from the executive functions and provide assurance to the Board that there are robust processes in place for the effective management of:
    - financial strategy;

- financial planning and management;
- financial performance, activity and control;
- capital expenditure and schemes; and
- financial risk management.

- Oversee and monitor delivery of the ICB key statutory requirements.

- Ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements.

- Have oversight of the Terms of Reference and work programmes for the groups reporting into the Finance Committee.

Financial Strategy

- Provide oversight of the financial strategy
- Receive and evaluate recommendations from the Executive Finance officers for the key financial priorities that are included within the ICB strategy/ annual plan, including priorities to address variation/ inequalities in care
- Oversight of payment policy reform and impact of commissioning reforms such as place based allocations
- Oversight of provider collaboration and impact on finance.

Financial planning

- Oversight of the development of system financial management information systems and processes, forming recommendations to the Board on the model of financial planning to be adopted and the contractual frameworks to be operated within the system.
- Provide assurance on the development and delivery of the continuous improvement and efficiency agenda

Financial performance and controls

- Have oversight of the monthly financial performance of the system and provide the Board with an accurate understanding of the system's current and forecast financial position and the development and oversight of the system's financial strategy/ recovery plans to address any underlying challenge.
- To review exception reports on any material in-year overspends against delegated budgets, including adequacy of any proposed remedial action plans
- Receive assurance that appropriate arrangements are in place to ensure robust system financial control.
- Consider and proposals for the system financial architecture and financial controls required to ensure the system is able to meet the value for money criteria and ensure financial sustainability.

Capital

- Oversight of the system capital plans including robust in year monitoring and forecasting to provide the Board with an accurate understanding of the system's current and forecast position.

- Ensure capital plans are aligned to LLR strategic, clinical, operational and innovation priorities.

Financial risk management

- To have oversight of strategic financial risks on the Board Assurance Framework and high-risk operational risks and oversight of associated mitigations. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner

7. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Finance 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 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.

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 / Conflicts of Interest Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. DECLARATIONS OF INTEREST

All 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 by the Corporate Governance Team this 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.

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 J – Quality and Safety Committee terms of reference

NHS Leicester, Leicestershire and Rutland Integrated Care Board

Quality and Safety Committee
Terms of Reference (v1, July 2022)

1. CONSTITUTION

The Quality and Safety Committee (the Committee) is established by the NHS Leicester, Leicestershire and Rutland Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR) 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 will be chaired by a Non-Executive Director, it 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 Quality and Safety Committee has been established to provide the ICB with assurance that it 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 in the 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, that there is 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.

3. 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 Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

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 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.

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.

Members

- Non-Executive Director – Quality, Safety, Performance and Transformation (Chair)
- Non-Executive Director – Health Inequalities, Public Engagement, Third Sector and Carers (vice Chair)
- ICB Director of Nursing or nominated deputy
- ICB Medical Director or nominated deputy
- Chair of the Patient and Public Involvement Assurance Group or nominated deputy / representative
- Clinical Lead for primary care
- One Non-Executive Director from University Hospitals of Leicester NHS Trust
- One Non-Executive Director from Leicestershire Partnership NHS Trust
- One Non-Executive Director from East Midlands Ambulance Service

Only members of the Committee have the right to attend committee meetings. Other individuals may be invited to attend all or part of any meeting as and when appropriate. The following individuals may be asked to attend on a regular basis, however they would not form part of the membership and therefore do not have voting rights:

- Assistant Director of Performance and Quality Improvement
- Head of Patient Safety
- Communications and engagement lead.

Chair and vice chair

In accordance with the Constitution, the Committee will be chaired by a Non-Executive Member of the Board and the second Non-Executive Member will be the vice Chair of the Committee.

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 the Committee Chair has a conflict of interest then the vice chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

5. MEETING QUORACY AND DECISIONS

The Quality Committee shall meet on a monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

For a meeting to be quorate a minimum of two Non-Executive Members of the Committee, at least one being a Non-Executive Director of the Board are required, plus at least the Director of Nursing or Medical Director, plus one other member.

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.

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.

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. 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.

6. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Quality and Safety Committee will be authorised by the ICB Board. It is expected that the Committee will:

- Be assured that there are robust processes in place for the effective management of quality, patient safety, patient experience and involvement, and health inequalities.
- Scrutinise structures in place to support quality planning, control and performance 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
- Oversee and monitor delivery of the ICB key statutory requirements
- Review and monitor those risks on the BAF 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 (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 and Safety Improvement Programmes
- Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered, including clinical outcomes, by providers and place
- 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 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
- Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality Committee (e.g. System Quality Group, Patient and Public Involvement Assurance Group)

7. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Quality & Safety Assurance 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 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.

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 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 by the Corporate Governance Team this 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.

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 K – Health Equity Committee

NHS Leicester, Leicestershire and Rutland Integrated Care Board

Health Equity Committee
Terms of Reference (v1, July 2022)

1. CONSTITUTION

The Health Equity Committee (the Committee) is established by the NHS Leicester, Leicestershire and Rutland Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These terms of reference 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 will be chaired by a Non-Executive Director of the ICB, it 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 statutory functions and making decisions to enable inclusion, improve health outcomes for patients and service users, and reduce unwarranted health inequality. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective and sustainable system of monitoring our progress in reducing health inequalities that supports effective deliver of the ICB's strategic objectives and provides 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

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 (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.

Members

- ICB Non-Executive Director – Health Inequalities, Public Engagement, Third Sector and Carers (Chair)
- ICB Non-Executive Director – tbc (vice Chair)
- ICB Director of Strategy or nominated deputy
- ICB Director of People or nominated deputy
- Public health leads for Leicester, Leicestershire and Rutland
- Clinical lead - tbc

Only members of the Committee have the right to attend committee meetings. Other individuals may be invited to attend all or part of any meeting as and when appropriate. The following individuals may be asked to attend on a regular basis, however they would not form part of the membership and therefore do not have voting rights:

- Representative from Healthwatch Leicester and Leicestershire
- Representative from Healthwatch Rutland

Chair and vice chair

In accordance with the Constitution, the Committee will be chaired by a Non-Executive Member of the Board and the second Non-Executive Member will be the vice Chair of the Committee.

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 the Committee Chair has a conflict of interest then the vice chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

5. MEETING QUORACY AND DECISIONS

The Health Equity Committee shall meet on a bi-monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy
For a meeting to be quorate a minimum of four members will be required with the Chair or vice Chair being present, an ICB executive director or nominated deputy and two other members.

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.

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.

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. 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.

6. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

- Gain assurance from the executive functions and provide assurance to the Board in the following areas:
    - The population of LLR is receiving equitable access and experience
    - That the system health inequalities strategy is being delivered effectively
    - Ensure the ICB is delivering better health outcomes for all its population
    - Be assured that the leadership across the system is inclusive
    - There is a representative and supported workforce.

- Influence to ensure equality and inclusion are embedded within key health care policy, strategy and in the delivery of services.

- Ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements.

- Support the interface with other Board Committees to ensure effective implementation of the priorities relating to equity and inclusion.

- Provide oversight of the equity and inclusion strategy and associated frameworks and implementation plans.

- To have oversight of strategic risks on the Board Assurance Framework and high-risk operational risks and oversight of associated mitigations. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner

7. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Health Equity 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 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.

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 / Conflicts of Interest Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. DECLARATIONS OF INTEREST

All 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 by the Corporate Governance Team this 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.

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 L – GP Practices across LLR

Leicester, Leicestershire and Rutland

Primary Medical Care Services providers and Primary Care Networks (April 2022)

Leicestershire PCN Contact

PCN NAME	PRACTICE CODE	PRACTICE NAME	CD	PCN MANAGER
BEACON PCN	C82041	CHARNWOOD MEDICAL GROUP	annapurna.rao@nhs.net	Alison.Hipkin@nhs.net
	C82064	FOREST HOUSE SURGERY	geoffreyp.hanlon@nhs.net	Kristy.Mackinson1@nhs.net
	C82656	FIELD STREET SURGERY		Helen.Rose8@nhs.net
	C82103	DISHLEY GRANGE MEDICAL PRACTICE		
BOSWORTH PCN	C82051	NEWBOLD VERDON MED.PRACT.	james.ogle@nhs.net	nicola.warren1@nhs.net
	C82121	HEATH LANE SURGERY		
	C82650	DESFORD MEDICAL CENTRE		Claire.Wood43@nhs.ne
	C82634	RATBY SURGERY		
CARILLON PCN	C82026	BRIDGE STREET MEDICAL PRACTICE	ls.borrill@nhs.net	Alison.Hipkin@nhs.net
	C82035	PARK VIEW SURGERY		Kristy.Mackinson1@nhs.net
	C82070	WOODBROOK MEDICAL CENTRE		Helen.Rose8@nhs.net
	C82011	PINFOLD MEDICAL PRACTICE		
	C82111	NN VAGHELA'S PRACTICE		
FOSSEWAY PCN	C82054	THE BURBAGE SURGERY	vikram.bolarum@nhs.net	nicola.warren1@nhs.net
	C82027	THE OLD SCHOOL SURGERY		
	C82093	THE ORCHARD MED PRACTICE		Claire.Wood43@nhs.net
	C82061	BARWELL & HOLLYCROFT MEDICAL CENTRES		
HINCKLEY CENTRAL PCN	C82075	CASTLE MEAD MEDICAL CENTRE	ray.dockrell1@nhs.net	nicola.warren1@nhs.net
	C82082	THE CENTRE SURGERY		
	C82047	MAPLES FAMILY MED.PRACT.		Claire.Wood43@nhs.net
	C82043	STATION VIEW HEALTH CENTRE		

Leicestershire PCN Contact

PCN NAME	PRACTICE CODE	PRACTICE NAME	CD	PCN MANAGER
CROSS COUNTIES PCN	C82001	SOUTH LEICESTERSHIRE MEDICAL PARTNERSHIP	anuj.chahal1@nhs.net ricky.badiani@nhs.net	chris.lyon3@nhs.net rachael.plews@nhs.net
	C82022	THE BILLESDON SURGERY		
	C82067	THE CROFT MEDICAL CENTRE		
G3 PCN	C82056	THE GLENFIELD SURGERY	n.chotai@nhs.net	shahid.akhtar1@nhs.net
	C82005	GROBY ROAD MEDICAL CENTRE		
	C82628	GROBY SURGERY		
MELTON, SYSTON AND VALE PCN	C82038	LATHAM HOUSE MEDICAL PRACTICE	fahreen.dhanji@nhs.net	lynne.abley@nhs.net
	C83653	STACKYARD		
	C82016	LONG CLAWSON MEDICAL PRACTICE		
	C82078	THE JUBILEE MEDICAL PRACTICE		
	C82042	THE COUNTY PRACTICE		
MARKET HARBOROUGH & BOSWORTH PCN	C82009	MARKET HARBOROUGH MED.CTR	hamantk.mistry@nhs.net	dan.markovic@nhs.net karen.partyka1@nhs.net
	C82112	SPECTRUM HEALTH		
	C82109	HUSBANDS BOSWORTH MEDICAL CENTRE		
NORTH BLABY PCN	C82039	KINGS WAY SURGERY	ricky.badiani@nhs.net	chris.lyon3@nhs.net rachael.plews@nhs.net
	C82055	THE LIMES MEDICAL CENTRE		
	C82066	FOREST HOUSE MEDICAL CENTRE		
	C82631	ENDERBY MEDICAL CENTRE		
OADBY & WIGSTON PCN	C82079	SOUTH WIGSTON HEALTH CTR.	ravi.sahdev@nhs.net mark.shaffu@nhs.net	james.watkins3@nhs.net
	C82021	THE CENTRAL SURGERY		
	C82071	WIGSTON CENTRAL SURGERY		
	C82013	BUSHLOE SURGERY		
	C82048	ROSEMEAD DRIVE SURGERY		
SOUTH BLABY & LUTTERWORTH PCN	C82098	HAZELMERE MEDICAL CENTRE	danny.jones3@nhs.net	james.goode1@nhs.net
	C82002	COUNTESTHORPE HEALTH CENTRE		
	C82068	NORTHFIELD MEDICAL CENTRE		
	C82025	THE WYCLIFFE MEDICAL PRACTICE		
	C82611	THE MASHARANI PRACTICE		

Leicestershire PCN Contact (Cont.)

PCN NAME	PRACTICE CODE	PRACTICE NAME	CD	PCN MANAGER
NORTH WEST LEICESTERSHIRE PCN	C82050	DR NR PULMAN'S PRACTICE	mj.aram@nhs.net k.moore@gp-C82017.nhs.uk	Jake.Cooke@nhs.net Samantha.Hayes6@nhs.net
	C82052	DR AM LEWIS' PRACTICE		
	C82012	IBSTOCK HOUSE SURGERY		
	C82072	BROOM LEYS SURGERY		
	C82096	HUGGLESCOTE SURGERY		
	C82028	MARKFIELD MEDICAL CENTRE		
	C82045	THE SURGERY		
	C82102	MANOR HOUSE SURGERY		
	C82120	WHITWICK HEALTH CENTRE		
	C82017	MEASHAM MEDICAL UNIT		
	C82007	CASTLE DONINGTON SURGERY		
	C82014	CASTLE MEDICAL GROUP		
SOAR VALLEY PCN	C82032	DR NW OSBORNE'S PRACTICE	umar.abdulmajid@nhs.net	Alison.Hipkin@nhs.net Kristy.Mackinson1@nhs.net Kristy.Mackinson1@nhs.net
	Y00252	DR SJC CLAY'S PRACTICE		
	C82062	BARROW HEALTH CENTRE		
	C82600	THE BANKS SURGERY		
	C82095	ALPINE HOUSE SURGERY		
	C82034	QUORN MEDICAL CENTRE		
	C82644	DR MK LAKHANI'S PRACTICE		
	C82097	CHARNWOOD SURGERY		
WATERMEAD PCN	C82678	THURMASTON HEALTH CENTRE	asma.bukhari@nhs.net	Alison.Hipkin@nhs.net Kristy.Mackinson1@nhs.net Helen.Rose8@nhs.net
	C82003	GREENGATE MEDICAL CENTRE		
	C82091	BIRSTALL MEDICAL CENTRE		
	C82627	SILVERDALE MEDICAL CENTRE		

Rutland PCNs Contact

PCN NAME	PRACTICE CODE	PRACTICE NAME	CD	PCN MANAGER
RUTLAND HEALTH PCN	C82010	OAKHAM MEDICAL PRACTICE	jamesburden@nhs.net	clare.jackson24@nhs.net
	C82077	THE UPPINGHAM SURGERY		
	C82044	EMPINGHAM MEDICAL CENTRE		nicola.turnbull5@nhs.net
	C82649	MARKET OVERTON & SOMERBY SURGERIES		

Leicester City PCNs Contact

PCN NAME	PRACTICE CODE	PRACTICE NAME	CD	PCN MANAGER
AEGIS HEALTHCARE PCN	Y00137	THE WILLOWS MEDICAL CENTRE	rishabh.prasad@nhs.net	farahnaz.pinto@nhs.net kavita.kachiwala@nhs.net
	C82122	CLARENDON PARK ROAD HEALTH CENTRE		
	C82623	HEATHERBROOK SURGERY		
	C82060	THE PRACTICE-SAYEED		
	C82105	AR-RAZI MEDICAL CENTRE		
	C82626	PASLEY ROAD HEALTH CENTRE		
	C82029	WILLOWBROOK MEDICAL CENTRE		
BELGRAVE & SPINNEY HILL PCN	C82037	EAST PARK MEDICAL CENTRE	prakash.pancholi1@nhs.net	Anisah.ikleriya@nhs.net Pritesh.pancholi@nhs.net
	C82024	SPINNEY HILL MEDICAL CENTRE		
	C82667	THE CHARNWOOD PRACTICE		
	C82651	BROADHURST ST MED PRACT		
	C82084	DR B MODI		
CITY CARE ALLIANCE PCN	C82680	RUSHEY MEAD HEALTH CENTRE	umesh.roy@nhs.net	Maxine.Rowley@spirit-clinical.co.uk
	C82073	MERRIDALE MEDICAL CENTRE		
	C82114	DR U K ROY		
	C82614	ASQUITH SURGERY		
	C82610	THE PARKS MEDICAL CENTRE		
	C82624	THE PRACTICE BEAUMONT LEYS		
LEICESTER CENTRAL PCN	C82642	HIGHFIELDS MEDICAL CENTRE	rajiv.wadhwa@nhs.net	helen.feely1@nhs.net dina.kotecha@nhs.net
	Y02469	HERON GP PRACTICE		
	Y02686	BOWLING GREEN STREET SURGERY		
	C82080	SHEFA MEDICAL PRACTICE		
	C82643	COMMUNITY HEALTH CENTRE		
	C82116	HIGHFIELDS SURGERY		
LEICESTER CITY SOUTH PCN	C82046	SAFFRON GROUP PRACTICE	amit.rastogi2@nhs.net	s.cousins1@nhs.net Philippa.guy@nhs.net
	C82019	STURDEE ROAD HEALTH AND WELLBEING CENTRE		
	C82100	THE HEDGES MEDICAL CENTRE		
	C82670	INCLUSION HEALTHCARE		
	Y00344	LEICESTER CITY ASSIST PRACTICE		

Leicester City PCNs Contact (cont.)

PCN NAME	PRACTICE CODE	PRACTICE NAME	CD	PCN MANAGER
SALUTEM PCN	C82676	ST ELIZABETH'S MEDICAL CENTRE	aileen.tincello@nhs.net	katie.billson@nhs.net
	C82030	DOWNING DRIVE SURGERY		
	C82031	JOHNSON MEDICAL PRACTICE		
	C82033	HUMBERSTONE MEDICAL CENTRE		
	C82063	EAST LEICESTER MED PRACTICE		
LEICESTER CITY & UNIVERSITY PCN	C82124	VICTORIA PARK HEALTH CENTRE	aruna.garcea@nhs.net	krishna.solanki@nhs.net
	C82008	OAKMEADOW SURGERY		
	C82053	HOCKLEY FARM MED PRACT		
MILLENNIUM PCN	C82086	FOSSE MEDICAL CENTRE	moses.bandrapalli1@nhs.net	dinesh.vadgama@nhs.net (temp)
	C82018	PARKER DRIVE SURGERY/ MANOR MC		
	C82094	BEAUMONT LODGE MEDICAL PRACTICE		
	C82662	WALNUT ST MED CTR		
ORION PCN	C82020	DE MONTFORT SURGERY	gopi.boora@nhs.net	dinesh.vadgama@nhs.net
	C82059	WESTCOTES GP SURGERY (ONE)		
	C82620	DR S SHAFI		
	C82107	COSSINGTON PARK SURGERY		
	C82092	AYLESTONE HEALTH CENTRE		
	C82653	WESTCOTES GP SURGERY (TWO)		
	C82639	WESTCOTES HEALTH CENTRE		
THE LEICESTER FOXES PCN	C82088	HORIZON HEALTHCARE	khalid.choudhry2@nhs.net	kamlesh.parmar@nhs.net
	C82660	ST PETER'S MED CENTRE		
	C82671	DR GANDECHA & PARTNER		
	C82099	AL-WAQAS MEDICAL CENTRE		
	C82669	THE SURGERY @ AYLESTONE		
	C82659	DR R KAPUR & PARTNERS		
	C82119	NARBOROUGH ROAD SURGERY		

5

Leicester, Leicestershire, and Rutland Integrated Care Board

People and Communities Strategy 2022-24

A Strategy for the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board for working with people and communities

Contents

Introduction

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.

National ICS implementation guidance on working with people and communities sets out the following key points:

- A strong and effective ICS will have a deep understanding of all the people and communities it serves
- The insights and diverse thinking of people and communities are essential to enabling ICSs to tackle health inequalities and the other challenges faced by health and care systems
- The creation of statutory ICS arrangements brings fresh opportunities to strengthen work with people and communities, building on existing relationships, networks and activities.

Integrated Care Boards (ICBs) are NHS bodies. Local authorities are included as members of its Board to strengthen collaborative working. The ICB will take on the NHS commissioning functions of CCGs, as well as some of NHS England's commissioning functions. It is also accountable for NHS spend and performance within the system.

Key actions for ICBs:

- ICBs are expected to develop a system-wide strategy for engaging with people and communities by late Spring 2022, using the 10 principles in the guidance as a starting point (see page 16)
- ICB constitutions are expected to include principles and arrangements for how the ICB will work with people and communities
- ICBs should work with partners across the ICS to develop arrangements for ensuring that Integrated Care Partnerships (ICPs) and place-based partnerships have representation from local people and communities in priority-setting and decision-making forums
- ICBs are expected to gather intelligence about the experience and aspirations of people who use care and support and have clear approaches to using these insights to inform decision-making and quality governance

The guidance sets out that ICBs should set out principles for how they will engage with people and communities and how they will develop arrangements for engagement across 'place' based areas, ensure appropriate representation, and how they will gather and use information to inform decision-making and quality governance.

The ICS design framework sets the expectation that partners in an ICS should agree how 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.

Each area will also have an Integrated Care Partnership or ICP, a joint committee which brings together the ICB and their partner local authorities, and other locally determined representatives (for example from health, social care, public health; and potentially others, such as social care or housing providers).

The ICP will be tasked with developing a strategy to address the health, social care and public health needs of their system, and being a forum to support partnership working. The ICB and local authorities will have to have regard to ICP strategies when making decisions.

The ICB and ICP will also have to work closely with local Health and Wellbeing Boards (HWBs) as they have the experience as 'place-based' planners, and the ICB will be required to have regard to the Joint Strategic Needs Assessments (JSNAs) and Joint Local Health and Wellbeing Strategies (JHWSs) produced by HWBs.

The LLR ICB and ICP will have Provider collaboratives. They are partnership arrangements involving at least two trusts. working at scale across multiple places, with a shared purpose and effective. decision-making arrangements. The collaboratives work will focus on reducing unwarranted variation and inequality in health outcomes and improving access to services and patient experience.

Purpose of this Strategy

The LLR (LLR) ICB is committed to inclusive involvement of our local population. The purpose of this strategy is to outline our ICB strategic approach to engagement including the principles that will underpin all our work.

This collaborative strategy sets out how the ICB will work with people and communities. It has been developed by partners in the health system and after discussion with stakeholders. It recognises that we are committed to discussions with key partners including upper tier local authorities (Leicester City Council, Leicestershire County Council and Rutland County and District Councils) during 2022 and early 2023, which will result in a clear definition of how organisations will work together, which currently is at a formative stage.

This Strategy responds to the views and experiences from the local population and stakeholders collected over the last 2 years and engaged on in April 2022. It brings together strategies for collaborative working across ICB partners and with communities.

ICS overview

The local NHS and councils have come together to create the LLR ICS with the purpose of helping our local population to have healthy, fulfilling lives.

Our job is to coordinate all of the resources available (including people, money, buildings, talent, volunteering, local knowledge and innovation) to better join up GP practices, community services and hospitals; physical and mental healthcare; social care and other NHS services; to give the people of LLR more seamless care.

We were formally designated as an ICS on 1 April 2021. The ICS is due to take on a statutory role from 1 July 2022.

Figure 1: LLR ICS partner organisations

More than 1.1 million people live in LLR, with an NHS workforce of 21,000 and a social care workforce of 32,000.

The people of LLR represent one of the most diverse populations in the country in terms of age, education, ethnicity, wealth, health and health needs. The proudly diverse city of Leicester has about half of its population identifying as from an ethnic minority. Leicester has the highest proportion of British Indians in the UK (28% of its population). Leicestershire is predominantly rural, but each of the seven local authorities district that it comprises of have their own distinctive characters. 70% of the population of Leicestershire live in areas classed as Urban City and Town. Even though Leicestershire is relatively affluent there are pockets of deprivation in some

neighbourhoods in Loughborough and Coalville. Rutland is also a very rural county with a population set to grow by 5% to 42,277 by 2025 (increase of 1,890 residents). Although largely affluent there are some communities known to have poorer health outcomes including the Armed Forces, the prison population, carers, people living with learning disabilities, some farming communities and children with special educational needs.

Our ICS is marked by stark health inequalities, both within LLR and when compared to the rest of England. A boy born today in the most deprived area of LLR could be expected to die up to 8.7 years earlier than a boy born in the least deprived area.

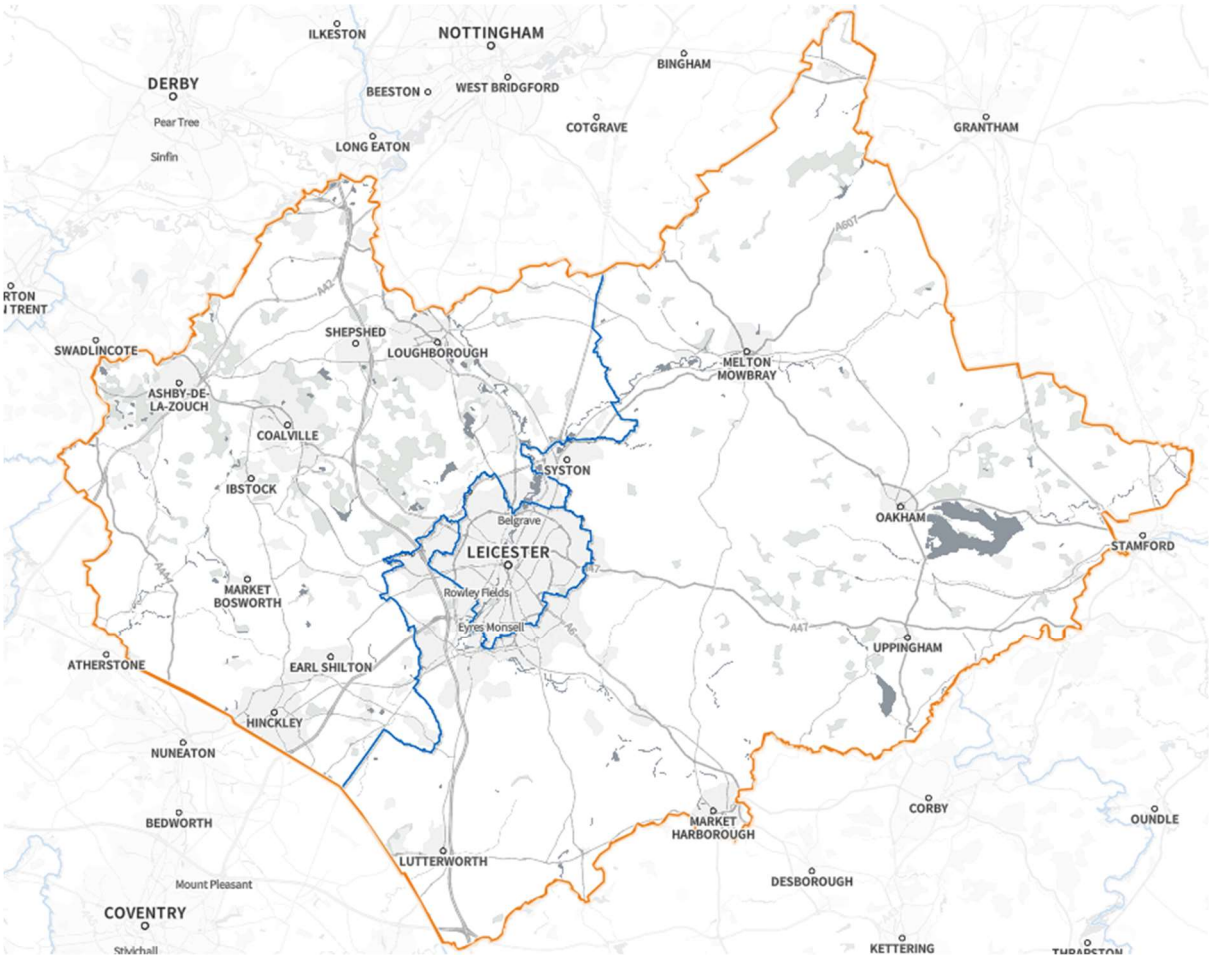


Figure 2: Area covered

Over the last two years we have maximised our care to patient, carers, service users and staff during the pandemic by working with local authorities at the city, county, district and parish authority level, driving out organisational boundaries. This has been particularly successful in tackling the inequalities agenda, where joint working has considered the wider determinants of health such as housing, education, transport, employment and environment. It has given us foundations on which to build, and the partnership approach represents the best way forward joining forces with colleagues in local authorities and collaborating even more closely. However, this strategy outlines that we are at the early stages of a shared enterprise in terms

of engagement with people and communities. We still work in two different worlds with distinct cultures and sometimes in the ‘tone of voice’ we use.

Through this strategy we will work to bring our worlds together and develop joint partnerships that result in more co-design and the improved health and wellbeing of our local communities

Working with local people and communities

This People and Communities Strategy builds on firm foundations of participation, involvement and engagement with people and communities over many years in LLR organisations – commissioners, providers and partners.

The Strategy has also been built on an inclusive learning culture. We have recognised what has worked well and what can be done better - reflected on it and implemented improvements.

We combine this strong track record with modern and effective systems of engagement that link into ICS and ICB governance systems and processes. In LLR we benefit from:

1. **A communications and engagement cell** (meets weekly) and comprises of communications and engagement professionals from health organisations. This group shares knowledge and information, and where cross-cutting solutions are needed, develops plans to reach out to communities, for example, as seen in the Covid-19 vaccination programme which targeted specific community groups.

2. **System engagement partners** (meet bi-weekly), comprising of communications and engagement professionals from health organisation meet **with Healthwatch Leicester and Leicestershire and Healthwatch Rutland** – to discuss strategy and operational issues. In addition, both Healthwatch organisations meet the LLR ICS chief executive every six weeks and sit on ICS Board.

3. We have two Healthwatch organisations across our health system – Healthwatch Leicester and Leicestershire and Healthwatch Rutland. Established following the Health and Social Care Act 2012, local Healthwatch are statutory organisations and **the local consumer champion for patients, service users and the public**, covering both health and social care.

With its network of local organisations, Healthwatch listens to what people like about services and what could be improved, and shares this insight with commissioners, providers and regulators. Healthwatch has a broad remit, covering health and social care for both children and adults. It serves the whole community, not specific groups, and provides an independent source of insight gathered outside service delivery.

It is expected that legislation will change the existing statutory duties of local Healthwatch to advise and inform CCGs so that they apply to ICSs.

In LLR we already have system-level arrangements in place with Healthwatch organisations that link them to the CCGs (to become ICB) and the ICP. We also have a history of joint working on programmes of work This includes an ICS team approach to improving mental health services which is a partnership of commissioners, Leicester Partnership NHS Trust, all local authorities and primary care. This Strategy will see those joint working arrangement continue and be enhanced particularly through initiatives like the Insights, Behaviour and Research Hub.

4. Across our key health partners we have a **dedicated engagement and patient experience workforce**. At the time of writing this strategy, we have recruited to our first joint engagement post for the ICS, where the role holder will focus their attention on engagement with children, young people and families.

5. The foundations in place for **an Insights, Behaviour and Research Hub**. The hub will be a valuable tool for enhancing services and improving the health and wellbeing of people locally. The hub will be a central point for research and inequality data. Data and insights from patients, carers and staff which helps us to understand needs will support us to develop our services to fit these needs.

The Hub will contain all public and patient involvement and experience data, insights and business intelligence from NHS and other sources. For a long time, we have collected a reach seam of insights from people, essential to design and deliver high quality services, but it has not always been used effectively in the design of services. The data will now be brought together in one place and promoted across the ICB and ICS. Staff who are designing and delivering services will be supported to both understand the insights and use them appropriately to plan health and care services in a way that truly means that people are at the heart of care. We will also work with staff to ensure that they can articulate clearly to people how their insights have shaped services.

Figure 12 shows how the hub will function. It outlines an engagement architecture for hearing from patients, public, staff and carers, as well as key organisations and groups, who provide valuable information about experiences of health and care. It also outlines the Hub partners, data retrieval system and management system, publication schemes, both with partners and the public and the feedback mechanisms.

6. Engagement being embedded into **place and neighbourhood-led plan groups and design cells**, supporting business intelligence and informing plans and decision-making.

7. A **Citizens' Panel** in place, made up of more than 1,100 people. This panel largely works online, providing a systematic approach to gathering insight and feedback on a range of health and care issues from a representative sample of our 1.1 million population. It assists in gathering the views of citizens that demographically and attitudinally are representative of the citizens of LLR.

8. A **Public and Patient Involvement Assurance Group** (PPIAG) that brings creative, fresh, objective and independent perspectives on our decision-making and is a critical friend of the NHS in relation to engagement and involvement. The group exists to gain assurance that (a) all proposals to change and improve healthcare services are developed with appropriate and sufficient public and patient involvement, and (b) that insights and business intelligence from patients, staff, carers and public that tell us what matters to them are regarded and have influenced the decision that are made.

9. **A network of Patient Participation Groups** (PPGs) In LLR (Meeting monthly - virtually) to provide key information and engage with their communities. This

network has traditionally had the ability to network on behalf of the NHS, amplifying messages to their local communities and provided insights. During the pandemic many PPGs have been less active, and work that was commencing with Primary Care Networks (PCNs) has not gathered the desired pace.

10. Leicester's Hospitals regularly **communicate via email with more than 5,500 of their public members**. Members are located across LLR and receive regular invitations to participate in events, focus groups and research as well as reviewing news from across the local NHS. Leicester's Hospitals also support two long-standing patient and community reference groups. The Trust's **Patient Partners** are members of the public with experience of hospital services. The group meets every six weeks and acts as a consultation group for staff. Patient Partners sit on a number of keyboards and committees to provide a patient perspective. Patient Partners participate in service development projects, review patient literature and also provide a patient perspective on serious incident review meetings. The Trust also has an **Equality Advisory Group**. The group meets quarterly and is comprised of representatives from across the protected characteristics identified in equalities legislation. Some services at UHL also support their own patient reference groups. Recent examples include the renal services patient group and a newly formed youth forum which has been established by the children's hospital. The various cancer services also support a number of patient groups.

The Patient Experience Team at UHL oversees the Friends and Family Test (FFT) collection process within UHL, ensuring all inpatient areas, the Emergency Department, Maternity Services and Outpatient Departments collect feedback from patients and families in line with national guidance. During 2021-22 approximately 206,000 responses were received. Methods of collection include paper forms, touch screen devices, QR codes, Web Surveys and SMS Text mobile phone feedback.

In addition to the FFT, feedback is sought and shared through patient stories, and "Message to Matron" cards. Patient Feedback Driving Excellence' is another key work stream involving support to all areas to access and interpret their Patient Experience results, and a number of reward schemes such as the Star Award for Wards and departments that most improve their positive scores and the Patient Recognition Award for staff following individual positive feedback from patients.

The Trust also has a free online programme of health talks to support people, Trust colleagues and members called Leicester's Marvellous Medicine. Hosted by a different leading medical expert each month, the programme offers an insight into medical specialties at Leicester's Hospitals and an opportunity to experience what is at the forefront of medicine in Leicester, Leicestershire and Rutland.

11. Leicestershire Partnership NHS Trust has a **People's Council**, an advisory body for the trust board, made up of individuals with a lived experience of receiving healthcare from the trust, patient and carer leaders, and representatives from the voluntary and community sector. The Trust also has an involvement **network of 140 patients and carers** who are working with the Trust in the design and delivery of its services. Work is underway to develop a Lived Experience Framework which will establish a lived experience workforce with capability in improvement methodology. This alongside trust-wide systems and processes will allow for the creation of paid

opportunities for those with lived experience whilst developing skills and experience, which may in turn support them to return to full time paid employment. LPT also has a **membership database of our 2,500 public members** from across LLR who have signed up to receive regular information, news and involvement opportunities within the Trust. These are managed through a specific paid database and receive regular news and invitations to LPT events including the annual general meeting. In addition, LPT has a **Youth Advisory Board,** which is jointly managed by the city council, with the aim of involving young people in service improvements, testing out ideas and codesigning solutions specifically targeted at young people. There are also around **500 volunteers** at LPT who offer insight and a patient voice. An enhanced volunteer voice initiative is also being developed. In addition, LPT has a network of community groups and corporate partners who with the LPT **charity – 'Raising Health'** have influence into the local population. Ten voluntary sector agencies have received specific funding to support community health and wellbeing through outreach initiatives from National Charities Together – managed jointly by UHL, LPT and EMAS.

12. A genuine **partnership arrangement with the voluntary and community sector, social enterprises and individual communities, initially with NHS and overtime across all partners**. We have started discussions with the sector and communities about establishing a new way of working of involving people in decision about designing and providing services. We want to move beyond a system of merely contracting in support as and when needed to a basis where we attempt to find solutions to issues on an ongoing mutual basis that is commissioned and financial recompensed with consideration of sustainability. This will build on the relationships and alliances that we have already established through recent public consultations.

We recognise that concurrent to these conversations, additional financial resources have come into our health system during late 2021 and early 2022 to support the voluntary, community and social enterprise sector, particularly supporting mental health care including the Getting Help in Neighbourhoods initiative which aims to and tackle health inequalities. We need to be mindful of the impact this may have to ensure that it doesn't put due strain on the sector, cause confusion or create duplication.

13. Having undertaken **significant work over the last 18 months** to engage with our population. Key projects have seen qualitative information gained from nearly 22,000 people including patients, service users, staff and carers, including work with communities including those with protected characteristics. Engagement has included Building Better Hospitals for the Future (5,675 people), Step Up to Great Mental Health (6,650 people), Covid 19-hesitancy engagement (4,094 people) and primary care survey (5,483 people).

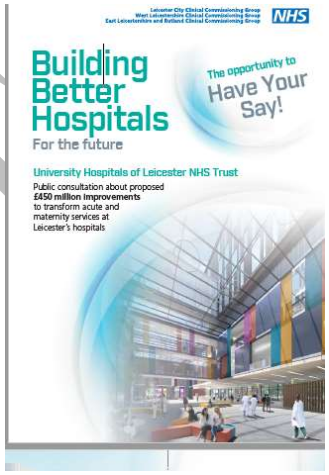
14. **Digital methods of engagement in the NHS have increased significantly** during the pandemic. Investment in digital involvement across all NHS partners has been created to mirror new ways of living and working. Whilst some audiences are not digitally enabled, the vast majority have moved to a digital world. How long this behaviour will continue is unclear, but we do know there will be no return to the old ways of engaging and at the very least face-to-face engagement will need to sit

alongside digital but digital interaction surpassed it. Peoples' expectations for what constitutes "basic" digital capabilities have shifted permanently, and the ICS will be expected to support digital enablement. Convenience and ease will become key drivers, likely leaving face-to-face activities for specific and niche programmes of work.

15. There are examples of joint working between the NHS and upper tier local authorities, districts and parish councils. The response to the pandemic and particularly tackling health equalities brought partners together to work jointly. The LLR Local Resilience Forum, bringing wider organisations together is another instance of organisations working in partnership.

Engagement case study one

The Building Better Hospitals public consultation, which ran from September to December 2020, was hugely successful in attracting more than 5,000 responses and becoming shortlisted for a HSJ Award in the 'communications initiative of the year' category.



The consultation on £450 million proposals to transform local hospitals in LLR reached a staggering 1.8 million people. It was held during the Covid-19 pandemic which led to many traditional forms of face-to-face engagement being replaced by cutting edge, multi-channel, real time online techniques. The consultation findings are critical in shaping the future of acute and maternity services in LLR.

With innovation central to our approach and an energised and committed team in place (with clinical and non-clinical members of staff), our engagement figures were staggering – 971,657 digital media engagements, 853,048 print and broadcast media reach, 4,960 through online event promotion, 1,049 stakeholders (including MPs, councillors, voluntary sector organisations) and 25,000 staff engaged with.

Where face-to-face engagement was legally possible this was utilised, but we knew we had to rely more on utilising the latest in online techniques – paid, earned, owned and shared digital and social media, using channels such as Microsoft Teams, Facebook Live and smart TV advertising.

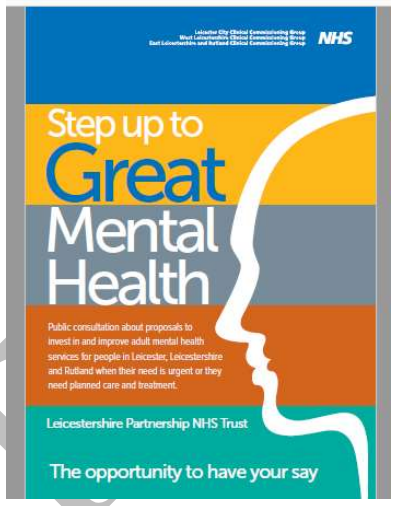
We set up an adaptive strategy, with demographic response analysis happening on a real time basis, so we could continually reach out to communities that were at that time seen as being under-represented. We recognise that not all communities are digitally-enabled, so we partnered up with local voluntary and community sector organisations to use their networks to get messages out and increase response rates. And yet, despite all this progress in new approaches and techniques, there was still a place for publicity postcards in community village shop windows.

Our ambition was that we wanted to give every adult in LLR every conceivable opportunity to take part and have their say, getting to the heart of all our local

communities. Everything we heard fed directly into the Report of Findings and the Decision-Making Business Case. We also used the insights to develop a set of principles which we would adhere in the implementation of the plans.

Engagement case study two

Our Step up to Great Mental Health public consultation, which closed in August 2021, covered a range of services largely provided by Leicestershire Partnership Trust. The consultation received 6,650 responses from across the community – with a final report expected to be received by November 2021.



We asked people about proposals to invest in and improve adult mental health services for people in LLR when their need is urgent, or they need planned care and treatment. This included proposals for building self-help guidance and support, introducing a central access point, expanding and strengthening the role of crisis cafes, improving and expanding the crisis service, and expanding the hours and the use of the triage car.

We used a multi-channel approach, both online and offline tools and techniques. Among the many different activities carried out, we built on our previous work and commissioned 40 voluntary and community organisations to reach out to seldom heard and often overlooked communities, gained extensive media coverage, placed newspaper, TV and radio adverts, used social media to reach more than two million people, held 70 online events and had 74 events hosted by voluntary and community groups. In other areas, we carried out email marketing to schools, engaged local business HR professionals, engaged with sports clubs, hairdressers and beauty clinics.

The insights from this engagement were captured in the consultation's Decision-Making Business Case and its Equality Impact Assessment. Both reports noted the huge success of the stakeholder engagement and the need for this to continue so that we 'co-design' the improvements that are planned under the transformation of mental health services. This will result in the voluntary and community sector partners being brought into the new governance arrangements for 'Better Mental Health for All', the new name for the transformation of mental health services across LLR.

Legislation and guidance

The ICS Design Framework (2021) sets the expectation that ICS partners should agree how they listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

The ICS implementation guidance on working with people and communities (2021) sets out how ICSs should have a deep understanding of their communities, using these to tackle health inequalities, and taking the opportunity to strengthen existing work and build stronger relationships. The guidance also outlines that **ICBs are expected to develop a system-wide strategy** for engaging with people and communities by July 2022, using the 10 principles in this document as a starting point.

Gathering insights from our diverse population about their experiences of care and understanding what matters most to them is a key component of an effective and high performing ICS to ensure equality of access. There is a clear expectation in the guidance that this will be implemented in a range of ways, including embedding co-productive purposes.

"*The parties in an ICS, including those of the NHS Partnership, the NHS ICS Body and place-based partnerships, will be expected to agree how to listen consistent, to, and collectively act on, the experience and aspirations of people and communities*".

The creation of statutory ICS arrangements will bring new opportunities in how we work with people and communities, that build on existing work, networks and relationships.

This strategy has considered the guidance. It also takes account of the range of legislation that relates to involvement and decision making including:

1. Section 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012 (current guidance)
2. Brown and Gunning Principles
3. Human Rights Act 1998
4. NHS Act 2006
5. NHS Constitution
6. Communities Board Principles for Consultation

The LLR ICB, once formed, is subject to legal duties to give due regard or regard to addressing health inequalities and advancing equality of opportunity. These separate duties are the Public Sector Equality Duty (PSED), section 149 (1) of the Equality Act 2010 and the health inequalities duties set out as section 13G of the National Health Service Act 2006 as amended.

An Equality and Health Inequalities Impact Assessment (EHIA) has been produced and explains how the LLR ICB has considered and addressed these 'equality duties'

in developing this People and Communities Strategy. The EHIA has assisted partners to make informed decisions about the Strategy and these legal obligations.

In developing this strategy, we have also followed guidance produced by NHS England and NHS Improvement – *Strategic content guide for Integrated Care Boards – working with people and communities (November 2021 draft).* We have also paid due regard and consciously considered the equality duty: eliminate discrimination, advance equality of opportunity and foster good relations.

Our engagement vision

The purpose of this strategy is to outline the LLR ICB strategic approach to involving people and communities in setting the priorities for the local health system and ensuring the voice of the local population influences all decision-making.

The strategy will act as a blueprint for collaborative working with ICS partners. We understand the values, aims and objectives of each partner, and recognise our commonality. But, while recognising that working together, we prove stronger and more effective, we have also appreciated that individual organisations have key requirements placed on them that they have a duty to deliver. It is worth noting here that this is the involvement and engagement strategy of the ICB and that individual organisations such as Leicestershire Partnership NHS Trust and University Hospitals of Leicester NHS Trust will also have their own complementary organisational strategies.

Principles of engagement

The principles that underpin this strategy and our subsequent action plan include the ten national principles for how ICSs should work with people and communities, as shown below:

1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.	6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
2. Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.	7. Use community development approaches that empower people and communities, making connections to social action.
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.	8. Use co-production, insight and engagement to achieve accountable health and care services.
4. Build relationships with excluded groups, especially those affected by inequalities.	9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.
5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.	10. Learn from what works and build on the assets of all ICS partners - networks, relationships, activity in local places.

Figure 3: Ten national ICS principles for engagement

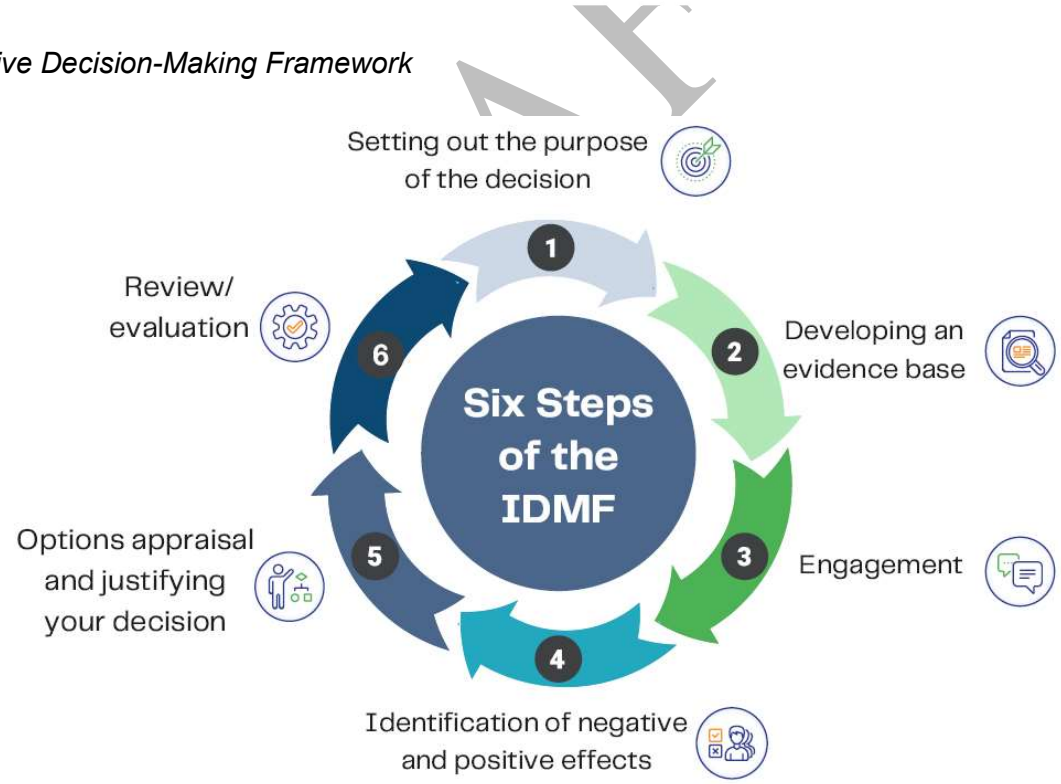
In addition to the ten national principles, we are adding the following additional principles at a local level:

The 5 local principles

Five local principles for how ICS work with people and communities

- Build on the engagement capability and capacity in our workforce and empower our 21,000 members of staff – as the NHS or social care family, service users/patients, community members and carers, to make connections to social change
- Embed business intelligence and insights from people and communities into the heart of the ICS, ensuring that at all levels of decision making and implementation they are a valued asset, used to improve experiences and enhance the health and wellbeing of our population
- Harness the power of Equality Impact Assessments to support the eradication of health inequalities. To help embed equality considerations (including health inequalities) within decision-making, we will use the six steps approach of the LLR Inclusive Decision -Making Framework.
- Build relationships with children, young people, families and groups that represent them ensuring that they have a voice in decision making across health and care.
- Build stronger relationships with family carers and groups that represent them ensuring that they can share their experiences of care and drive improvements across health and care.

Inclusive Decision-Making Framework



Our engagement approaches

Public involvement is not about a single methodology - it is a continuum of different methods and approaches – as show in the 'ladder of engagement and participation' illustration below.

Figure 4: The ladder of engagement and participation

The LLR ICB wants to build on all our engagement work, particularly activities developed over the past 18 months, and aspires to develop deeper and stronger relationships using more of the activity at the top of the ladder. It is important to note that when the ladder is applied to different programmes of work, that the level of interest and power of individuals and communities involved will mean that they will move to different points on the ladder

We recognise that when we use the word 'community', this conjures up different meanings for people. Our work will take appreciation of this and recognises that a community could be a social group whose members have something in common e.g. geographic location, work, culture, sense of identity or heritage. We also now that community could be where people live which could be a town, city village or other geography boundaries. It could be that a group shares some trait, common interest or quality that separate them from the wider population.

These communities are often already strong and resilient networks. It is our desire to work with these communities, rather than impose on them. We recognise that this could be directly or through leaders of these established communities or through local authorities or voluntary, community and social enterprises.

In developing system-wide research and insight projects, partners have committed to base their approach to public, community or patient involvement and patient

experience predicated on the e-cycle, shown below, which allows for involvement at every stage of the commissioning and planning cycle.

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Figure 5: The e-cycle of engagement

Moving from theory (the 'ladder') to practice, LLR ICB benefits from an established system architecture for engagement, as shown in Figure 6. This sets out the forums and processes for an engagement loop within the system.

All insights gathered from people through a range of mechanisms shown in the e-cycle would be consolidated into an Insights, Behaviour and Research Hub (explained later in this document). Work undertaken and the insights gathers would be assured by the Public and Patient Involvement Assurance Group (a group of patients/public). The insights would then be shared across all decision making, collaboratives and deliver groups to inform plans and services. Decision making would then feedback to the public on how their insights had influences the healthcare services – 'you said, we did'.

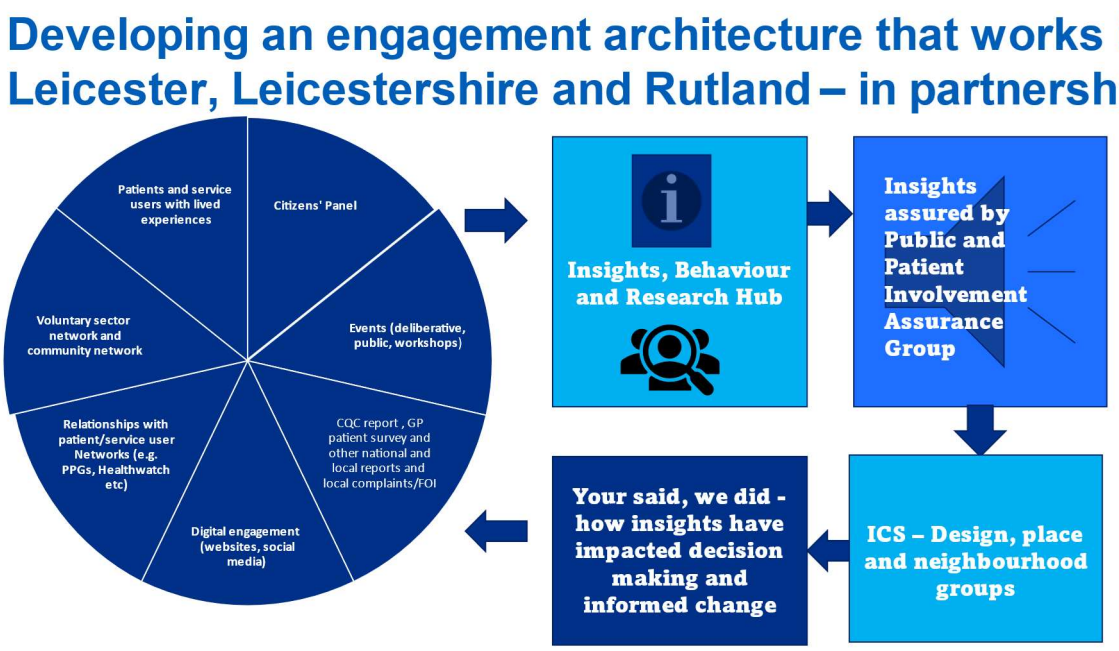


Figure 6: Engagement system architecture in LLR

We are committed to investing sufficient time and attention to all forms of engagement. We know that since the pandemic that digital engagement has increased considerably. But we also know that while for some it may be a preferred method of interaction, particularly young people, many other people want to be assured that more traditional engagement channels will continue to be used. In addition, some people may want the interaction to be with someone they trust and recognise as 'like them' a member of their community. Therefore, our engagement architecture responds to this by offering multiple ways of engaging both directly and indirectly.

Priorities and action planning (2022-24)

This strategy sets the direction for engagement within the LLR ICB. Detailed action plans will be drawn up to sit alongside this strategy, guiding implementation. At this stage, we are setting out our priorities that the system will be taking forward. Some initiatives are already in place, some will need to be launched in support of the strategy.

Priorities in detail

The table below elaborates on the priority actions. Each priority will have strategic leadership, but the operational ownership will reside with all partners who have the collective responsibility to deliver. A delivery plan will be developed jointly by partners for each priority action.

Priority action	Strategic Lead organisation / individual	From/to dates
1. Build on the engagement capability and capacity in our workforce and **empower our 21,000 members of staff**. They are part of the NHS family, they are service users, friends, neighbours and part of communities and possibly carers and as such have considerable insights. We will develop plans to train staff to share insights, which will integrate into the Insights, Behaviour and	Joint leadership across ICB, UHL and LPT	July 2022 – July 2023

Research Hub to inform decisions and also embed work into existing quality improvements frameworks		
2. **Develop further the Insights, Behaviour and Research Hub (see Figure 11)** and our capacity and capability to interrogate high quality data to provide robust business intelligence that allows excellence in decision-making across the ICS. Maintain a high standard of data that is trusted and not devalued by poor research models. Promote the data and business intelligence across all ICS partners and ensure that it impacts on all decision making. Overtime explore with Healthwatch, local authorities and public health their role in further development of the Hub.	ICB	December 2021 – December 2022
3. Review governance architecture for engagement, mapping key stakeholder groups, in light of new system structure and degree of commonality on priorities to ensure it is fit for purpose.	ICB (formerly CCGs)	July – August 2022
4. **Promote more widely the existence of business intelligence** and stimulate its use by educating teams on how to use it to improve the health and wellbeing of our population.	Joint leadership across ICB, UHL and LPT	July – December 2022
5. **Create a customer relationship management system** that brings our stakeholder data together to provide better knowledge of stakeholders and partners. But particularly to improve communications across key health partners to ensure that messages are not duplicated or inconsistent and there are no gaps. This piece of work *does not* include our various patient memberships and panels as each partner will still have the requirement to maintain their own engagement specific to their organisation.	LPT	Project start in June - September 2022
6. Develop strong and **mutually beneficial relationships with the [1]voluntary and community sector, social enterprises, individual communities and the volunteering infrastructure (see figure 10)** to tackle health	ICB (formerly CCGs) and LPT	December 2021 – September 2022

[1] Voluntary and community sector, social enterprises and communities includes a very diverse range of organisations including some or all of the following components: voluntary organisations, community groups, tenants and residents groups, faith groups, housing associations, most co-operatives and social enterprises (provided profits are retained for the benefit of the members or community served), most sports organisations.

inequalities and empower communities. Firstly, we need to scope out and understand the breadth of organisations working as formal voluntary and community sector organisations or social enterprises, as well as informal community group across LLR, from the largest to the smallest bodies. Secondly, we want to develop a cascade alliance model - the ICB will develop alliances with voluntary sector organisations, social enterprises and communities which then, in turn, will form their own alliances to widen ICB reach and reach into the ICS.		
7. Leverage lived experiences and business intelligence through potentially developing a number of paid employment roles. These roles would act as **ambassadors for embedding business intelligence** to ensure it influences all decision-making. This will be a blueprint for the system to consider. Alongside this, reignite expert patient panels to support self-care and prevention.	LPT	October 2021 – July 2022
8. Ensure all projects are informed by the production of an **Equality Impact Assessments** [2]and they harness the power of the assessment to drive out inequalities, including any engagement or consultation plans. This to be combined with rigorous use of the LLR Inclusive Decision-Making Framework.	Joint leadership across ICB, UHL and LPT	From July 2022 and ongoing
9. **Share knowledge and learning across engagement teams** within the ICB to ensure continued innovation and design a development programme for 'leaders' and staff highlighting the importance of involvement and business intelligence.	Joint leadership across ICB, UHL and LPT	From July 2022 and ongoing
10. Understand the current membership of the Citizens' Panel and **Grow the Citizens' Panel**, increasing membership to ensure that it is statistically representative of the LLR population, in particular, of young people (18 to 24-year-olds) and family carers. Develop a benefits package to health and wellbeing to support the retention of members	ICB (formerly CCGs)	March 2022 - ongoing

[2] An equality impact assessment (EIA) is an evidence-based approach designed to help organisations ensure that their policies, practices, events and decision-making processes are fair and do not present barriers to participation or disadvantage any protected groups from participation. In programme design where engagement and or/consultation is undertaken it is useful to do an EIA before and after involving the public to demonstrate how insights have impacted on decisions.

and develop a self-care asset. Explore and enhance access options to the Citizens' Panel through different devises. Liaise with our various engagement groups including voluntary groups and the PPGs across LLR to understand how we best develop the Citizens' Panel.		
11. Work with the ICB to enable partners to move away from compartmentalised engagement and involvement to **system co-design**, outlining a systematic process to ensure that it is embedded into our ways of working across the ICS and that the process of involving people starts at a formative stage on all programmes of work. (This does not remove the need for engagement at the level of a single organisation where a topic is specific to that organisation). We have established clear definitions for co-design and co-production as part of this process, so everyone has the same understanding. The following section sets out our definitions for these key terms.		Development starts January 2023 to March 2023
12. **Create a primary care engagement framework** (see figure 12) which outlines how, at ICB, primary care networks and GP practice levels, will work with and involve people and communities to co-deliver the best possible health and wellbeing outcomes.	ICB (formerly CCGs)	March - December 2022
13. Develop plans for the **systematic and effective delivery of engagement activities and public consultation**, ensuring that legal requirements are adhered to and the views of our communities, including those with protected characteristics, the vulnerable, those living in areas of deprivation and those living across our borders, but dependent on services, are sought using multiple engagement techniques and methods and that their views influence decision making.	Lead dependent on project	Timeline appropriate to project
14. **Support the development of place and neighbourhood-based plans** by working in partnership with local authorities at a county, city, district, town and parish level to reach communities to ensure that we hear from and involve people in developing solutions to issues and break down barriers.	ICB (formerly CCGs)	Timeline appropriate to project

15. Support the development of a **framework for engaging with families, carers and children, young people and families,** ensuring that they have a voice and their views influence decision making across health and care.	ICB (formerly CCGs)	May – December 2022
16. Continue to digitally (engagement) innovate enhancing our capabilities to engage and develop relationships with people and groups by improving and **making the digital experience with the NHS more human and interactive.**		From May 2022
17. Work with decision makers and programme leads to ensure that post-decision making that the impact that **insights and business intelligence have made on programmes are clearly fed back to the public without exception** – to ensure a 'you said, we did' culture across the ICB.	ICB (formerly CCGs)	From May 2022

Key definitions

Considerable work has been undertaken nationally to develop definitions for both co-design, co-production and co-delivery. The terms of often confused and used interchangeably along with involvement, engagement and consultation. We define them here to distinguish them.

In the next two years this Strategy commits us to move to **creating a culture of co-designing, adopting and embedding this approach in all that we do**. We recognise that this is ambitious. It is only once this initial step is taken that we can move to co-production and then co-delivery. We see this as a longer-term strategy.

Co-design

We can define co-design as the:

"Effective engagement of people and communities to help get services right for them. This goes beyond basic stakeholder consultation to encourage joint working, aiming to create solutions. It is the engagement of people in decisions about the buying, planning, design and reconfiguration of health services, proactively as design partners."

Co-production

NHS England, NHS Improvement and the Coalition for Personalised Care define co-production as:

"A way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.

"Co-production acknowledges that people with 'lived experience' of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives. Done well, co-production helps to ground discussions in reality, and to maintain a person-centred perspective.

"Co-production is part of a range of approaches that includes citizen involvement, participation, engagement and consultation. It is a cornerstone of self-care, of person-centred care and of health-coaching approaches."

The co-production model outlines five values and seven steps to making co-production happen (set out below).

For co-production to become part of the way we work, an organisation has to create a culture where the following values and behaviours are the norm:

Figure 7: Values required to achieve co-production

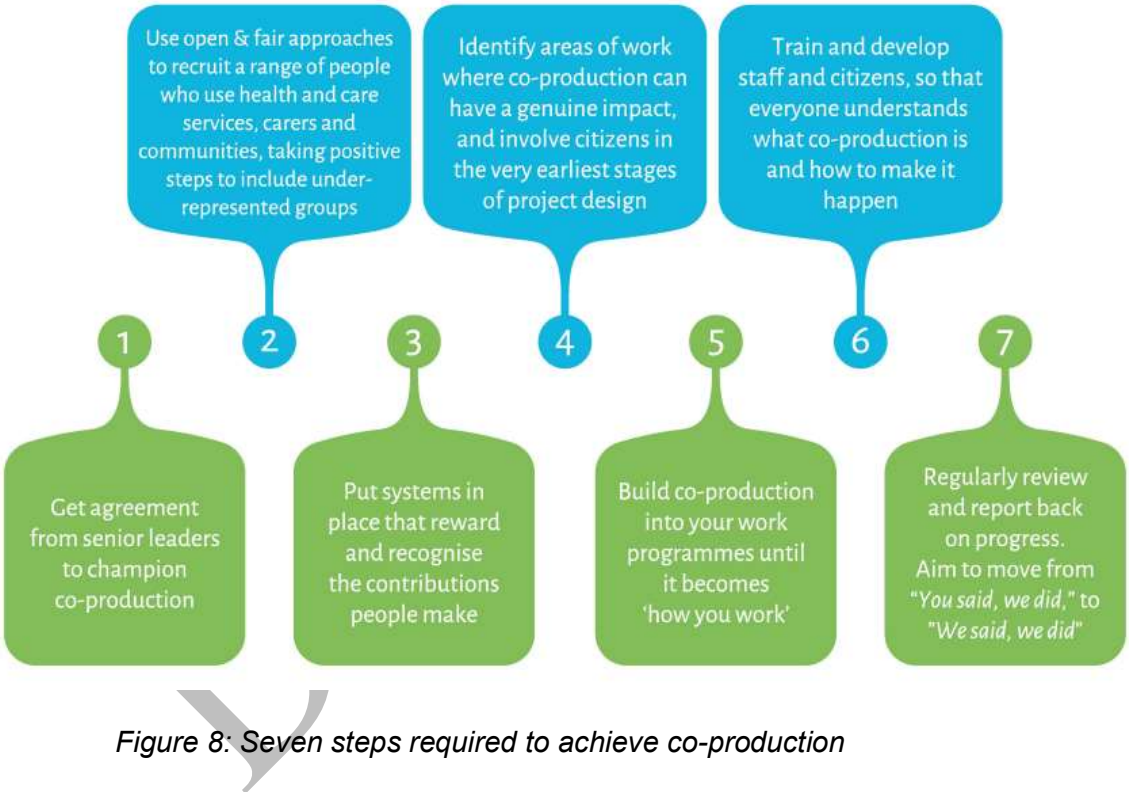


Figure 8: Seven steps required to achieve co-production

Co-delivery

We can define co-delivery as the:

"Development and recruitment of individuals with lived experience to work in a range of paid/volunteer roles within services and the system to support patients and carers, leadership and delivery of services."

Public involvement roadmap

Our roadmap for aims and activities in 2022-23 and 2023-24.

Governance roles, responsibilities, and resources

Often patient and public engagement or service user experience can feel like a last-minute thought or an add-on rather than being at the heart of health and care organisations. We will place the voice and experience of people and communities in LLR at the heart of the work of the ICB and ICS and as a golden thread through the governance structure. This will help the system and all partners to understand what people need, what is working, what can be improved and how they can work together to deliver what matters to the people they serve.

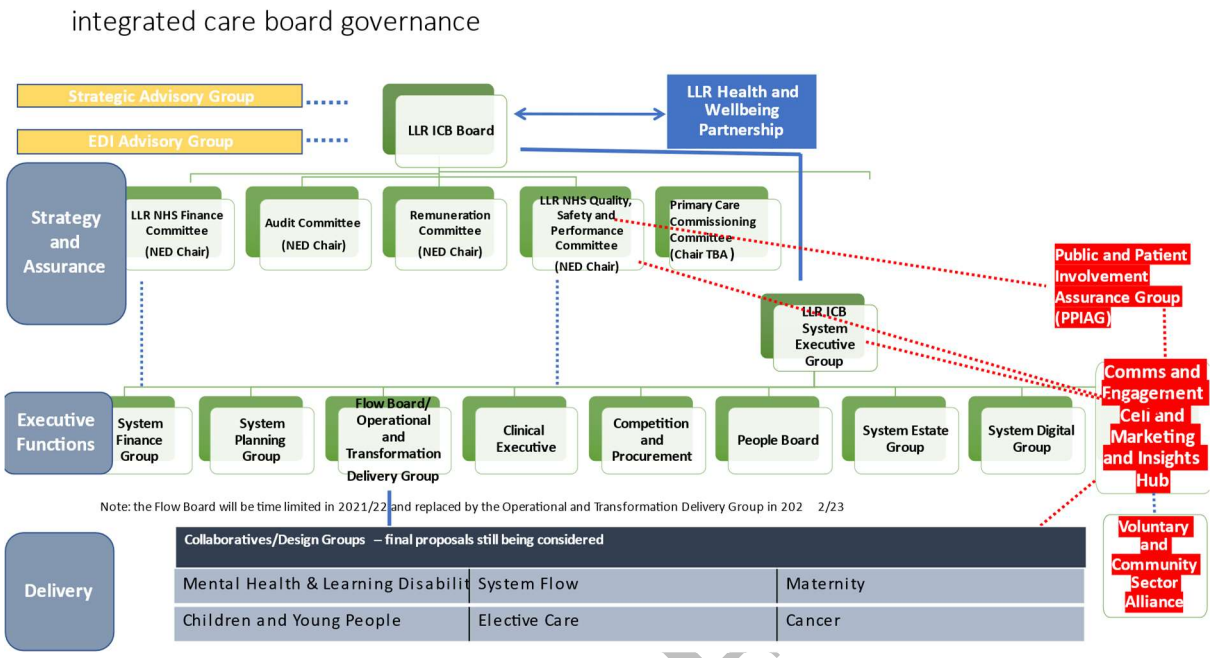
Figure 9 below, shows the key governance points for the public voice to integrate into the ICS. It is important that at all stages we can demonstrate clearly that we have created a culture in which listening to people and communities is valued and influences decision.

At the Strategy and Assurance level, the Quality, Safety and Performance Committee can be advised of and act on evidenced based insights and business intelligence, of the experiences of people into the delivery of safe, high quality and compassionate care by local health and care providers. It is this committee that then provides assurance to the LLR ICB Board.

In addition, it will be the role of the Public and Patient Involvement Assurance Group (PPIAG) to assure the system that appropriate engagement and involvement has been undertaken across all communities yielding high quality insights, which are impacting on decision making.

At Executive Level the Communications and Engagement Cell will drive insights and business intelligence through the Delivery Groups, strategy and assurance and executive functions. Business intelligence will be managed through the Insights, Behaviour and Research Hub and Voluntary and Community Sector Alliance, both of which are explained later in this section.

Figure 9



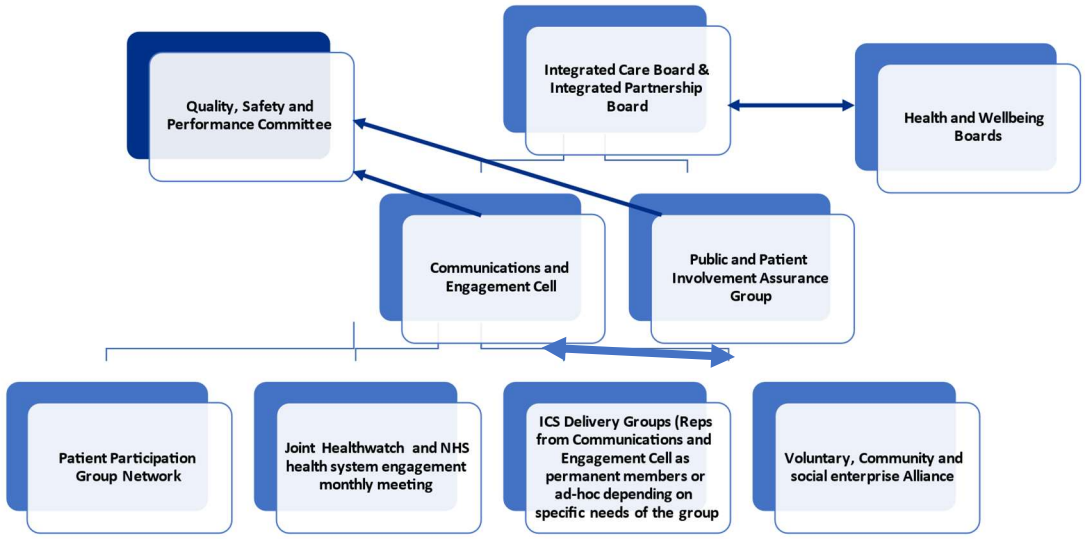
NB – the final governance chart currently being finalised

Each partner organisation will also use their own current governance and assurance structures to feed in the work of the wider ICS alongside their organisational activities at the different levels. This will ensure multiple points of entry. However, to ensure clarity and consistency and to avoid duplication the Communications and Engagement Cell and Insights, Behaviour and Research Hub will be the central points for all ICB activities to be logged and discussed. Overtime and with further discussion with ICS partners this central point may expand or have defined links to system partner insights.

Figure 10 below shows the second-tier governance for engagement and involvement, as it looks currently. It shows new groups being introduced to implement some our priorities that are more advanced in their development. Going forward, as we implement our priority to review our architecture, the structure below is likely to change.

Figure 10

Second tier governance for engagement and involvement



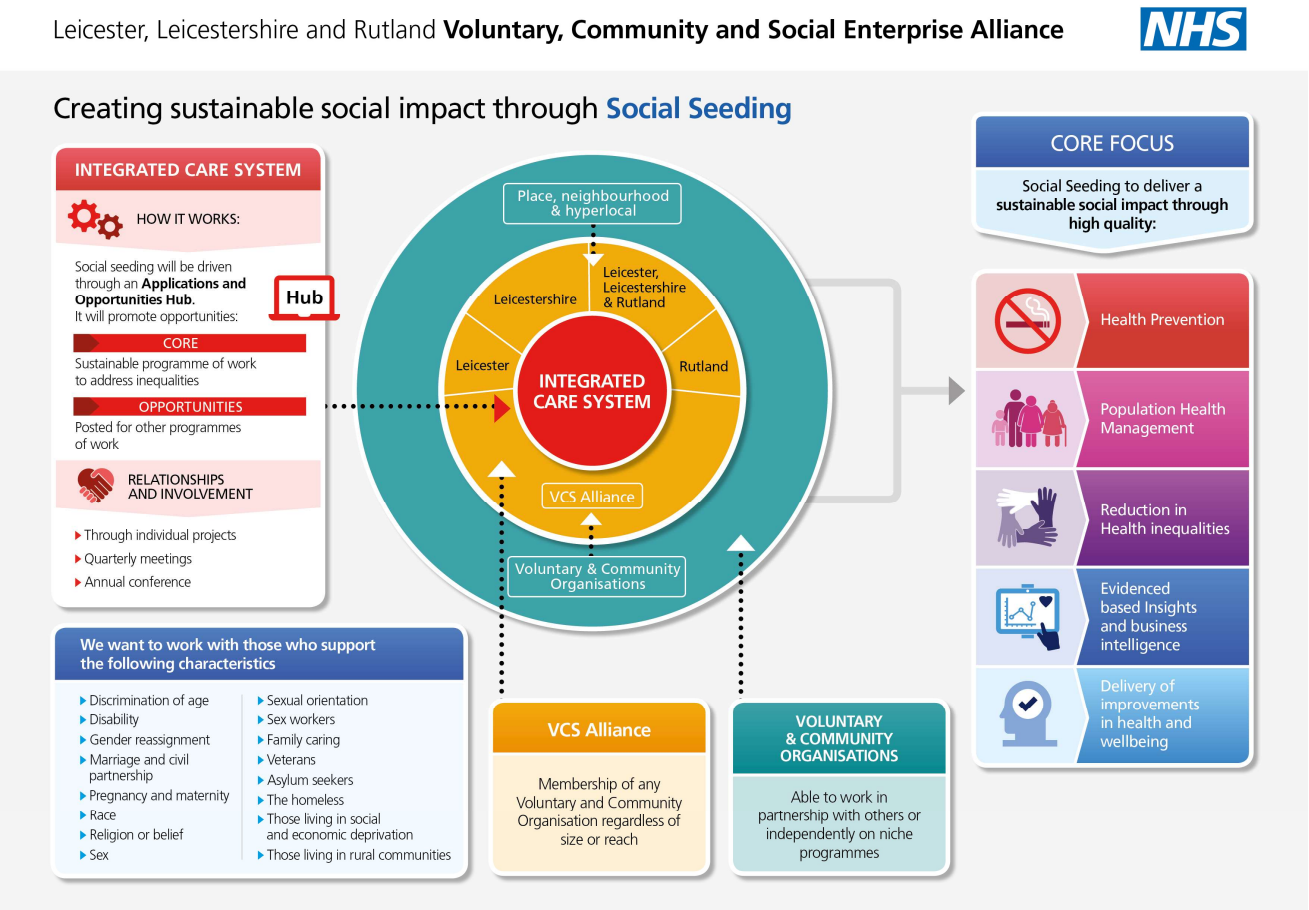
Creating sustainable social impact through Social Seeding

Voluntary, Community and Social Enterprise (VCSE) contribute to shaping, improving and delivering healthcare services. They also support the development and implementation of plans that tackle the wider determinants of health.

Figure 11 shows a model of how we will effectively include this diverse and creative sector in the emerging ICS in LLR, through an Alliance created supported by Social Seeding resources. This will ensure it influences decision making, whilst remaining resilient and an effective part of the wider system.

Social Seeding has a number of definitions across a range of sectors. In this instance, Social Seeding is the process of bringing together a carefully selected group who it is felt will maximise the effectiveness of a programme or programmes of work to improve the health and wellbeing of people in LLR. This work would be financially recompensed recognising that the sector needs to maintain financial resilience through longer term income sources.

Figure 11


Leicester, Leicestershire and Rutland **Voluntary, Community and Social Enterprise Alliance**
NHS
Creating sustainable social impact through Social Seeding
INTEGRATED CARE SYSTEM
HOW IT WORKS:
Social seeding will be driven through an **Applications and Opportunities Hub**. It will promote opportunities:
Hub
CORE
Sustainable programme of work to address inequalities
OPPORTUNITIES
Posted for other programmes of work
RELATIONSHIPS AND INVOLVEMENT
Through individual projects
Quarterly meetings
Annual conference
Place, neighbourhood & hyperlocal
Leicestershire
Leicester, Leicestershire & Rutland
Leicester
INTEGRATED CARE SYSTEM
Rutland
VCS Alliance
Voluntary & Community Organisations
CORE FOCUS
Social Seeding to deliver a **sustainable social impact through high quality:**
Health Prevention
Population Health Management
Reduction in Health inequalities
Evidenced based Insights and business intelligence
Delivery of improvements in health and wellbeing
We want to work with those who support the following characteristics
Discrimination of age
Disability
Gender reassignment
Marriage and civil partnership
Pregnancy and maternity
Race
Religion or belief
Sex
Sexual orientation
Sex workers
Family caring
Veterans
Asylum seekers
The homeless
Those living in social and economic deprivation
Those living in rural communities
VCS Alliance
Membership of any Voluntary and Community Organisation regardless of size or reach
VOLUNTARY & COMMUNITY ORGANISATIONS
Able to work in partnership with others or independently on niche programmes

Approach to reviewing engagement activity and impact, for continuous improvement

Too often data drawn from patient, carer and service user experience is not given as much importance as other operational data such as admissions to A&E or waiting times. Placing people's voices on an equal footing with other key operational data, creating population health management business intelligence, demonstrates both its importance and how it can add understanding and meaning to other data and information collected rather than being treated separately.

In addition, when designing, commissioning and implementing services it is important that the approach used is built around the idea that if we listen to and deeply understand people's experiences, we will design and implement better, more person-centred services that delivery better care for people in LLR.

Over the last 5 years there has been a history of engagement and involvement with a range of stakeholders. Public and patient participation has been refined over time with the NHS and local authorities doing more work to understand the needs of the local population in partnership and sharing the insights, learning and business intelligence to inform design and delivery of care.

We are moving to the term of 'business intelligence' [3]to describe insights about healthcare to enhance the standing it has against all other data and make decisions truly patient-centred. We are bringing all this business intelligence together into an Insights, Behaviour and Research Hub. The hub would contain raw data and Reports of the Findings produced by NHS bodies and other local organisations including Healthwatch Leicester and Leicestershire and Healthwatch Rutland. The Reports of Findings from just the last eighteen months alone total insights from 22,000 people, including staff, patients, carers and public. Combined with data pre-Covid-19, the Hub will provide a rich understanding of what people want from local NHS services now and in the future including our most vulnerable groups. The Insights, Behaviour and Research Hub will fully with General Data Protection Regulations (GDPR) in recognition that we are the guardians of health and care data and have a duty to ensure that data is handled securely and in line with the regulations.

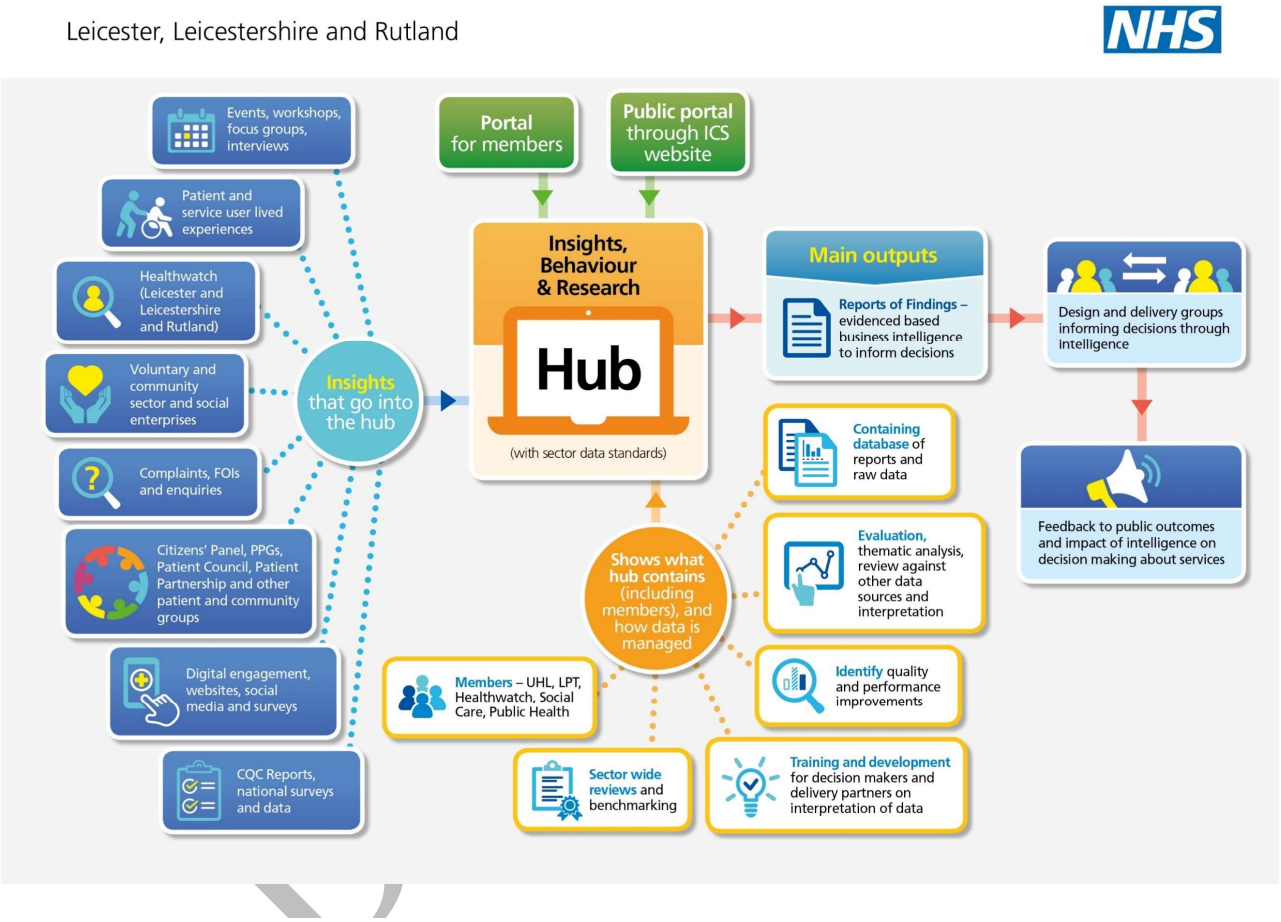
Figure 12 shows how the hub will function. It outlines an engagement architecture for hearing from patients, public, staff and carers, as well as key organisations and groups, who provide valuable information about experiences of health and care. It also outlines the Hub partners, data retrieval system and management system, publication schemes, both with partners and the public and the feedback mechanisms.

A key factor of the Hub will be staffing. A professional market research resource was brought into the LLR CCGs early in 2021 on a temporary basis. This experienced member of staff has proved invaluable in supporting the evaluation of

[3] Business intelligence (BI) combines business analytics, data mining, data visualisation, data tools and infrastructure, and best practices to help organisations to make more data-driven decisions for us these means patient-centred decisions.

insights and undertaking thematic analysis and reviewing different data sources. The business intelligence and health management data produced has impacted on many programmes of work including Covid-19 and Mental health and has influenced service changes and system transformation programmes.

Figure 12



Having good analysis is just one key area that we wish to develop further. However, the ability to interpret business intelligence and to use the information effectively is an essential element in any learning health care system. Analysis can help shape care for individual patients as well as informing decisions for services or across organisations and health systems. We will support ICB and ICS teams and delivery groups to interpret and utilise the data in planning and decision-making processes.

We will also improve the system for feeding back to people and communities, so that they can see how their voice has impacted on services. This is a key element to complete the 360-degree e-cycle of engagement and needs to be consistent across the ICB and ICS and the individual groups that form the governance. We will work with delivery groups to identify the impact of intelligence and articulate clearly, the difference it has made. This information will be added to the public facing section of the Insights, Behaviour and Research Hub on the ICB website and ICS website and people will be informed through mechanisms including the Citizens' Panel, the Voluntary and Community Sector Alliance, People's Council, Youth Advisory Board, Patient Partners and PPGs and LPT and UHL members.

Joint working

This strategy shows joint working across UHL, LPT and the ICB (currently the LLR CCGs) on programmes of work where there is a common interest and added value for organisations and patients. The Alliance with the voluntary sector, communities and social enterprise would also bring clarity and consistency of approach to this important sector. There are also financial savings by developing joint systems and processes that reduce duplication including the Hub and the Customer Relationship Management System.

The strategy also shows opportunities for partnerships, where appropriate. This is particularly apparent through the Insights, Behaviour and Research Hub which would have the potential for bringing together insights and data from local authorities and Healthwatch organisations, ensuring this is firmly embedded.

Joint work with patients, carers, practices and Primary Care Networks is vital to develop the primary care engagement framework. The framework would ensure that PPGs are revitalised and linked into their GP practice, their Primary Care Network and the ICB. Figure 12 shows a framework for working with and involving people and communities at all three levels to ensure the best possible health and wellbeing outcomes through primary care.

Figure 13

Monitoring and evaluation

The monitoring and performance of this strategy will be undertaken through the following groups:

1. The Communications and Engagement Cell who will be responsible for producing and delivering the individual plans for each of the 16 priority actions identified in this strategy.
2. The Quality and Performance Improvement Assurance Committee through Quarterly Reports who in turn provides assurance to the LLR ICB Board.
3. The Public and Patient Involvement Assurance Group, meeting monthly, reporting to the LLR ICB Board through the Chair.

The following evidence of delivery will be provided:

1. Patient, carer and public engagement activities and outputs report into the progress on delivery of the 16 priority actions and the plans produced to achieve the overall objectives.
2. Report of Findings from all market research showing public experiences and views
3. Shared learning from both positive and negative patient experiences and high impact actions needed to improve services
4. Demonstration of how patient experience and staff satisfaction correlates.
5. Compliance with equality duties, through Equality Impact Assessments.
6. Compliance with statutory and legal duties through Report of Findings.
7. Quarterly review of qualitative and quantitative feedback about patient experience and engagement across the ICB and ICS with a summary of what is going well, and lessons learned.
8. Priority plans to demonstrate how insights have impacted change – 'you said, we did'.
9. Annual review of this Strategy by a range of stakeholders on learning what we are doing well, what we could do better, what is having the best outcomes.

Budget and skills development

The NHS is committed to investing in the delivery of the priorities identified in this Strategy. Funding for the next two years will come from a range of budgets currently being discussed. A budget will be agreed as we progress into the ICB from 1 July 2022 and allocated to the priority actions shown below.

Project investment

Priority action
1. Empower our 21,000 members of staff.
2. Develop further the Insights, Behaviour and Research Hub
3. Promote more widely the existence of business intelligence
4. Create a customer relationship management system
5. Develop strong and mutually beneficial relationships with the voluntary sector, community groups and social enterprise
6. Create ambassadors for embedding business intelligence
7. Ensure the production of Equality Impact Assessments for all projects and the utilization of the findings impact on engagement/consultation.
8. Share knowledge and learning across engagement teams
9. Develop all aspects of Citizens' Panel – growth in membership, retention, benefits scheme and access
10. Work with ICS to move from compartmentalised engagement and involvement to full system co-production
11. Create a primary care engagement framework
12. Develop plans for the systematic and effective delivery of engagement activities and public consultation
13. Support the development of place and neighbourhood-based plans
14. Support the development of a framework for engaging with family carers and children, young people and families
15.Continue to digitally innovate making the digital experience with the NHS more human and interactive
16. Work with decision makers and programme leads to ensure that post-decision making the impact is clearly fed back to the public without exception – to ensure a 'you said, we did' culture across the ICB.

Skills development

In 2022, we will see the first joint post for the ICS recruited to. This post will enhance the engagement of our children, young people and families.

We have also invested on a temporary basis in the role of Market Research and Insights Officer to ensure that we produce high quality business intelligence and population health management data. We would like to permanently invest in this post to enhance the skills of the team and develop the Insights, Behaviour and Research Hub.

We are also committed to enhancing the current skills within ICB teams to refresh their knowledge of our statutory duties to ensure that insights from people are used to shape all decisions about services. We will particularly upskill staff to ensure we adhere to existing and any new requirements of an ICB and an ICS.

We will upskill our staff giving them opportunities to gain the knowledge, tools and ability they need to use advanced and ever-changing technologies that will support us to engage with people and communities.

Future needs

Community and voluntary sector development – building capacity and capability and developing new and emerging groups to become system partners

Quality Improvement expertise – using insight for improvement and working in collaboration with patients, carers and service users in QI

Training design and delivery – building capacity and capability of our workforce, do we want to consider developing our own local offer and then deliver through a train the trainer approach

Skills and capability development for lived experience/patient partners – programme to develop skills and competencies for those who are working in such roles

Volunteers – do we need to consider what role volunteers could play in our approach, if so what support/coordination would be required

Appendix

1. How the strategy was developed with people and communities

This Strategy have evolved over time. It has been developed taking the learning and feedback from over 2 years of conversations taking the learning from engagement and consultation activities that have undertaken.

Since creating the first draft version, we have continued to talk to people and have made changes based on those conversations. The engagement activity has included:

- Discussions with voluntary, community and social enterprise sector (VCSE) at an event in December 2021, one-to-one interviews with representatives VCSE sector in February and a second event in April 2022
- Healthcare colleagues – Primary Care Cell, GP practice manager forums, CCGs webinar
- UHL Patient Partners
- LPT People's Council
- Healthwatch Leicester and Leicestershire
- Healthwatch Rutland
- Citizens' Panel
- Public and Patient Involvement Assurance Group
- LPT Youth Advisory Board
- LPT Senior Leaders Forum
- East Midlands Patient Public Involvement Senate
- Voluntary Action Leicester
- VAL Health Event (61 VCSE organisations)
- Survey in April 2022 – 208 people responded, 2 email received and 2 reports

2. Links to other strategies (e.g., communications, carers, health inequalities)

This strategy links to a number of local Strategies and Plans including:

- Leicester City Council's Health, Care and Wellbeing Delivery Plan 2022-2027
- Leicestershire County Council's Strategic Plan 2022-2026
- Rutland Health and Wellbeing Strategy 2022-2025
- LLR Carer's Strategy (in development)
- NHS Long Term Plan
- Reconfiguration Communications and Engagement Strategy
- 'Step up to Great' Mental Health Communications and Engagement Strategy

6

LLR CCGs' Transition Policy Tracker (v8, 25 June 2022)

Current version
Review underway or awaiting approval
Review yet to commence
to be archived

Policy Ref and Number	Policy Title:	Lead responsible:	Current Status	Lead Update
CORPORATE				
LLR CORPORATE 001	Conflicts of Interest, Gifts and Hospitality and Sponsorship Policy	Daljit K Bains		Current CCG policy in place, this will be superseded by the ICB version.
(New - ICB ref required)	Conflicts of Interest, Gifts and Hospitality and Sponsorship Policy (also covers Standards of Business Conduct Policy)	Daljit K Bains		The ICB version to be approved on 1 July 2022 by the ICB.
LLR Corporate 015	Freedom of Information Act 2000 Policy and FOI Leaflet	Daljit K Bains		Policy to be reviewed in July 2022
LLR Corporate 019	Complaints Policy and Procedure	Daljit K Bains		Policy to be reviewed in July 2023
LLR Corporate 020	Standing Financial Instructions and Operational Scheme of Delegation	Daljit K Bains		to be archived
LLR Corporate 029.1	LC CCG Constitution	Daljit K Bains		to be archived
LLR Corporate 029.2	ELR CCG Constitution	Daljit K Bains		to be archived
LLR Corporate 029.3	WL CCG Constitution	Daljit K Bains		to be archived
NEW	ICB Constitution	Daljit K Bains		
LLR CORPORATE 040	Modern Slavery Statement	Chris West		
NEW	Modern Slavery Statement	Chris West		New version required for ICB website
NEW	ICB Policy for Policy Writing	Daljit K Bains		To compile July / August 2022
NEW	ICB Staff Handbook	Daljit K Bains		To compile July / August 2023
ELR CORPORATE 031	Policy on Fraud, Corruption and Bribery	Daljit K Bains/Counter Fraud		
NEW	ICB Policy on Fraud, Corruption and Bribery	Daljit K Bains/Counter Fraud		Review underway.
LLR HS001	Health & Safety Policy (including underpinning policies for specifics)	Daljit K. Bains		Review underway to be completed August 2022. Also adhere to County Hall health and safety procedures, and fire safety procedures.
INFORMATION GOVERNANCE				
LLR CORPORATE 008	Readiness for Incident Investigation Policy (EMT Policy Only)	Jayshree Raval/ LHIS Cyber Security Officer		Reviewed, only minor amendments made. For approval by end of June 2022.
LLR CORPORATE 014	IG Staff Code of Conduct	Jayshree Raval		
LLR CORPORATE 007	Information Governance Policy	Jayshree Raval		
LLR CORPORATE 009	Data Security and Protection Policy (Part 1) (formally Information Security Policy)	Jayshree Raval/ LHIS Cyber Security Officer		Review under way to be replaced by an Information Security Policy.
LLR CORPORATE 010	Data Security and Protection Policy (Part 2) (formally Information Security Policy)	Jayshree Raval/ LHIS Cyber Security Officer		
LLR CORPORATE 011	Internet and Electronic Communications Policy	Jayshree Raval/ LHIS Cyber Security Officer		
LLR Corporate 016	Subject Access Requests (SAR) Procedure	Jayshree Raval		
LLR CORPORATE 013	Data Protection Impact Assessment	Jayshree Raval		
LLR Corporate–037	Corporate Incident Policy	Jayshree Raval		Currently being refreshed to include data breach reporting processes.
LLR Corporate 031	Claims Management Policy and Procedure	Jagdip Poonia		
LLR CORPORATE 002	Risk Management Strategy & Policy	Daljit K Bains		Work in progress to amend CCG Strategy and Policy to reflect ICB arrangements. LPT colleague supporting with reviewing partner arrangements to support consistency in principles.
NEW	ICB Risk Management Strategy & Policy	Daljit K Bains		The ICB version to be approved on 1 July 2022 by the ICB.
LLR Corporate 018	Business Continuity Management Policy	Jagdip Poonia		Currently being reviewed for the ICB.
LLR Corporate 027-1	Staff Privacy Notice - ELR	Jayshree Raval		to be archived

LLR Corporate 027-2	Staff Privacy Notice - LC	Jayshree Raval		to be archived
LLR Corporate 027-3	Staff Privacy Notice - WL	Jayshree Raval		to be archived
NEW	ICB Staff Privacy Notice	Jayshree Raval		ICB version to be approved by EMT by end of June 2022.
LLR Corporate 027-4	public privacy notice - ELR	Jayshree Raval		to be archived
LLR Corporate 027-5	public privacy notice - LC	Jayshree Raval		to be archived
LLR Corporate 027-6	public privacy notice - WL	Jayshree Raval		to be archived
NEW	ICB Public Privacy Notice	Jayshree Raval		ICB version to be approved by EMT by end of June 2022.

Transition Policy Tracker

	Current version
	Review underway or awaiting approval
	Review yet to commence
	to be archived

Policy Ref and Number	Policy Title:	Lead responsible:	Current Status	Comments/Queries
PEOPLE & INNOVATION				
LLR Corporate 021	Equality and Inclusion Strategy	Nigel Skea		
LLR HR01	Organisational Change Policy	Nigel Skea		
LLR HR02	Recruitment and Selection Policy	Nigel Skea		
LLR HR03	Special Leave Policy	Nigel Skea		
LLR HR04	Secondment and Acting Up Guidance	Nigel Skea		
LLR HR05	Maternity, Paternity, Adoption and Parental Leave Policy	Nigel Skea		
LLR HR06	Disciplinary Policy	Nigel Skea		
LLR HR07	Retirement Policy	Nigel Skea		
LLR HR08	Agency and Off Payroll Workers Policy	Nigel Skea		
LLR HR09	Appraisal and Pay Progression Policy	Nigel Skea		
LLR HR10	Managing Capability (Work Performance) Policy	Nigel Skea		
LLR HR11	Disclosure and Barring Policy	Nigel Skea		
LLR HR12	Annual Leave Policy	Nigel Skea		
LLR HR13	Apprenticeship Policy	Nigel Skea		
LLR HR14	Education, Learning and Development Policy	Nigel Skea		
LLR HR15	Health and Wellbeing Policy	Nigel Skea		
LLR HR16	Sickness Absence Policy	Nigel Skea		
LLR HR17	Travel and Expenses Policy	Nigel Skea		
LLR HR18	Flexible Working Policy	Nigel Skea/Alice McGee		
LLR HR23	Agile Working Policy	Nigel Skea		Under review at present.
LLR HR19	Grievance Policy	Nigel Skea/Alice McGee		
LLR HR20	Harassment and Bullying Policy	Nigel Skea/Alice McGee		
LLR HR21	Job Matching and Re-banding Policy	Nigel Skea/Alice McGee		
LLR HR22	Professional Registration Policy	Nigel Skea/Alice McGee		Anticipate approval by end of Q4
LLR HR24	Career Break Policy	Nigel Skea		Anticipate approval by end of Q4.
ELR HR 001 LC - HR013 WL - ER05	Freedom to Speak up (Whistle-blowing Policy)	Head of HR and OD		to be archived
NEW	Freedom to Speak up (Whistle-blowing Policy)	Nigel Skea		new policy to be developed.
ELR HR 002 (WF 023) LC - HR018 WL - ER23	Alcohol, Drugs and Substance Misuse Policy	Head of HR and OD		
NEW	Alcohol, Drugs and Substance Misuse Policy	Nigel Skea		need ICB version
ELR HR 015 (WD 017) LC - HR023	Trade Union and Professional Organisation Recognition Agreement	Head of HR and OD		
NEW	Trade Union and Professional Organisation Recognition Agreement	Nigel Skea		need ICB version
LC - HR 002	Social Media Policy	Richard Morris		
NEW	Social Media Policy	Richard Morris		need ICB version
LC - Corporate 009	Media handling and Photography policy	Richard Morris		
NEW	Media handling and Photography policy	Richard Morris		need ICB version
LC - Corporate 090	CCG recordings policy	Richard Morris		
NEW	CCG recordings policy	Richard Morris		need ICB version
LC - 004 WL - ER32	Secondary employment / work policy	Nigel Skea		
NEW	Secondary employment / work policy	Nigel Skea		need ICB version
NEW	on call policy	Nigel Skea		
LC - Corporate 061	Pay protection policy	Nigel Skea		
NEW	Pay protection policy	Nigel Skea		need ICB version
	Employee volunteering policy	Nigel Skea		
NEW	Employee volunteering policy	Nigel Skea		need ICB version
LC - Corporate 081	Relocation expenses policy	Nigel Skea		
NEW	Relocation expenses policy	Nigel Skea		need ICB version
LC - Corporate 095	Human rights policy	Nigel Skea/Alice McGee		
NEW	Human rights policy	Nigel Skea/Alice McGee		need ICB version

Transition Policy Tracker

Current version
Review underway or awaiting approval
Review yet to commence
to be archived

Policy Ref and Number	Policy Title:	Lead responsible:	Current Status	Comments/Queries
FINANCE				
ELR FINANCE 001	Corporate Finance Budget Manual	Pratish Parmar		
NEW	Corporate Finance Budget Manual	Pratish Parmar		Work underway to compile new manual for ICB.
LLR CORPORATE 001	Losses and Special Payments Policy	Pratish Parmar		
NEW	Losses and Special Payments Policy	Pratish Parmar		Need ICB version. Model policy published by NHSE/I and shared for comments.
NEW	Patient and Public Reimbursement Policy	Pratish Parmar		Consider if needed for ICB.
CONTRACTING				
LLR Corporate 022	Procurement Strategy	sarah Shuttlewood / Jo McKenna		
LLR Corporate 023	Agreed Financial Assistance for Practices Experiencing The Impact of Dispersed List	sarah Shuttlewood / Jo McKenna		
LLR Corporate 032	Practice and/or Contract Merger Policy	sarah Shuttlewood / Jo McKenna		
LLR Corporate 033	Contract & Quality Review Process	sarah Shuttlewood / Jo McKenna		
LLR Corporate 034	Practice / PCN Allocation Policy	sarah Shuttlewood / Jo McKenna		
LLR	LLR Violent patient scheme / policy (LLR)	sarah Shuttlewood / Jo McKenna		
ELR CORPORATE 050	Boundary Changes principles LLR	Jamie Barrett / Priya Pandya		
LLR Corporate 030	Policy for boundary variation requests	Jamie Barrett / Priya Pandya		
LC - Corporate 097	Policy for managing appeals made by GP providers in respect of decisions made by the CCG / PCCC	Jamie Barrett / Priya Pandya		
NEW	Policy for managing appeals made by GP providers in respect of decisions made by the ICB	Jamie Barrett / Priya Pandya		need ICB version

Transition Policy Tracker

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Review yet to commence
to be archived

Policy Ref and Number	Policy Title:	Lead responsible:	Current Status	Comments/Queries
Quality & Nursing				
ELR CORPORATE 025 LC Corporate 069 WL ER19	Children and Adult Safeguarding Policy 2017-18	Wendy Hope / Jannette Harrison		Policy under review.
NEW	Children and Adult Safeguarding Policy	Wendy Hope / Jannette Harrison		need ICB version
ELR CORPORATE 026	Allegations that a worker may be harming a child or adult in need of Safeguarding Policy 2014-2016	Wendy Hope / Jannette Harrison		Under review as to whether policy requierd going foroward.
NEW	Allegations that a worker may be harming a child or adult in need of Safeguarding Policy	Wendy Hope / Jannette Harrison		need ICB version
ELR CORPORATE 027 LC corporate 058	Safeguarding Adult and Children Training Strategy 2016-18	Wendy Hope / Jannette Harrison		to be archived
NEW	Safeguarding Adult and Children Training Strategy	Wendy Hope / Jannette Harrison		need ICB version
ELR CORPORATE 028 LC Corproate 059 WL CS02	Safeguarding Strategy (Children and Adults)	Wendy Hope / Jannette Harrison		
NEW	Safeguarding Strategy (Children and Adults)	Wendy Hope / Jannette Harrison		need ICB version
LC - Corporate 087	Prevent strategy	Wendy Hope / Jannette Harrison		
NEW	Prevent strategy	Wendy Hope / Jannette Harrison		need ICB version
ELR CORPORATE 030	NHS England Serious Incident Framework	Wendy Hope		
NEW	NHS England Serious Incident Framework	Wendy Hope		need ICB version
ELR CORPORATE 034 LC corproate062 WL - yes no ref	Mental Capacity Act 2005 (MCA) including Deprivation of Liberty Safeguards (DoLS) Policy	Wendy Hope / Jannette Harrison		under review
NEW	Mental Capacity Act 2005 (MCA) including Deprivation of Liberty Safeguards (DoLS) Policy	Wendy Hope / Jannette Harrison		need ICB version
ELR CORPORATE 038 LC - Corporate 066 LC - CS03	Safeguarding Children Supervision Policy	Wendy Hope / Jannette Harrison		under review
NEW	Safeguarding Children Supervision Policy	Wendy Hope / Jannette Harrison		need ICB version
ELR CORPORATE 044	NHS Continuing Healthcare Inter-agency Disputes Policy	Jennie Palmer-Vines		
NEW	NHS Continuing Healthcare Inter-agency Disputes Policy	Jennie Palmer-Vines		need ICB version
ELR COPORATE 052	ELR CCG Announced & Unannounced Provider Visit Policy	Chris West		Chris West to advise
NEW	LLR ICB Announced & Unannounced Provider Visit Policy	Chris West		need ICB version
ELR CORPORATE 053 (previously ELR HR 021) LC - HR028 WL - ER25	Domestic Violence Policy	Wendy Hope / Jannette Harrison?		under review
NEW	Domestic Violence Policy	Wendy Hope / Jannette Harrison?		need ICB version

LLR CORPORATE 003 (previously ELR CORPORATE 035)	LOCAL POLICY FOR THE REPORTING, INVESTIGATION AND LEARNING FROM SERIOUS INCIDENTS	Caroline Trevithick		
ELR CLINICAL 002 LC - Corporate 054	Oral Anticoagulation Operational Guidance for General Practice in East Leicestershire & Rutland	Gill Stead		need ICB version
ELR CLINICAL 006	Antimicrobial Policy and Guidance for Primary Care	Gill Stead		need ICB version
ELR CLINICAL 008 LC - corporate 053	Policy for Managing Rebates on Prescribed Products in Primary Care	Gill Stead		need ICB version
ELR CLINICAL 009	Policy for Patient Group Directions (PGD)	Gill Stead		need ICB version
ELR CLINICAL 017 (LLRCCGPGD07)	Fluorescein Sodium Eye Drops for the detection of Corneal Abrasion Registered Nurses and other by Registered Practitioners working in CCG commissioned services	Gill Stead?		need ICB version
ELR CLINICAL 018 (LLRCCGPGD10)	Supply of codeine phosphate tablets by Registered Nurses and other Registered Practitioners working in CCG commissioned services	Gill Stead		need ICB version
ELR CLINICAL 020 (LLRCCGPGD15)	PGD for Oral Phenoxymethylpenicillin	Gill Stead		need ICB version
ELR CLINICAL 021 (LLRCCGPGD13)	PGD for Lidocaine Hydrochloride 1% and 2% Injection for Local Anaesthesia	Chris West		need ICB version
ELR CLINICAL 022 (LLRCCGPGD14)	PGD for Benzylpenicillin Sodium Injection for suspected Bacterial Meningitis or Meningococcal Septicaemia	Gill Stead		need ICB version
ELR CLINICAL 023 (LLRCCGPGD17)	PGD for the Administration of Salbutamol solution via a nebuliser in acute asthma	Gill Stead		need ICB version
ELR CLINICAL 026 (LLRCCGPGD12)	PGD for the administration of oxybuprocaine as local anaesthetic for eye trauma	Chris West		need ICB version
ELR CLINICAL 027 (LLRCCGPGD16)	PGD for the supply and administration of prednisolone for the management of acute exacerbation of COPD/Asthma	Gill Stead		need ICB version
ELR CLINICAL 029 (LLRCCGPGD19)	PGD for Salbutamol Inhaler with Spacer device in acute asthma: administration and supply	Gill Stead		need ICB version
ELR CLINICAL 030 (LLRCCGPGD20)	Topical chloramphenicol for the Prevention of Infection Secondary to Corneal Abrasion	Chris West		need ICB version
ELR CLINICAL 032 (LLRCCGPGD23)	PGD for Oral Amoxicillin for Otitis Media	Gill Stead		need ICB version
ELR CLINICAL 033 (LLRCCGPGD26)	PGD for Oral Metronidazole for Human and Animal Bites	Chris West		need ICB version
ELR CLINICAL 034 (LLRCCGPGD25)	PGD for Oral Co-Amoxiclav for Human and Animal Bites	Chris West		need ICB version
ELR CLINICAL 035 (LLRCCGPGD24)	PGD for Erythromycin in Penicillin allergy for Sore Throat/Tonsillitis, otitis Media, Impetigo & Human Bites	Chris West		need ICB version
ELR CLINICAL 038	Guidelines for Clinical Supervision for Nurses and Midwives within ELR CCG	Chris West		
NEW	Guidelines for Clinical Supervision for Nurses and Midwives within LLR	Chris West		need ICB version
ELR CLINICAL 039	Pneumonia Guidance and Care Bundle	Chris West		need ICB version
LC - Corporate 092	Equity and Choice Policy	Nigel Skea		
ELR CLINICAL 041	Settings of Care Policy	Chris West		need ICB version
NEW	Equity and Choice / Settings of Care Policy	Chris West		need ICB version
ELR CLINICAL 043	Childrens and Young peoples continuing care policy	Jennie Palmer-Vines		need ICB version
ELR CLINICAL 044	PGD for PROCHLORPERAZINE MALEATE (buccal) tablets for the treatment of severe nausea, vomiting, vertigo or acute exacerbations of labyrinthine disorders.	Gill Stead		need ICB version
ELR CLINICAL 045	PGD for oral DOXYCYCLINE for Animal Bites	Gill Stead		need ICB version
ELR CLINICAL 046	Nitrofurantoin	Gill Stead		need ICB version

ELR CLINICAL 047	Trimethoprim	Gill Stead		need ICB version
ELR CLINICAL 048	Flucloxacilin	Gill Stead		need ICB version
ELR CLINCIAL 049	Clarithromycin for human bites in conjunction with Metronidazole	Gill Stead		need ICB version
ELR CLINCIAL 050	Policy for Personal Health Budgets policy (PHB)	Jennie Palmer-Vines		
NEW	Policy for Personal Health Budgets policy (PHB)	Jennie Palmer-Vines		need ICB version
Region-wide policy	East Midlands Cosmetic Procedures policy	CCG officer tbc		
NEW	East Midlands Cosmetic Procedures policy	CCG officer tbc		need ICB version
Region-wide policy	IVF policy	CCG officer tbc		
NEW	IVF policy	CCG officer tbc		
ELR CORPORATE 037 LC - corporate 011 WL - Corproate 011	Individual Funding Request Policy	Jennie Palmer-Vines?		
NEW	Individual Funding Request Policy	Jennie Palmer-Vines?		need ICB version
LLR Corporate 024	Quality and Performance Iimprovement Strategy	Hannah Hutchinson		
LC - Corporate 046	Pharmaceutical joint working and sponsorship with the pharmacuetical industry policy	Gill Stead		need ICB version
LC - Corporate 055	Confidentiality and security guidelines in relation to mobile working for the medicines management team	Gill Stead		need ICB version

Transition Policy Tracker

Current version
Review underway or awaiting approval
Review yet to commence
to be archived

Policy Ref and Number	Policy Title:	Lead responsible:	Current Status	Comments/Queries
Planned Care (LLR Policies)				
ARP 1	Policy for Leicester Leicestershire and Rutland Approved Referral Pathways	Helen Mather		
ARP 2	Policy for Abdominal Hernias in Adults – Management of	Helen Mather		
ARP 3	Policy for Abdominoplasty/ Apronectomy	Helen Mather		
ARP 4	Policy for Actinic Keratosis	Helen Mather		
ARP 5	Policy for Alopecia	Helen Mather		
ARP 6	Policy for Arthroscopy of the Knee	Helen Mather		
ARP 7	Policy for Benign Skin Lesions	Helen Mather		
ARP 8	Policy for Botulinum Toxin for Wrinkles, Frown Lines or Ageing Neck	Helen Mather		
ARP 9	Policy for Botulinum Toxin – The Use of	Helen Mather		
ARP 10	Policy for Botulinum Toxin for Adults with Chronic Migraines	Helen Mather		
ARP 11	Policy for Breast Asymmetry	Helen Mather		
ARP 12	Policy for Breast Implant/ Reinsertion	Helen Mather		
ARP 13	Policy for Breast Reduction	Helen Mather		
ARP 14	Policy for Breast Uplift (Mastopexy)	Helen Mather		
ARP 15	Policy for Brow Lift (Blepharoplasty)	Helen Mather		
ARP 16	Policy for Bunions (Hallux Valgus)	Helen Mather		
ARP 17	Policy for Calf Augmentation	Helen Mather		
ARP 18	Policy for Carpal Tunnel Syndrome	Helen Mather		
ARP 19	Policy for Cataracts	Helen Mather		
ARP 20	Policy for Chalazion – Excision of	Helen Mather		
ARP 21	Policy for Chin/ Cheek Implants	Helen Mather		
ARP 22	Policy for Cholecystectomy - Asymptomatic	Helen Mather		
ARP 23	Policy for Circumcision – Adult Male	Helen Mather		
ARP 24	Policy for Collagen Implant	Helen Mather		
ARP 25	Policy for Complementary and Alternative Therapies	Helen Mather		
ARP 26	Policy for Congenital Pigmented Lesion on the Face	Helen Mather		
ARP 27	Policy for Correction of Nipple Inversion	Helen Mather		
ARP 28	Policy for Cranial Banding for Positional Plagiocephaly	Helen Mather		
ARP 29	Cryopreservation	Helen Mather		linked to Gamete Policy - due to be reviewed East Mids wide.
ARP 30	Policy for Dermabrasion and/ or Laser Resurfacing	Helen Mather		
ARP 31	Policy for Dupuytren's Disease	Helen Mather		
ARP 32	Policy for Ear Wax Removal	Helen Mather		
ARP 33	Policy for Earlobe Repair	Helen Mather		
ARP 34	Policy for Endo- Vascular Aneurysm Repair	Helen Mather		
ARP 35	Policy for Endoscopic Thoracic Sympathectomy for Facial Flushing/ Sweating	Helen Mather		
ARP 36	Policy for Endoscopy for Dyspepsia	Helen Mather		
ARP 37	Policy for Epidermoid/ Pilar (Sebaceous) Cyst	Helen Mather		
ARP 38	Policy for Epidural Injections for Radicular Pain (Sciatica)	Helen Mather		
ARP 39	Policy for Erectile Dysfunction (Impotence)	Helen Mather		
ARP 40	Policy for Excision of Skin for Cosmetic Indicators	Helen Mather		
ARP 41	Policy for Facelift	Helen Mather		
ARP 42	Policy for Facet Joint Injection for Non Radicular Back Pain	Helen Mather		
ARP 43	Policy for Facial Hyper Pigmentation – Treatment for	Helen Mather		
ARP 44	Policy for Fat Grafts	Helen Mather		
ARP 45	Policy for Fungal Nail Infection (Onychmycosis)	Helen Mather		
ARP 46	Policy for Ganglion – Hand or Wrist	Helen Mather		
ARP 47	Policy for Gastric Fundoplication for Chronic Reflux Oesophagitis	Helen Mather		
ARP 48	Policy for Gender Reassignment – treatments not included in the original package of care	Helen Mather		
ARP 49	Policy for Gluteal Augmentation	Helen Mather		
ARP 50	Policy for Grommet Insertion – Adults only	Helen Mather		
ARP 51	Policy for Hair Depilation for Excessive Growth (Hirsutism)	Helen Mather		
ARP 52	Policy for Hair Transplantation	Helen Mather		

ARP 53	Policy for Hip and Knee Replacement	Helen Mather		
ARP 54	Policy for Hip Arthroscopy	Helen Mather		
ARP 55	Policy for Hip Resurfacing	Helen Mather		
ARP 56	Policy for Hybrid Hip Replacement/ Revision	Helen Mather		
ARP 57	Policy for Hybrid Knee Replacement/ Revision	Helen Mather		
ARP 58	Policy for Intraocular Lens Implants	Helen Mather		
ARP 59	Policy for Intrauterine (IUI) and Donor Insemination (DI) (excluding In Vitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI))	Helen Mather		
ARP 60	Policy for Knee Resurfacing	Helen Mather		
ARP 61	Policy for Labiaplasty, Vaginoplasty and Hymen Reconstruction	Helen Mather		
ARP 62	Policy for Laser Treatment	Helen Mather		
ARP 63	Policy for Laser Treatment for Myopia	Helen Mather		
ARP 64	Policy for Lipoma – Removal of	Helen Mather		
ARP 65	Policy for Liposuction	Helen Mather		
ARP 66	Policy for Low Back Pain – Surgical Interventions	Helen Mather		
ARP 67	Policy for Lower Urinary Tract Symptoms (LUTS)	Helen Mather		
ARP 68	Policy for Magnetic Resonance Guided Focused Ultrasound for Uterine Fibroids	Helen Mather		
ARP 69	Policy for Male Breast Reduction	Helen Mather		
ARP 70	Policy for Mandibular/ Maxillary Osteotomy	Helen Mather		
ARP 71	Policy for Medial Branch Block and Facet Joint Injection	Helen Mather		
ARP 72	Heavy Menstrual Bleeding	Helen Mather		review underway
ARP 73	Policy for Myringotomy with or without Grommets – Children Only	Helen Mather		
ARP 74	Policy for Non Cosmetic Nasal Treatment for All Ages	Helen Mather		
ARP 75	Policy for Ozurdex Intravitreal Implant	Helen Mather		
ARP 76	Policy for Phalloplasty	Helen Mather		
ARP 77	Policy for Photodestruction of Electrolysis Lesion of Skin	Helen Mather		
ARP 78	Policy for Prominent Ears (Pinnaplasty)	Helen Mather		
ARP 79	Policy for Radio Frequency Denervation in the Management of Chronic Back Pain	Helen Mather		
ARP 80	Rectal Bleeding	Helen Mather		
ARP 81	Policy for Restless Leg Syndrome	Helen Mather		
ARP 82	Policy for Reversal of Sterilisation – Male and Female	Helen Mather		
ARP 83	Policy for Rhinophyma	Helen Mather		
ARP 84	Policy for Scar Reduction	Helen Mather		
ARP 85	Policy for Scotopic Sensitivity Syndrome	Helen Mather		
ARP 86	Policy for Scrotal Swelling (Varicocele) - Asymptomatic	Helen Mather		
ARP 87	Policy for Second and Third Specialist Opinion for the Same Condition	Helen Mather		
ARP 88	Policy for Sleep Apnoea Referral for Obstruction Sleep Apnoea	Helen Mather		
ARP 89	Policy for Sterilisation – Female and Male	Helen Mather		
ARP 90	Policy for Surgical Biological Mesh – the Use of	Helen Mather		
ARP 91	Policy for Tonsillectomy and Adenoidectomy	Helen Mather		
ARP 92	Policy for Temporo-Mandibular Joint Dysfunction (TMD)	Helen Mather		
ARP 93	Policy for Thigh, Buttock and Arm Lift – Excision of Redundant Skin or Fat	Helen Mather		
ARP 94	Policy for Tongue Ties (Ankyloglossia) – Division of	Helen Mather		
ARP 95	Policy for Topical Negative Pressure (TNP) for Wound Closure	Helen Mather		
ARP 96	Policy for Trigger Finger	Helen Mather		
ARP 97	Policy for Ultrasound for Low Intensity for Bone Healing	Helen Mather		
ARP 98	Prolapse	Helen Mather		
ARP 99	Pessary	Helen Mather		
ARP 100	Policy for Varicose Veins – Surgical Treatment of	Helen Mather		
ARP 101	Policy for Venous Angioplasty for MS	Helen Mather		
ARP 102	Policy for Vitiligo	Helen Mather		
Other				
LLR Corporate 025	Incident Response Plan	Amita Chudasama		
LLR Corporate 026	Emergency Preparedness, Response and Resilience standards	Amita Chudasama		

7

Leicester, Leicestershire and Rutland ICS

Professional Leadership Strategy

April 2022

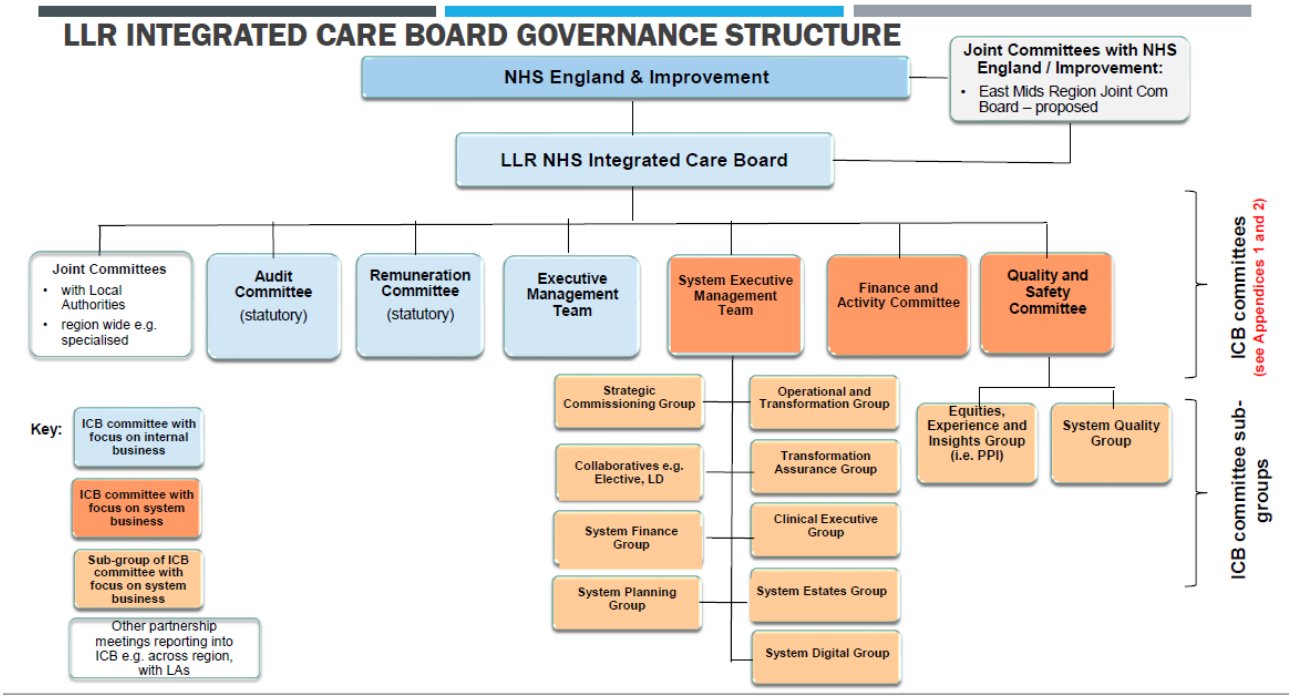
Introduction

Fully inclusive multi-professional clinical and care professional leadership is central to delivering integrated care and the Leicester, Leicestershire and Rutland Integrated Care System (LLR ICS) has made this a priority. There is much evidence that strong clinical and care professional leadership is associated with better organisational performance and that diverse clinical leadership, both demographic and in terms of roles, brings greater depth and breadth of experience and perspective which in turn realises better outcomes for our people.

Locally, we have considerable clinical and care leadership experience already and are committed to developing a further pipeline of leaders to nurture a culture that embraces shared learning, collaboration and innovation.

This strategy sets out the ambition for professional leadership in LLR ICS, building on previous iterations of the clinical leadership approach within the Better Care Together Programme and identifies key areas for action to develop a professionally led ICS that works to achieve better outcomes for our people.

LLR ICS Governance and Quality Structure



Through the inclusivity of our clinical and care professional leadership, we want to reflect the broad range of professionals who need to work together through the Integrated Care Board (ICB) and Integrated Care Partnership (ICP) and across placed-based partnerships, provider collaboratives and primary care networks, breaking down traditional organisational barriers and championing creative and forward-thinking models of care to best serve our patients, people and communities.

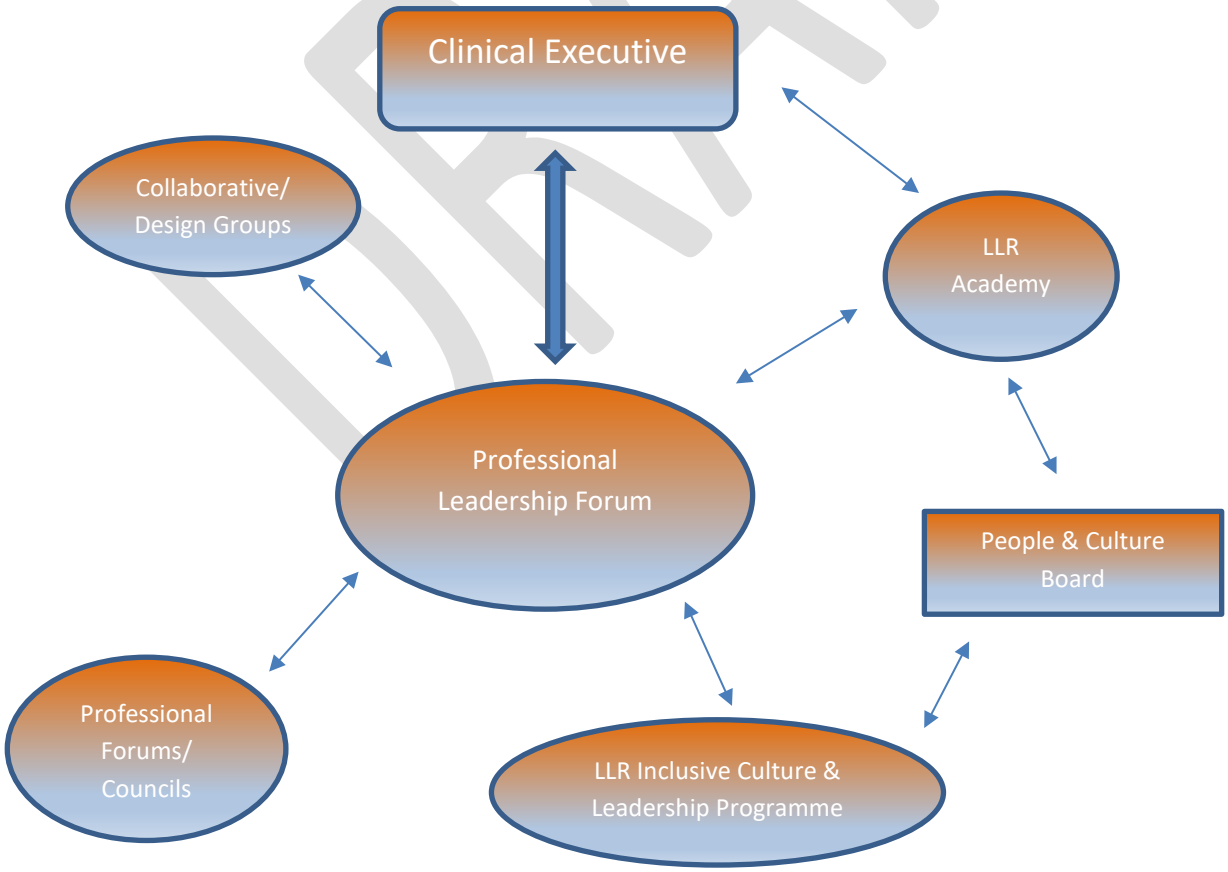
ICS Clinical and Professional leadership arrangements

ICS Clinical Executive Group

The LLR ICS Clinical Executive Group is the key clinical decision-making group of the ICS. It forms part of the governance and accountability framework of the ICS, with representation from providers and ICS Executive Clinical Leads. Key functions include

- Advising and challenging the ICB on the clinical agenda
- Driving, enabling and overseeing clinical change
- Clinical prioritisation and overseeing system clinical risk
- Scrutiny of key system plans and business cases
- Promoting health and well being of communities and addressing health inequalities
- Oversight of clinical interdependencies across pathways and Collaboratives/Design Groups
- Oversight of the Professional Leadership Forum in setting the clinical/professional strategy for the ICS

Framework to support delivery of the Professional Leadership Strategy



Collaborative and Design Groups

Clinically led groups with multi-professional representation from providers (health and care) to develop system pathways to deliver the system operational plan and transformation agenda. Focus is to improve outcomes and lived experience through use of performance and quality data, delivering value for money and addressing health inequalities.

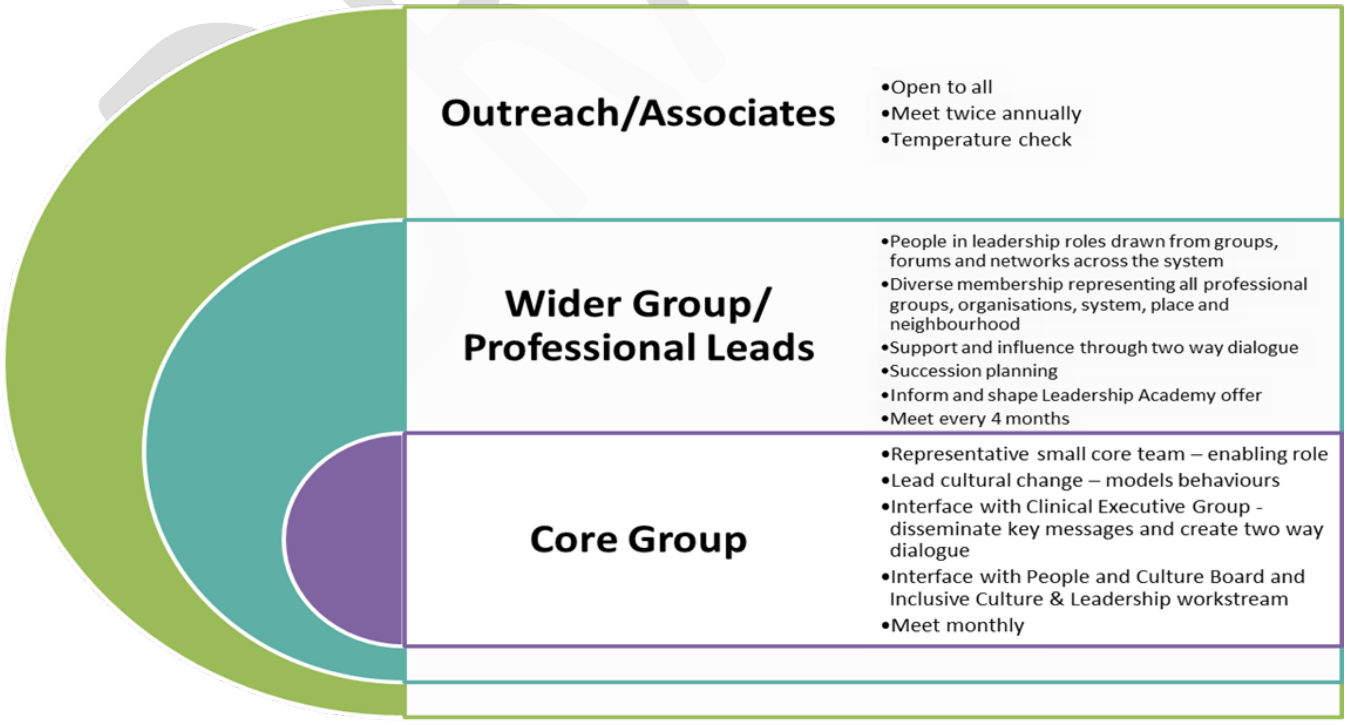
LLR ICS Professional Leadership Forum

The purpose of the Professional Leadership Forum (PLF) is to bring Clinical and Care Professional Leaders together across LLR to deliver better outcomes for our people. Specifically, the intention is to:

- Be inclusive of all multi-disciplinary care professionals
- Listen and seek to understand diverse perspectives
- Enable professional leaders to make decisions and solve problems
- Support multi-professional and multi-agency working and bring primary and secondary care together
- Support and develop professional leaders to reach their full leadership potential
- Agree behaviours of professional leaders to embed cultural change
- Develop the Professional Leadership Strategy and support delivery

We intend, through our Professional Leadership Forum, to develop a support offer for clinical and care professional leaders at all levels of the system that includes coaching and mentoring for those emerging or maturing into system roles, supportive programmes of organisational development and the establishment of clinical and care professional networks across our system but also at place and neighbourhood level.

Professional Leadership Forum structure



The PLF core group is made up of clinical and care professional leaders from health and social care, (including acute, community and mental health and primary care) and multi-professionals including AHPs, nursing, medical, social workers (adult and children), healthcare scientists and pharmacists.

Professional Leadership Principles

The four principles underpinning our Professional Leadership Strategy have been developed and agreed by multi-professional clinical and care leaders across the ICS. They are based on the national principles for Clinical and Care Professional Leadership published in September 2021.

Principle one:

Integrate Clinical and Care Professional Leaders into decision making at all levels

We will:

- Ensure plans co-developed with professional leaders and underpinned by commitment to patient care and health equality
- Demonstrate professional leaders at all levels of decision making through defined governance arrangements
- Work in partnership with providers, partners, service users across health and social care to deliver continuous quality improvement
- Directly involve professional leaders in service redesign or changes to care pathways
- Give professionals a voice, developing a two-way communication and engagement plan to ensure all clinical and professional staff in LLR can influence decision making

Principal Two:

Develop a culture that supports Clinical and Care Professional leaders to learn, collaborate and innovate

We will:

- Develop a leadership community that is multi-professional, actively seeking to identify and nurture leadership in under-represented groups
- Map our existing professional groups, encouraging alignment within the ICS
- Create strong links with the inclusion agenda including all protected characteristics, and build on BAME networks and the Inclusive Culture and Leadership workstream
- Model the culture we aim to build and help colleagues to think differently
- Pay attention to the language we use and how we communicate
- Develop fora for shared learning and a sense of being 'part' of the system
- Listen to our professional leaders, respond to feedback and change what is not working

Principle Three:

Support professionals across the ICS to engage in the development and delivery of the ICS

We will:

- Work with the LLR Academy and through the LLR People Plan to identify and support future leaders, creating a pipeline of strong professional leaders
- Seek opportunities for co-development of ICS transformation plans with front-line professionals, patients/service users and voluntary groups
- Support collaborative working, sharing knowledge and expertise between organisations and redesigning services around the needs of our population
- Set out a framework for governance and quality improvement across the ICS that is understood by our staff and has professional leadership at its core
- Create a sense of 'ownership' of system plans & performance within our ICS

Principle Four:

Support Clinical and Care Professional leaders to develop and deliver the ICS strategy

We will:

- Ensure funded and protected time available for professional leaders within LLR
- Create opportunities for new leaders, including mentoring and shadowing
- Ensure leadership roles are created and described in a way that promotes diversity of applicants
- Ensure equity, access and support for leadership development across the system
- Seek to make professional leadership roles attractive to professionals in LLR
- Utilise the LLR Academy to support and develop our leaders
- Encourage strong collaboration between professional and non-clinical leaders

How will we deliver this

In year one our priorities are to:

- Widely share and engage on the strategy across our leadership community, building on the open communication events held throughout December 2021 and February 2022
- Develop a programme of engagement events over the next six months
- Map existing professional groups and networks within the ICS, ensuring they are engaged and included in delivery of the strategy
- Deliver a workshop for Collaborative/Design Group Chairs to understand support and development needs and how they will align themselves to the Professional Leadership Strategy
- Develop our ongoing system support offer to Collaborative/Design Group Chairs and newly appointed Primary Care Transformation Leads
- Agree how we will support our 'Talent Pipeline' to develop system leadership skills for future leaders, including those not successful in appointment to leadership roles
- Continue to support staff that have attended our 'Leadership Conversations' to engage in system leadership
- Strengthen the relationship between the LLR Academy, Inclusive Culture and Leadership Programme and PLF, to deliver the leadership development for the ICS
- Engage through PLF-led outreach events in a conversation with leaders and future leaders across the ICS to test implementation of the strategy and future priorities

Appendix 1

Terms of Reference (April 2022)
Leicester, Leicestershire, and Rutland Professional Leadership Forum

Purpose
The Leicester, Leicestershire and Rutland Professional Leadership Forum provides a forum for multi-professional leaders to meet and share their specialist expertise, clinical experience, and strategic knowledge in an impartial and collaborative manner.

The Professional Leadership Forum will provide health and care professional expertise to the LLR Integrated Care System and exist to provide collective knowledge and strategic leadership on behalf of the LLR health and care community.

- To provide objective, evidence-based solutions on major clinical strategy areas which address quality and safety issues in LLR free from organisational bias.
- To provide a space where professional leaders can meet to share collective knowledge on clinical and care issues, both to each other and to relevant stakeholders.
- To support and provide expert advice to ICS Collaboratives and Design Groups on the development of pathways spanning system, place and neighbourhood.
- To encourage collaboration, participation, joint understanding, and a holistic view of LLR's health and care system.

Responsibilities

- Develop and inform the strategic direction for professional leadership
- Enable involvement of LLR professionals to both influence & develop strategy & plans, and to ensure they are informed and involved in implementing them
- Become an Engine Room for innovation
- Focus on problem solving across organisations/pathways/professions relating to system working
- Support the Transferring Care Safely work by sourcing appropriate task and finish group members to resolve issues
- Engage with organisational clinical and professional forums on ICS priorities
- To work in partnership with the Inclusive Culture in Leadership Group and the LLR Academy
- Champion and lead professional culture change across LLR by establishing and working with organisational leaders.
- Spotting talent and supporting opportunities for development and system working amongst local leaders

Membership

Core Members

- CCG/ ICB
- Primary Care
- UHL
- LPT
- Leicester City Council
- Leicestershire Council
- Rutland Council
- Academy
- Inclusive Culture Leadership Programme

Attendees

The meeting will also be attended by other senior officers responsible for specific aspects of work as required by the agenda items.

Quoracy – decisions can be made virtually, so meetings will go ahead provided there are at least 5 organisations represented

Chair (role)

The Professional Leadership Forum chair will rotate every 6 months between Professional Leads and will be nominated by consensus.

Meetings

- Core Group will meet monthly; 2nd Monday of the Month 17.00-18.00hrs

- Wider Professional meetings and engagement events will be arranged as required and timetable of events to be planned

Accountability

The Professional Leadership Forum will be accountable to the Clinical Executive Group and the Professional leads will nominate a lead to be a member of that Group. It will provide a quarterly report to the Clinical Executive Group.

May also be required to provide reports to other ICB Committees as required as the organisation develops

Review

The Terms of Reference will be reviewed Annually, or if indicated by change in circumstances.

8

LEICESTER, LEICESTERSHIRE, AND RUTLAND INTEGRATED CARE SYSTEM

QUALITY AND PERFORMANCE IMPROVEMENT STRATEGY

Contents

Introduction

What is an Integrated Care System?

1. An Integrated Care System (ICS) is a way of working collaboratively, between a range of health and social care organisations, to help improve people's health. Across the LLR system, we are now approved as an Integrated Care System (ICS), consisting of the NHS bodies of the LLR Clinical Commissioning Groups (CCGs), the three local authorities: Leicester City Council, Leicestershire County Council, and Rutland County Council, and wider partners such as the voluntary and community sector and key provider agencies. These organisations work collectively for the needs of the population, sharing budgets, staff, and resources where appropriate. This ambition combines quality of care alongside performance improvement at System, Place and Neighbourhood levels driving the delivery of quality assurance. Delivering safe, high quality health, social care and support to people in Leicester, Leicestershire and Rutland (LLR) is at the centre of our ICS ambitions.

What is its Purpose?

2. The purpose of the LLR ICS is working together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives. This is driven and underpinned by the 10 System Expectations that we have committed to. The LLR 10 System Expectations are:

    - Safety First
    - Equitable Care for All
    - Involve our Patients and the Public
    - Have a virtual by default approach
    - Arrange care in local settings
    - Provide excellent care
    - Enhanced care in the community
    - Have an enabling culture
    - Drive technology, innovation, and sustainability
    - Work as one system with a system workforce.

How will the ICS achieve its purpose?

3. To continue our journey of System improvement nine Design Groups have been established to establish meaningful change which will in due course evolve into Collaboratives which is the coming together of providers to plan, design and deliver services. These alliances are models of care at system level for transformation, service delivery and quality through a pathway approach rather than by organisation.

4. Uniting Quality and Performance Improvement as an ICS outlines the cultural shift away from monitoring performance and quality metrics through a contractual framework to reviewing performance improvement and quality as a collaborative health and social care system.

5. Quality Improvement (QI) need to be at the centre of service transformation and service delivery for meaningful change to occur. As UHL state, "a clearly understood

and universally practised approach to QI starts with the Trust Board and a determined focus on a relatively small number of key quality priorities".

How will high quality care be achieved in the ICS?

6. In order to deliver high quality care within a culture where there is shared accountability for both quality and performance improvement, it is crucial that the ICS has the following in place:

    - Strong united system leadership and clear vision;
    - Contributions from health, local authority and voluntary sector stakeholders;
    - Uniting with the Clinical Leadership Strategy;
    - Engagement of Design Groups with clinical and social care leadership supported by the wider infrastructure;
    - Improved patient and carers safety and experience through forums in place;
    - coproduction and evaluation with our population including those who use services and those who represent our service users;
    - Horizontal and vertical assurances of improved outcomes;
    - Measurement and evaluation of the impact of a change;
    - Performance improvement at System, Place and Neighbourhood levels driving the delivery of quality assurance;
    - Health and Wellbeing boards in place for promoting greater integration and partnership between bodies from the NHS, public health and local government

7. A key component in the delivery of safe, high quality care is to create agile, multidisciplinary, clinical, and professional networks with involvement operationally at System, Place and Neighbourhood.

8. Clinical engagement needs to be central to local governance and scrutiny meetings and transformation and improvement should remain clinically led and co-produced with the local population. Patient involvement and feedback, as one of the three pillars of quality, needs to be explicit and in the construction of our priorities the voices of patients and stakeholders are influential. Our desired approach has to be that given the significant changes in health and social care that we want to bring about, we should recognise that we stand a greater chance of 'getting it right' if we involve the people who use our services in the planning of those services. It is only by actively engaging with our many and diverse local communities that we can understand their experience and build services that are mindful of their needs and expectations.

What does national quality information require?

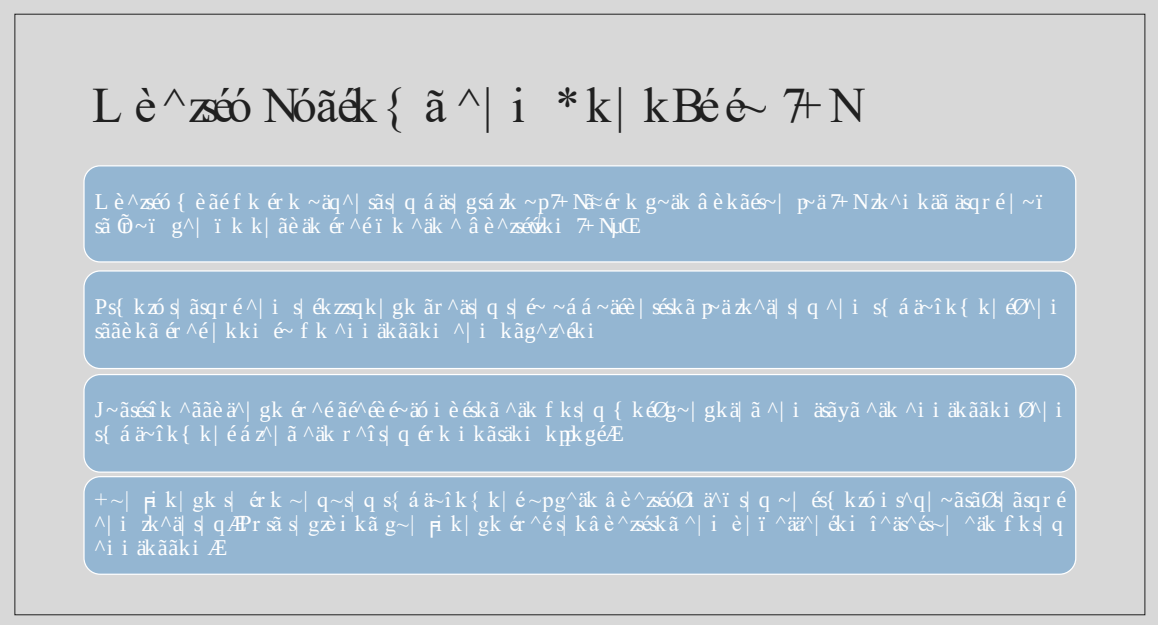
9. The quality of health and care matters because we should all expect care that is consistently safe, effective and provides a personalised experience. This care should also be delivered in a way that is well-led, sustainable and addresses inequalities. This means that it enables equality of access, experiences and outcomes across health and care services. This definition of quality forms the National Quality Board's (NQB) Shared Commitment and Position Statement for Integrated Care Systems (ICSs), published in April 2021.

10. The LLR ICS Quality and Performance Improvement Strategy is built on the foundations of the National Quality Board (NQB) System requirements thus meeting both national and local requirements. The seven steps to improving quality from the National Quality Board can be seen in Table 1.

Table 1 – NQB Improving Quality Steps

- Set a clear direction and priorities
- Bring clarity to quality
- Measure and publish quality
- Recognise and reward quality
- Maintain and safeguard quality
- Build capability, improving leadership and culture
- Stay ahead by developing research and innovation

11. In summary the benefits to having quality systems within the ICS in LLR can be seen below.



Vision, Ambition and Principles

Vision:

10. The integrated Care System (ICS) Vision is 'to develop an outstanding, integrated health and care system that delivers excellent outcomes for the people of LLR'. Our overall vision is to nurture safe, healthy, happy & caring communities in which people start well and thrive together throughout their lives. To do this, the principles we adhere to are seen in Table 2 where quality appears at the forefront.

Table 2 – the Principles of the LLR ICS

Principles **We will work together with respect, trust, openness and common purpose to**		
Ensure that everyone has equitable access and high-quality outcomes	**Make decisions that enable great care**	**Deliver services as locally as possible**
Develop and deliver services in partnership with our citizens	**Make LLR health and care a great place to work and volunteer**	**Use our combined resources to deliver the very best value for money and to support the local economy and environment**

Purpose:

11. The purpose of the ICS is to "work together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives". As stated in the Rutland Wellbeing Strategy - good health is the result of much more than clinical healthcare. It is also the product of our circumstances, our lifestyles and choices, our environment, and our engagement with the communities in which we live.

Ambition:

12. Our ambition is to optimise wellbeing of the population and reduce inequalities and unwarranted variation for our population. The vision will be delivered through the development of strategic partnership working with service providers, the NHS, public sector agencies, universal services and the voluntary sector; and the creation and delivery of a person-centred leadership framework (PCLF) which is underpinned by four key enablers.
    - Transformation;
    - Integration;
    - Communication, Engagement and Inclusion;
    - Multi-professional and System Leadership.

What is Quality?

13. Since the publication of High-Quality Care for All in 2008, the NHS has used a three-part definition of quality. NHS England describes this as: 'the single common definition of quality which encompasses three equally important parts". These are care that is:

- Clinically effective - not just in the eyes of clinicians, but in the eyes of patients themselves
- Safe
- Provides as positive an experience for patients as possible.

Clinically Effective:

14. To ensure the system is clinically effectively LLR will work towards preventing people from dying prematurely, enhancing quality of life, and helping people to recover following episodes of ill health. This will be done through a workforce who are adequately upskilled, supported and adaptable as per the Professional Leadership Strategy.

Safe Care:

15. NHSEI describe patent safety as the "avoidance of unintended or unexpected harm to people during the provision of health care. We support providers to minimise patient safety incidents and drive improvements in safety and quality. Patients should be treated in a safe environment and protected from avoidable harm". Learning from incidences nationally and locally and reviewing services in line with new policy is crucial to delivering safe care and part of the ICS Quality and Performance Improvement remit within LLR.

16. Safeguarding leads across the LLR ICS will work collaboratively to seek and gain assurance to ensure that children and adults at risk of abuse or neglect are supported to live safe lives through the priorities of prevention, learning, awareness and quality.

Positive Experience:

17. To determine if quality is improving, it is essential that services are co-produced with patients and the public and that the patient voice is heard throughout the process. Health and social care leaders in LLR are looking at the Think Local, Act Personal methodology within system groups to capture this information. Patient reported outcome measures need to be considered as part of the improvement process with learning from thematic complaints, serious incidents, surveys, audits, and a wealth of other data which is available to health and social care organisations.

18. The ICS is currently developing a Public Involvement and Engagement Strategy 2022-24 which aims to build on the established firm foundations of participation, involvement

and engagement with commissioners, providers and partners; combining this strong track record with modern and effective systems of engagement that link into ICS governance systems and processes.

"Within our local system we work collaboratively and recognise that when we involve the people who use our services in the planning of those services, we are able to "get it right". It is only by actively engaging with our many and diverse local communities that we can understand their experience of health care and build services that are mindful of their needs and expectations"

Values required to achieve co-production

19. Alongside this quality improvement also needs to be:

Sustainable	***Accountable & Assurance Focused***
Quality improvement needs to be sustainable. The Kings Fund describes it as 'the systematic use of methods and tools to try to continuously improve quality of care and outcomes for patients. Improving quality, care and performance outcomes can be undertaken using methodologies such as Lean; PDSA (Plan, Do, Study, Act), and Six Sigma. However, whichever methodology is utilised needs to provide assurances that the process is effective, leading to a culture of continued improvement against operational and contractual commitments and within the financial envelope available to the system.	The system in Leicester, Leicestershire and Rutland has developed a Performance and Quality Improvement Framework to provide assurance and accountability at "each level of the system and organisation to improve quality and encourage innovation" (Greater Manchester Quality Strategy 2017). Having a system framework meets the five elements that Matthews et al 2016 define as a requirement of a Quality Improvement Framework: - Define a unifying purpose - Establish a fractal organisational structure - Develop a common framework for understanding quality and safety - Develop tools for communication and reporting; and - Create a system of shared leadership responsibility. Assurance needs to be provided vertically and horizontally across the System.

Intelligence Driven	***Equitable***
Triangulating data and reviewing qualitative and quantitative intelligence drives improvement whilst also providing the system with assurance. One of the initiatives NHSE/I developed in 2020 is the need for ICS areas to have System Quality Groups to "share intelligence on early warning signs and quality risks." The purpose of the System Quality Groups will be to understand the key issues such as: • Where are we most worried about the quality of services? • What risks are we missing? • Do we need to do more as a system to address concerns, or collect more information? • Are we confident that enough action is being/has been taken? • Is there learning that we can take from other systems/regions to address the issue and/or improve quality? • Are there any potential risks/unintentional consequences for the system that we need to factor in?	The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health. Systematic variation in these factors constitutes social inequality, an important driver of health inequalities. Local Authorities have influence and responsibility over some of the wider determinants such as education, housing, transport, clean air, licensing of food and alcohol outlets etc. A joint outcomes framework will be developed from the strategy which will be a useful engagement tool to demonstrate ownership of performance and quality at every level of the system, not just the top.

20. Whilst recognising the importance of driving quality and performance improvement we can focus on the benefits for the service users and their carers but must remember the workforce who drive this work. Leicestershire Partnership Trust (LPT), one of the ICS key partners already has a commitment to workforce to drive quality both internally and externally by
    - Looking after our people – with quality health and wellbeing support for everyone
    - Belonging in the NHS – with a particular focus on tackling the discrimination that some staff face
    - New ways of working and delivering care – making effective use of the full range of our people's skills and experience
    - Growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return

What is Performance Improvement?

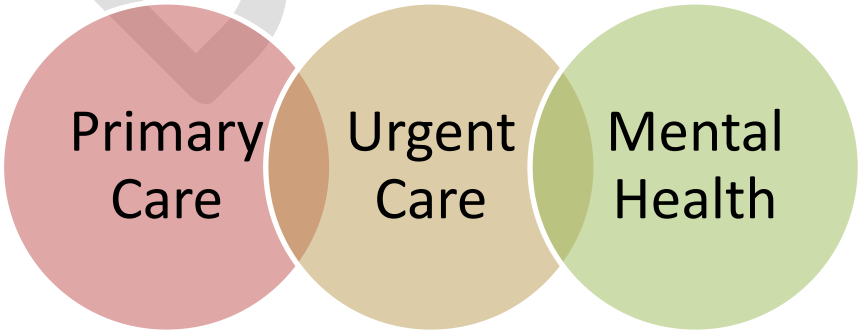
21. Improving performance is at the heart of what LLR strives to achieve and this will enable continuous improvement in delivering quality, efficient and patient-focused services through a cycle of Plan-Do-Review.

22. An organisational approach to improvement is one where a culture of continuous improvement and learning within the system are drivers for change. This needs the leadership, governance, financial means, and clinical drivers at each level to make it a reality. It is essential that there is a shared vision that is understood and supported at every level of the organisation to drive performance improvement; "this vision is then realised through a coordinated and prioritised programme of interventions aimed at improving the quality, safety, efficiency, timeliness and person-centredness of the organisation's care processes, pathways and systems" (The Health Foundation, 2020).

23. It is crucial at system level in LLR that the governance which wraps around quality and performance improvement is defined, shared and agreed. In addition, the system needs to consider and review performance improvement from an integrated health and social care perspective. In LLR the primary purpose of a Quality and Performance Improvement Strategy is to provide the system with a structure with which to make systematic, continuous improvements to performance enabling achievement of its objectives.

24. Metrics are only one source of intelligence. The current metrics being measured as an ICS are primarily the Constitutional Performance Standards for which NHSE/I require submissions alongside the provider Quality Schedules. The latter are contractual and contain national and local indicators. The purpose of the ICS System Performance Improvement will be to use data and intelligence to determine areas of success, pressure and challenge and where transformation can be made.

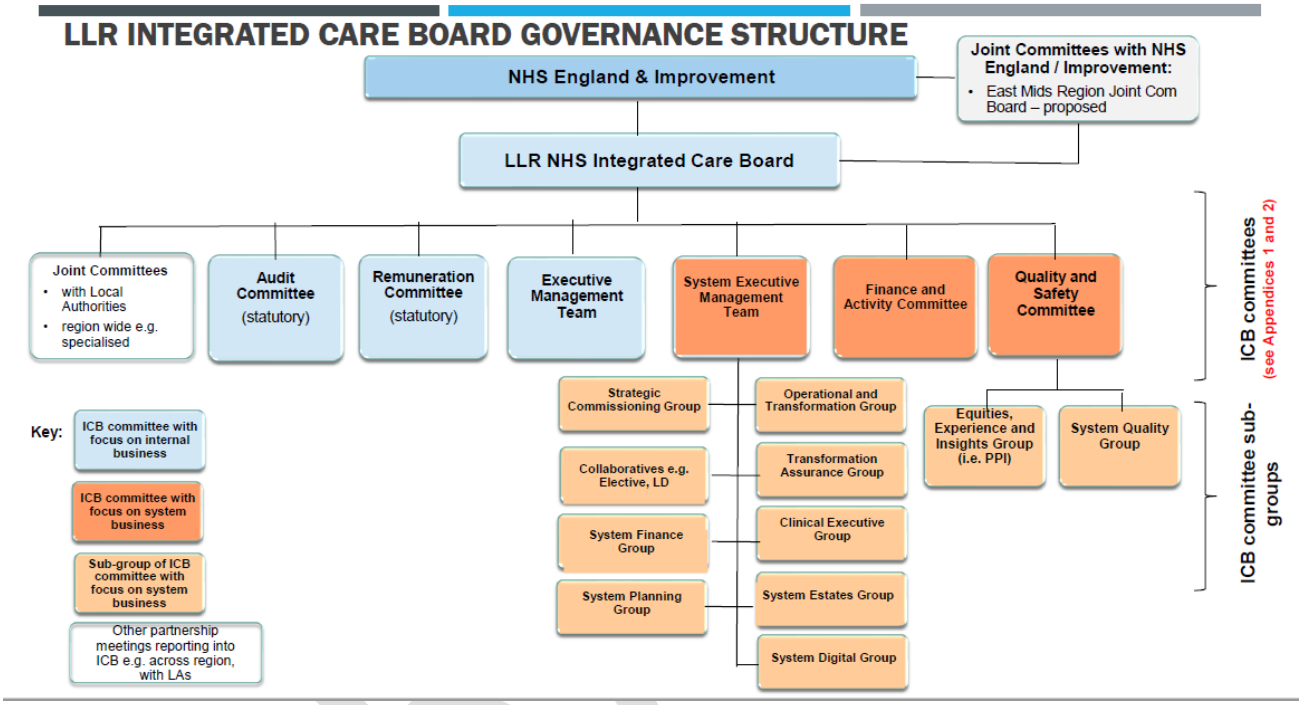
25. Processes to improve the achievement of the standards have been implemented and significant progress has been made and will continue against the following standards:



ICS Assurance: Measuring and Monitoring Quality of Health and Social Care

System Governance

26. The national quality board has determined that each ICS needs to have a separate assurance function to the system quality group. This will be the case in LLR where the governance will be as follows:



Assurance

27. In August 2021 an ICS Quality and Performance Improvement Assurance Committee (QPIAC) had its inaugural meeting as the System Quality Group in LLR ICS. This meeting will continue as the Quality and Safety Assurance Committee to receive intelligence from the System Quality Group and provide assurance to the Integrated Care Board.

28. The LLR ICS quality governance structure recognises the relationships between health and social care that are mutually accountable for opportunities to improve the quality of care and the outcomes in performance for the patient. There is the recognition that within LLR it is essential that our services and performance are benchmarked against similar peers nationally to enable continual learning within the system and improvement in performance and quality. Cultural change of this type requires strong leadership in relation to the importance of the vision along with person-centred values and behaviours.

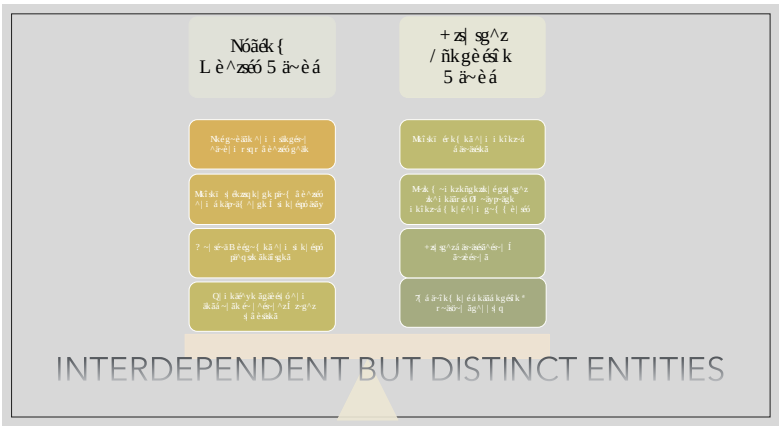
System Quality Group

29. Intelligence will feed into the Assurance Committee from the System Quality Group.

30. The System Quality Group will include intelligence from health inequalities, provider, place, system, pathway and performance information:

Clinical Executive Group

31. Interdependent but separate to the quality functions of the LLR ICS is the Clinical Executive Group (CEG) which will provide executive clinical leadership to the Integrated Care System, including: approving the clinical strategy for LLR; approving the implementation of new clinical pathways across the system; driving clinical culture change to improve pathways for the population of LLR ensuring integration of health and social care; promoting and overseeing major service change; monitoring clinical risk across the system associated with major change; providing senior health and social care professional leadership across LLR for transformational change by empowering clinical leaders across the system and unblocking barriers to change.



Internal

32. As the CCG moves to an ICS to share intelligence within the Clinical, Quality and Performance directorate there is a monthly Quality Review Meeting. This internal meeting allows the triangulation of intelligence where information is collated and coordinated which will feed into the System Quality Group. It also provides the opportunity to have a proportional assurance approach to quality at provider, place and system level as per the NQB requirements of a System Quality Group.

Conclusion

"Every system is perfectly designed to deliver the results it does" - Paul Batalden, 2007.

33. To have a fully functioning ICS Quality and Performance Improvement Strategy within LLR which serves to improve outcomes for our population, quality and performance assurance must have the governance around it to operate effectively. LLR is clinically led, independently assured, and managerially supported to unite common health and social care objectives at system level.

34. Improvement outcomes need to be based around a population health management approach across the life course to have the person at the centre of their care at System, Place and Neighbourhood level. Each of these three levels needs intelligence which is timely; triangulated with health and social care indicators; and demonstrates value in its widest sense to support planning to meet local needs, improving population level outcomes, and tackle inequalities. The ICS will lead the way on ensuring quality and improvement are central to the work that is being undertaken to deliver sustainable outcomes.

9

Leicester, Leicestershire and Rutland Integrated Care Board

Risk Management Strategy and Policy

Reference number:	LLR CORPORATE xx
Title:	Risk Management Strategy and Policy
Version number:	Version 1 – July 2022
Policy Approved by:	
Date of Approval:	
Date Issued:	
Review Date:	Every three years
Document Author:	Daljit K. Bains, Head of Corporate Governance
Executive Lead:	Nicci Briggs, Executive Director of Finance

Version Control

Version number	Approval / Amendments made	Date
Version 1	• Adopting the legacy strategy and policy from the ICB.	July 2022

DOCUMENT STATUS:
This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of the document are not controlled.

RELATED DOCUMENTS:
This document will reference additional policies and procedures which will provide additional information.

All policies can be provided in large print or Braille formats upon request. An interpreting service, including sign language, is also available.

Contents Page

RISK MANAGEMENT STRATEGY

AIMS AND OBJECTIVES

1. The purpose of this strategy is to define an effective and systematic framework and process that NHS Leicester, Leicestershire and Rutland Integrated Care Board (hereafter the ICB) and the board of the ICB will utilise to identify, manage and reduce its strategic and operational risks that threaten the organisation's ability to meet its strategic objectives.

2. The ICB has have a statutory and regulatory obligation to ensure that control systems are in place to minimise the impact of all types of risk, which could affect the proper functioning of the organisation.

3. All actions contain inherent risks and risk management is good practice, seen as an overall management approach, rather than an end in itself. It is central to the overall governance of the organisation in directing, controlling and delegating accountability arrangements to maintain control. The ICB will ensure that decisions made on behalf of the organisations ensure sound risk management practice.

4. Risk management is the process by which risks are identified, analysed, evaluated, rated and managed. This strategy sets out the ICB's approach to risk management which is based on:

    - NHS Resolution (previously NHS Litigation Authority) Risk Management Standards
    - NHS England and NHS Improvement guidance
    - Taking it on Trust (Audit Commission, April 2009)
    - ISO 31000:2009, Risk Management – Principles and Guidelines, Geneva: International Standards Organisation, 2009
    - Integrated Governance Handbook (Department of Health, February 2006, Gateway ref: 5947)
    - Corporate Governance Handbook (6th edition, Department of Health, August 2002, Gateway ref: 2003)
    - Good Governance Institute, The New Integrated Governance Handbook (2016)
    - Head of Internal Audit's Review and Opinion on the internal controls and assurances in place
    - The respective ICB's Corporate Governance Framework (i.e. the Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions)
    - Data Security and Protection Toolkit requirements
    - The Health and Safety at Work Act 1974 and associated legislation
    - The Management of Health and Safety at Work Regulations 1999 and the Workplace (Health, Safety and Welfare) Regulations 1992 (As Amended 2002
    - The Corporate Manslaughter and Homicide Act 2007

- Civil Contingencies Act
- Conflicts of Interest, Sponsorship and Gifts and Hospitality Policy

5. This strategy ensures that the ICB maintains a robust system of internal control and critically examines and effectively manages all risks that could affect the ability of the organisation to carry out its normal activities and achieve its strategic objectives.

6. The strategy involves creating an awareness and responsibility for the principles of risk management both as organisations and as part of the commissioning process. To this end, the risk management systems across the ICB are designed to ensure:

    - a culture that supports and encourages employees to identify, assess, report, control and monitor risks. That learning from the activity and experience is adopted, promoting the safest possible environment for patients, staff and visitors;

    - the development of a risk awareness culture throughout the organisation to help embed the consideration and assessment of risk in all daily work activities;

    - risks within the organisations are identified, assessed, treated and monitored as part of corporate and clinical governance arrangements;

    - all elements of the commissioning process, including needs assessment, tendering, contract management and evaluation include robust risk management mechanisms;

    - compliance with all relevant legislative and statutory requirements and non-statutory standards relating to the assessment and control of risk;

    - the identification and elimination of risk, or reduction and control of remaining risks by appropriate means;

    - the development of a risk management policy to provide a framework for the management of risk;

    - the establishment of controls and monitoring procedures to assure and measure the effectiveness of risk management throughout the ICB;

    - that there are effective organisational structures for risk management so that an ICB wide consistent approach to risk management is taken; and

    - that risk management is integrated into all areas of governance.

7. This strategy encompasses those risks associated with partnership and collaborative working arrangements and sets out to influence and control partnership risks through agreed management processes.

8. Risk management is an iterative process and engagement of all staff and partners is essential for its successful implementation. The ICB will work with its partners to promote robust risk management systems across the whole health and social care economy, working towards improving patient safety and learning from all incidents.

9. This strategy facilitates the embedding of risk management into the day-to-day management of the ICB. It is underpinned by a risk management policy, which sets out responsibilities for all levels of management and defines the role of the board of the ICB. The policy also specifies the responsibilities of the Chief Executive (i.e. the Accountable Officer), who is ultimately accountable for risk management within the organisation and the Executive Director of Finance, Contracting and Corporate Governance, who has responsibility for reporting progress to the board. Managers in all areas/directorates are accountable for ensuring that risks in their area are identified, monitored and controlled in line with this strategy.

10. The application of the strategy will be embedded into the organisation's business systems, including strategy and policy setting processes, to ensure that risk management is an intrinsic part of the way business is conducted.

11. The strategy will be reviewed and updated regularly to reflect the changing role and functions of the ICB and in accordance with appropriate good practice or legislation.

12. In addition to this strategy the following documents support the risk management systems across the ICB:

    - Conflicts of Interest, Gifts and Hospitality and Sponsorship Policy
    - Corporate Incident Reporting Policy
    - Serious Incidents Policy
    - Complaints Management Policy
    - Claims and Litigation Policy
    - Health and Safety Policy and associated policies
    - Information Governance Policy and associated policies
    - Information Security Policy and associated policies
    - Bullying and Harassment Policy
    - Whistleblowing Policy
    - Fraud, Bribery and Corruption Policy

13. The ICB aims to balance drive towards quality, innovation and improvement in commissioning and service delivery with its responsibility to safeguard public money. By applying sound risk management practice the organisation will aim to commission safe and effective health care. Therefore in some areas the organisation will wish to be more risk tolerant than in others.

THE BOARD's INTENT

14. The ICB board is committed to commissioning safe and effective care and leading the organisation to deliver its stated objectives. It intends to use the risk management processes in this strategy to help achieve their objectives and vision. The ICB is committed to having robust governance arrangements in place, which underpin the Risk Management Strategy.

SCOPE OF THE STRATEGY

15. The scope of the strategy primarily relates to the resources directly managed by the ICB. However, it is recognised that there are services provided by other agencies, for example other ICBs, Local Authorities, primary care contractors, and other organisations outside the ICB which may act on its behalf. There are also commissioning support services and shared services with other NHS organisations. These activities and actions represent a level of risk to the ICB and are included within the scope of this strategy. Risk in these situations is managed through formal partnership governance arrangements and/or is a contractual requirement.

16. Each directorate, in line with the policy and procedures, will be expected to identify its own risks and to address them ensuring that they do not impede the delivery of directorate or departmental objectives, nor the ICB's overall objectives. The main objective for managers, clinicians, and staff is to eliminate, or reduce so far as is reasonably practicable, the potential for any risks or adverse incidents that could occur in their own area of responsibility.

BENEFITS AND OUTCOMES

17. The objective of the strategy is to embed risk management throughout the ICB so that we:

- enhance patient care through safer practices;
- minimise injury or loss through safer systems of work;
- create a safer environment for patients, visitors and staff;
- increase awareness and ownership of risk and liabilities;
- reduce the financial and other cost of risk taking and accidents;
- provide stakeholders with an understanding of our intent regarding the management of risk;
- prevent prosecution under Statute and Regulation improve the reputation of the ICB and confidence of the public in NHS services.

IMPLEMENTATION

18. For the Strategy to be effective, the ICB will:

- review the Risk Management Strategy and Policy annually, with a formal review every three years. The procedures and any accompanying action plans will also be reviewed annually to ensure they meet the needs of the organisations and the changing environment.

- continue the development and review of a training and awareness programme which assists staff in identifying and managing risk and in complying with policies and practices relating to risk management. This programme will be based on ongoing training needs analyses and personal development plans. Attendance records will be kept for all training, and evaluation forms will be completed and held by the Corporate Governance team.

- focus on the systematic use of information systems such as Datix (or alternative application or software), which provides ongoing identification and capture of relevant, reliable and up to date information relating to incidents and risk issues.

- raise general awareness among staff on risk management through briefings, communications, induction programmes and inclusion of relevant documents on the shared drive and / or intranet site.

REVIEW

19. The Executive Management Team and the board of the ICB will review the strategy and policy at least every three years.

RISK MANAGEMENT POLICY

POLICY STATEMENT

20. NHS Leicester, Leicestershire and Rutland Integrated Care Board (hereafter LLR ICB) and its board attaches great importance to the management of risk and acknowledge that commissioning health services is an inherently risky business and that risk can bring with it positive advantages, benefits and opportunities. The ICB therefore aims to create an environment where risk is considered as a matter of course and appropriately identified and managed.

21. Good risk management makes a positive contribution to the development and maintenance of a safer environment and better care for patients, staff and visitors, thereby assisting the ICB to capitalise on opportunities and fulfil its strategic objectives and obligations as a good corporate citizen.

22. It is imperative that a culture of open reporting is promoted and upheld throughout the ICB to ensure that risks are identified, evaluated, documented and managed by all who may encounter it.

23. The ICB is committed to making risk management a core organisational process and ensuring that it becomes an integral part of its philosophy, practices and business planning and that responsibility for its implementation is accepted at all levels of the organisation. The ICB recognises the importance of involving local stakeholders in their risk management processes and of working in partnership to identify, prioritise and control shared risks.

24. Partnership working with, for example local authorities, voluntary organisations, patients, carers etc, is key to the achievement of the strategic objectives. It is often at the interface between organisations where the highest risks exist and clarity about responsibilities and accountabilities for those risks is most difficult to ascertain. Only by working closely and collaboratively with a wide range of partner organisations can these risks be managed.

25. By implementing a proactive approach to business risk management, the ICB will be able to identify the risks, train and educate staff appropriately, plan for emergencies and business interruptions, monitor incidents, review practice and therefore be able to determine how expenditure is targeted and used most effectively.

26. The ICB aims to design and implement policy documents that meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and advances equal opportunities for all. This policy has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.

SCOPE OF THE POLICY

27. This document sets out the ICB's approach to the management of risk and the development of a consistent and integrated system which enables informed management decisions in the identification, assessment, treatment and monitoring of risk.

28. This policy applies to all employees of the ICB and contractors engaged in its work in respect of any aspect of that work.

29. Active leadership is required from managers at all levels to ensure that risk management is part of the total approach to quality, corporate and clinical governance and the ICB's Annual Governance Statement. The policy relates to all areas of ICB's activities and encompasses both clinical and non-clinical risks including information risk.

30. The policy applies to all ICB premises and persons engaged in business on behalf of the ICB. The ICB and the Executive Management Team are required to ensure the formal introduction and embedding of information risk management into the key controls and approval processes of all major business processes and functions of the ICB. The information risk assurance process is set out as a requirement of the Data Security and Protection Toolkit, which also requires that a board level Senior Information Risk Officer (SIRO) who takes ownership of the information risk policy, acts as advocate for information risk for the board and provides written advice to the accounting officer on the content of the Annual Governance Statement in regard to information risk.

31. The policy relates to the management of the risks faced by ICB. Its scope therefore primarily relates to the resources directly managed by the ICB. However, activities of primary care contractors, and the actions of organisations outside ICB but acting on its behalf through commissioning agreements, involve risks which impact on whether the ICB achieves their objectives. Hence, to this extent their activities and actions come within the scope of this policy. Local contracts with primary care contractors (e.g. General Practitioners) and service providers will be encouraged to meet the standards for risk management and compliance will be reviewed during contract and quality review meetings.

STATUTORY REQUIRMENTS

32. There is a legal requirement for all employers to ensure that assessments of health and safety risks to employees, patients, others and the organisation are carried out. Furthermore, they should be reviewed at regular intervals to ensure that they remain accurate and valid. The Management of Health and Safety at Work Regulations 1999 and the Workplace (Health, Safety and Welfare) Regulations 1992 (As Amended 2002) require that employers should carry out assessments of the risks created by their operations, which may affect their employees, or anyone else.

33. The Corporate Manslaughter and Corporate Homicide Act 2007 highlights the commitment required of senior management to take reasonable steps to protect employees, or anyone else who might be affected where risks are created by their operations, the implementation of robust risk management systems is of paramount importance.

34. The Data Protection Act 2018, the Freedom of Information Act 2000 and other legislation requires organisations to comply with rules relating to the handling of information and thus minimising information related risks.

DEFINITIONS

35. Risk is defined as the ”effect of uncertainty on objectives” and risk is often expressed in terms of a combination of an event and the associated likelihood of occurrence. It is the chance/likelihood of something happening which could provide a positive opportunity/consequence or could threaten the achievement of a directorate’s and/or organisation’s strategic objectives.

36. In the context of this strategy and policy, a risk encompasses anything from the possibility of injury to an individual patient or member of staff to anything which impacts upon the ICB’s ability to fulfil their aims and objectives including damage to the reputation of the ICB, which could undermine patient and public confidence in the organisations.

37. Risk management is the term applied to a logical and systematic method of identifying, assessing, evaluating, managing, controlling, reporting, monitoring and communicating risks associated with any activity in a way that will enable the ICB to minimise losses and maximise opportunities.

38. A detailed list of definitions is provided in Appendix 1.

RISK MANAGEMENT MODEL

39. Risk and risk taking is inherent in everything the ICB do. Commissioning and procuring services, determining service priorities, managing a project, purchasing new medical equipment, taking decisions about future strategies, or even deciding not to take any action at all are all examples of risk. Therefore, a structured, systematic and consistent approach to risk management, which encompasses all the ICB’s functions and activities has been adopted.

40. The resources available for managing risk are finite and so the aim is to achieve an optimum response to risk, prioritised in accordance with an evaluation of the risks and to take action to manage risk in a way, which it can justify to a level, which is tolerable.

41. The ICB have adopted the ISO 31000:2009 Risk Management – Principles and Guidelines risk management standard. This international standard sets out the internationally accepted generic best practice in risk management. The standard is based on and replaces the Australian/New Zealand standard 4360:2004. This

provides a generic model for identifying, prioritising and dealing with risks in any situation, whether at local or corporate level. Stages to managing risk are described in Table 1 below:

Table 1: Risk Management Model

Stage		Description
1.	**Establish the context**	• Define the activity • What are the goals and objectives? The environment in which the ICB function influences the risks faced and provides a context within which risk has to be managed. The ICB also work in partnership with other organisations to deliver their objectives. Full consideration needs to be given to the context in which the ICB function and to the risk priorities of partner organisations to ensure risk management is effective.
2.	**Identify hazards/ risks**	Articulate the risk: • what could happen? • how could it happen? • what would the effect be? Use the cause and effect **'x, y, z'** model to assist in articulating the risk: - concern that 'x' could happen - because of 'y' - resulting in 'z' ***For example**:* ***- concern that 'x' could happen*** e.g. loss of key personnel in business function A. ***- because of 'y'*** e.g. because of salary differentials due to local competition for skilled staff, because of work/life balance issues in relocation and restructuring. ***- resulting in 'z'*** e.g. results in significant reduction in ability to deliver to quality performance objectives; results in functional inability to deliver day-to-day to ops; results in loss of business - direct financial loss.
3.	**Analyse the assess the risk**	• how could risks occur? • what would be the effect if they did? • how could they be reduced?
4.	**Evaluate and prioritise risk**	• evaluate options for reducing risks; • quantify costs of actions to reduce risks; • identify action, which reduce total cost of risk and give best value for money; • compare costs against benefits.

5.	**Risk Treatment and Control**	• ***Terminate/avoid:*** not proceeding with the activity likely to generate the risk; • ***Treat/reduce:*** reducing or controlling the likelihood and consequences of the occurrence; • ***Transfer***: arranging for another party to bear or share some part of the risk, through contracts, partnerships, joint ventures etc; • ***Tolerate/accept:*** some risks may be minimal and retention acceptable.
6	**Monitor and review**	• monitor risk impact; • review effectiveness of action/s • has the risk priority changed?
7	**Communicate and consult**	• who needs to know? • who is affected?

42. Risk assessment under ISO 31000 comprising stages 2 – 4 in the table above and provides a list on how to deal with risk:

- Avoiding the risk by deciding not to start or continue with the activity that gives rise to the risk;
- Accepting or increasing the risk in order to pursue the opportunities;
- Removing risk source;
- Changing the likelihood;
- Changing the impact;
- Sharing the risk with another party or parties;
- Retaining the risk by an informed decision.

43. Each stage of the risk management process should be documented in order to:

- demonstrate that the process is conducted properly;
- provide evidence of systematic approach;
- provide a record of risk and to develop the ICB's knowledge of risk;
- provide relevant decision makers with a risk management plan for approval etc;
- provide an accountability mechanism and tool;
- facilitate review and monitoring;
- provide an audit trail;
- share and communicate information.

44. It is good risk management practice for all levels of the organisation to undertake risk assessments appropriate to their areas of responsibility. The strategy of the ICB is to manage and assess risks through an organisationally layered approach. Risks of all types are assessed and managed in accordance with this policy and any additional guidance circulated by the Corporate Governance Team.

45. The following provides an overview of the areas described within the model:

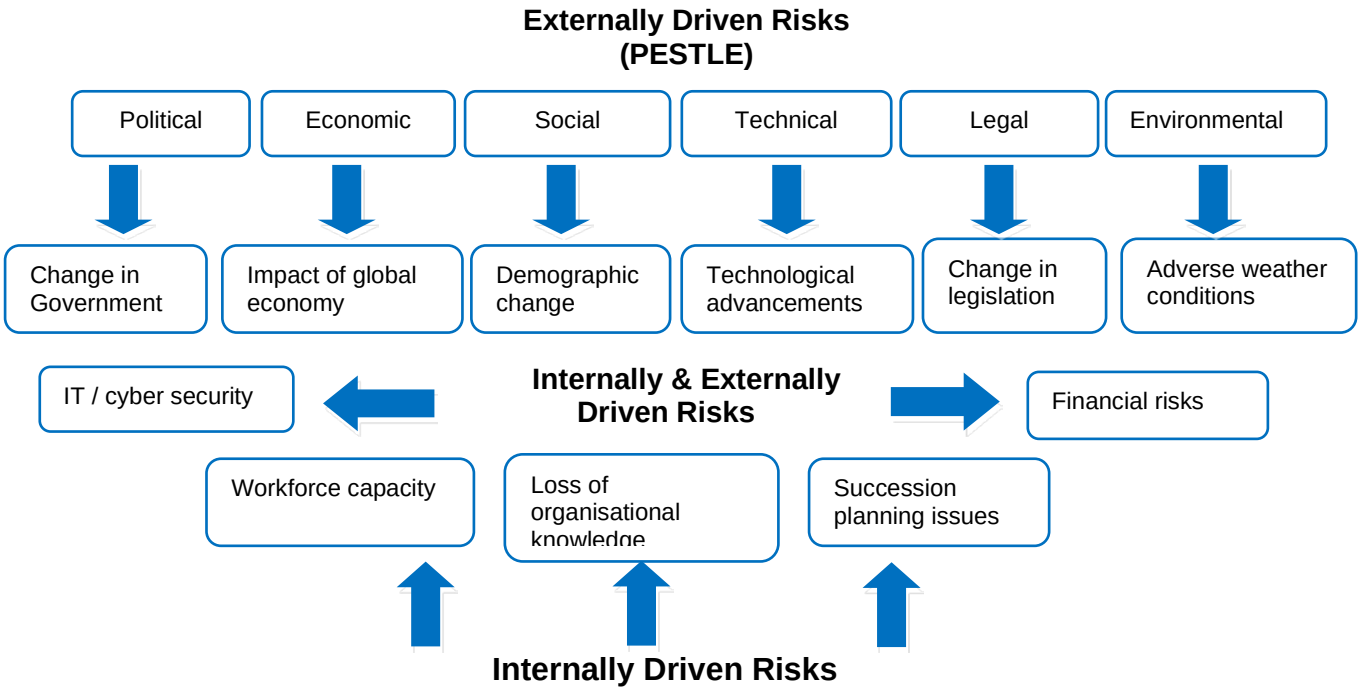
Risk Identification

46. The key to effective risk management lies with the ICB knowing what risks are likely to occur to enable them to proactively manage them. An effective mechanism to capture and report risks is therefore essential. Risk can be identified by staff at all levels within the organisation in two ways from internal and external sources, using proactive or reactive methods and should be recorded through the appropriate documentation for that function using the corporate tools and formats made available:

- **External methods**, such as media, national reports, new legislation, reports from assessments/inspections by external bodies, reviews of partnership working and considering the political, economic, social and technological environment (PESTLE). This is also known as a ***'top-down'*** approach.

- **Internal methods**, such as complaints, claims, serious incident reporting and corporate incident reporting and identification of trends, audits, QIPP related risks, project/programme risks based on achievement of strategic objectives, staff surveys, risk assessments, whistle-blowing and contract quality monitoring of commissioned services. This is also known as a ***'bottom-up'*** approach.

Examples of each category under PESTLE



Strategic Risks

47. Strategic risks identified are those that represent major threats to achieving the ICB's strategic objectives or to its continued existence. This will include the impact

of partnership and local health and social care system-wide risks and the impact of these risks on the ICB's objectives.

48. These will be identified through various forums e.g. partnership arrangements across LLR.

49. Strategic risks will be recorded in the ICB Board Assurance Framework (the corporate risk register) and managed through directorate risk registers locally. Strategically the Executive Management Team will have an overview of the Directorate Risk Registers.

Operational risks

50. Operational risks are bi-products of the day-to-day running of the ICB and include a broad spectrum of risks including clinical, fraud, security, financial, information and legal risks arising from employment law, health and safety legislation and risk of damage to assets or system failures to name but a few.

51. They are the responsibility of management and should be identified and managed by Executive Management Team and only considered by the ICB Board on an exception basis and when they meet the required risk score to be escalated to the Board Assurance Framework.

52. Effective risk management significantly contributes towards successful completion of projects, which in turn supports the delivery of the ICB's strategic objectives. Projects and programmes of work may be supported by a project/programme specific risk register, and escalation from these will be via the directorate level risk register and / or the ICB Board Assurance Framework.

53. Risk identification requires examination of the sources or nature of the threat (or impact) and then involves identifying what events might trigger the risk. Identifying new operational risks arising from training or changes to working practices or environment is a routine part of the day job for staff. All staff should be actively encouraged to identify and contribute to the risk management process. Furthermore, this should be enhanced by cross-organisational learning and review of past practice. For example, analysis of serious incidents can highlight risks that the ICB may not have successfully managed. A positive approach to learning from such risk management failures, underpinned by a culture of openness, will allow cross-organisational learning. Similarly proactive risk assessment will ensure that risks are managed actively before they are realised.

54. Risk assessments will be performed for all its information systems and critical information assets and will occur at the following times:

    - at least annually for the review of information risk for the SIRO to support the SIRO's written statement in the Annual Governance Statement;
    - at the inception of new systems, applications, facilities, etc, that may impact on the assurance of information and information systems;
    - before enhancements, upgrades, and conversions associated with critical systems and applications;

- when NHS policy or legislation requires risk determination;
- upon request from the ICB Board, or any other ICB committee;
- an annual exercise of internal audit will be undertaken in relation to information risks.

Categorising types of risk

55. For organisational reasons and to clarify management responsibilities, risks are categorised into four categories as described in Table 2.

Table 2: Categories of risk

Type of risk	Description	Examples
Clinical risks	Have a cause or effect that is primarily clinical or medical.	• clinical care activities; • consent issues; • medicines management.
Organisational risks	Primarily relate to the way in which ICB are organised, managed and governed.	• property related risks; • human resources; • corporate governance; • health and safety; • risks identified through equality impact risk assessments; • reputation; • quality etc.
Financial risks	Defined as those whose principal effect would be a financial loss or a lost opportunity to deliver a financial gain.	• poor financial control; • fraud and ineffective insurance arrangements.
Information risks	The principal effect results in the theft, disclosure or modification of personal, confidential or sensitive information.	• Loss of data, records or information; • Loss of access to servers or software (including destruction / damage); • Intentional or accidental unauthorised actions.

Assessing and evaluating risks

56. The ICB have adopted a 5 x 5 risk assessment matrix, as defined in guidance from the National Patient Safety Agency, for the purpose of risk assessment (see Figure 1 below). Risk assessment allows the ICB to establish which hazards and risks are most serious and to whom or which function, assess whether existing controls are adequate, devise mitigating actions to further control the risk, and revise the impact of the mitigating actions and assurances.

57. An assessment of the risk needs to be undertaken by evaluating both the likelihood of the risk being realised and of the impact/consequence if the risk is

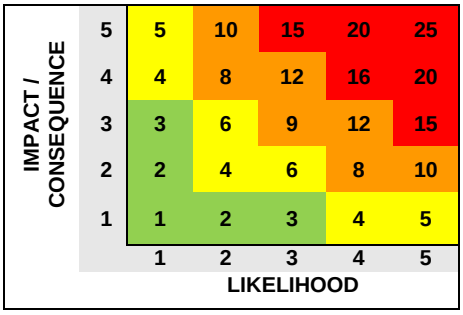
realised. Descriptors underpinning impact/consequence and likelihood can be found at Appendix 2.

- the ***impact/consequence*** describes the impact or outcome component of risk i.e. the outcome or the potential outcome of an event. There may be more than one impact/consequence of a single event.

- the ***likelihood*** describes the probability or frequency of a consequence occurring i.e. how probable it is that the risk (the event or outcome) will occur.

Figure 1: 5 x 5 Risk Assessment Matrix

IMPACT / CONSEQUENCE		LIKELIHOOD	
1	NEGLIGIBLE	**1**	RARE
2	MINOR	**2**	UNLIKELY
3	MODERATE	**3**	POSSIBLE
4	MAJOR	**4**	LIKELY
5	CATASTROPHIC	**5**	ALMOST CERTAIN



This will result in risks being rated in one of the following four categories

Risk score	Category
1 – 3	Low risk (green)
4 – 6	Moderate risk (yellow)
8 – 15	High risk (orange)
15 – 25	Extreme risk (red)

Risk Appetite (or tolerance level)

58. Each risk identified whether operational or strategic must have associated with it a tolerance level providing a clear indication of the risk appetite i.e. the level of exposure to the risk the organisation is willing to accept. This will be defined in terms of both tolerable impact if a risk is realised, and tolerable frequency of that impact using the 5 x 5 risk matrix.

59. Tolerability may be informed by for instance, stakeholder perception of an impact/consequence, patient safety, the balance of the cost of the control and the extent of exposure. This enables the ICB to know what its exposure will be if control(s) should fail.

60. By adopting the risk appetite the ICB can decide when considering its core objectives what threats it can accept before action is deemed necessary to reduce the risk. A defined acceptable level of risk means that resources are not spent on further reducing risks that are already at an acceptable level.

61. The risk appetite of the ICB Board is not necessarily static. The ICB Board may vary the amount of risk that they are prepared to tolerate depending on the circumstances at the time.

62. Where the residual risk score exceeds the risk appetite score the ICB Board will:

    (a) scrutinise the adequacy of mitigating actions;

    (b) agree the timeline for bringing the risk within the ICB's appetite;

    (c) monitor progress; and

    (d) determine any further actions and escalation routes if needed.

63. The main principles set out within this section are that:

    (a) the lower the risk appetite, the less the ICB are willing to accept in terms of risk and consequently the higher levels of controls that are put in place to manage the risk;

    (b) the higher the ICB's appetite for risk, the more the ICB are willing to accept in terms of risk and consequently the ICB will accept business as usual activity for established systems of internal control, and will not necessarily seek to strengthen those controls above all else.

Risk Appetite Level

64. The ICB's risk appetite level within its functions has been determined as follows:

a) Clinical quality and patient safety (clinical risks)

The ICB are responsible for ensuring the quality and safety of services it commissions from providers. It has a **low appetite** for risks that impact on patient safety and for providers' performance failures that impact on patient safety.

b) Statutory and mandatory compliance and governance (organisational and information risks)

Non-compliance with legal and statutory requirements, including information governance and information security undermines public and stakeholder confidence in the ICB; has the potential for harm and legal consequences; and therefore the ICB have a **low appetite** in relation to these risks. The ICB have a preference for safe delivery options rather than risk breaching statutory or compliance obligations and standards.

c) Financial statutory duties (financial risks)

The ICB are open to considering all potential delivery options that provide an acceptable level of reward and value for money. The ICB have a **low appetite** for risks that impact on its statutory duties of maintaining expenditure within allocated resource limits. Similarly, the appetite for fraud and negligent financial loss remains low.

d) Reputation

Patient confidence and trust in the ICB is important to good outcomes. The ICB therefore have a **low appetite** for risks that may cause reputation damage and undermine public and stakeholder confidence in the ICB.

65. The acceptable risk score considers the levels of control required to achieve the risk appetite to ensure that the ICB's response to risk is proportionate to how it can influence the likelihood of risk through improved controls.

66. A summary of the above, which includes risk appetite, acceptable risk score that is associated with that level of appetite, as well as the rationale for that risk score, can be found in Appendix 3.

Inherent risk (or gross risk evaluation)

67. Inherent risk is the effect of something that might happen before taking account of controls in place to manage or mitigate it. The higher the score the more attention the risk will require and more likely the ICB Board would seek assurance as to how it is being managed, whether directly or via a sub-committee.

68. Knowledge about the inherent risk also allows better consideration of whether there is over-control in place. If the inherent risk is within the risk appetite, resources may not need to be expended on controlling the risk.

69. Risk prioritisation involves agreeing the order in which risks need to be addressed. Generally risks will be prioritised according to their inherent risk rating, i.e. the higher the rating, the higher the priority afforded to the risk.

70. However, some minor risks may be easy to address and tackled sooner rather than later for that reason. Some extreme risks may be part of the nature of the business itself and difficult, impractical and even inappropriate to reduce. Reducing a risk may have an adverse impact on another aspect of the ICB's business, prevent the taking up of an important opportunity or stifle innovation. Risk prioritisation must take these broader considerations into account. For this reason, the Executive Management Team will have responsibility for prioritising risks for onward reporting to the Audit Committees and to the board.

71. The rating and prioritisation of the risk will determine the speed with which the risk action plan (as determined by EMT) should be implemented and at which level of the organisation the risk needs to be reported, as described within Table 3 below:

Table 3: Risk prioritisation and reporting

Risk Score	Category	Risk priority
1 - 3	Low risk (green)	▪ acceptable risk, can be managed by routine procedures at a local level, minimal action may be required. ▪ periodic monitoring and review to be undertaken at Directorate/departmental level to ensure that risk has not escalated and controls are still effective.
4 - 6	Moderate risk (yellow)	▪ specific responsibility for risk assessment and action planning must be allocated to a named person (manager, clinician). ▪ usually deadline for completion will be within 6 to 9 months and will depend on resource availability. ▪ action to eliminate or reduce these risks would normally be the responsibility of the relevant directorate. ▪ risk and proposed action plan to be reported to the lead Executive Director.
8 - 12	High risk (orange)	▪ urgent Executive Management Team attention required. ▪ action(s) within 3 – 6 months. ▪ action(s) to eliminate or reduce these risks would normally be the responsibility of the relevant directorate. ▪ progress and monitoring will be at Executive Management Team level. ▪ risk and proposed remedial action plan to be reported to Executive Management Team (via the ICB's Board Assurance Framework) and Audit Committees (via the ICB's Board Assurance Framework).
15 - 25	Extreme risk (red)	▪ immediate action required to remove/reduce risks; ▪ action(s) to be taken within 2 months. ▪ risk entered on ICB' Board Assurance Framework. ▪ an Executive Director must be informed and s/he will take responsibility for development and implementation of an appropriate risk action plan and inform the Accountable Officer. ▪ risk and proposed action plan to be reported to the Audit Committees and to the ICB's Board (via ICB's Board Assurance Framework) ▪ Progress and monitoring will be at Executive Management Team level with updates to Audit Committees at every meeting and to the ICB Board at frequency agreed by the ICB Board.

72. The rating of risks is useful as a guide for prioritising risks and in ensuring that risks are brought to the attention of the most appropriate staff, Directors and Committees.

73. The assessment of an operational risk must be recorded in the Directorate risk register as appropriate and a strategic risk must be recorded in the Directorate register and then escalated as appropriate depending on the assessment. This will include documenting existing controls in place to reduce the impact/consequence and likelihood of risks, e.g. policies and procedures, monitoring and reporting mechanisms, audits, etc. The effectiveness of these controls will need to be documented and whether action needs to take place.

Residual risk (or net risk evaluation)

74. Residual risk is the risk score after taking account of the controls in place to reduce the likelihood of it materialising, or to minimise its impact should this happen. This evaluation of a risk compared with the risk appetite is useful as a guide for prioritising risks and determines the appropriate level of managerial supervision and action.

Systems and processes for managing risk

75. "Internal control" is the response which is initiated within the organisation to manage a risk and may involve one or more of the following treatment options (as described in Table 4) to manage the risk:

Table 4: Treatment options for managing risks

Treatment options	Description
Terminate / avoid risk	When it is identified that an activity could lead to a risk the ICB may choose not to proceed with the activity likely to generate the risk
Treat/reduce risk	Reducing or controlling the likelihood of the occurrence, treating the risk in an appropriate way to constrain the risk to an acceptable level or actively taking advantage, regarding the uncertainty as an opportunity to gain a benefit.
Transfer risk	Arranging for another party to bear or share some part of the risk, through contracts, partnerships, joint working, etc.
Tolerate/accept risk	Some risks may be minimal and retention of them is therefore acceptable. It is never possible to eliminate all risks and there will be a range of risks that will be identified that would require the ICB to go beyond 'reasonable' action to reduce or eliminate them. Where the 'cost' (time or resources) to reduce the risk would outweigh the potential harm caused, in particular situations, it would be considered 'acceptable' to the ICB. Examples include low impact events such as minor property loss and damage, injuries that require minimum first aid only, which are unlikely to result in more serious injuries if left unresolved, or potentially more serious events that are unlikely to occur and for which reasonable preventative controls are in place.

76. Once the above options have been considered and the most appropriate way forward identified, EMT will determine whether a risk action plan (remedial action plan) will be drawn up by the risk owner and implemented.

77. The risk remedial action plans will contain details of each action and control required to treat the identified areas of risks set out in the risk registers. An individual will be the named lead with responsibility for ensuring the action is carried out by the chosen due date. Where possible an assessment will be made of the resources required to undertake the action. The assessment of the resources required should take into account staff resources as well as financial resources.

78. In situations where the risk can be realistically managed, or reduced within a reasonable timescale through cost-effective measures, such as developing safer systems of work, training, developing protocols etc these would be deemed 'manageable' risk. Examples would include procedure failures and minor manual handling injury. Action to reduce or eliminate these risks would normally be the responsibility of the directorate.

Types of controls

79. When the assessment of the residual risk is compared to the risk appetite the extent of action required becomes clear. It is not the absolute value of an assessed risk, which is important; rather it is whether or not the risk is regarded as tolerable, or how far the exposure is away from tolerability, which is important.

80. Effective controls need to be in place if risks are to be effectively managed. One specific risk may be mitigated by a number of controls. Some controls may only be effective when operating in conjunction with other controls and one control may relate to more than one risk. For each risk entered in the risk register the adequacy of the control(s) relating to the risk will be assessed and any necessary action determined and entered in the action plan.

Type of control	Definition	Examples
Preventative	These focus on the systems and processes which are introduced to deter problems before they arise.	• hiring qualified and competent personnel; • controlling access to physical facilities; • sound governance arrangements; • maintenance of equipment; • sound hand-washing practices etc.
Detective	These controls are designed to either discover problems or identify related risks soon after they arise, or measure deviations from expected norms or thresholds.	• failure to meet key performance indicators; • prescribing activity monitoring and financial balance data; • complaints and incident reporting etc.

Corrective	These are procedures put in place to remedy problems discovered by detective controls, or steps taken to correct errors arising out of a problem.	• changes to processes; • introduction of new policies etc.

Monitoring and Review of Risks

81. Progress in implementing the LLR ICB's risk action plans will be monitored on a bi-monthly basis at the Executive Management Team meetings to enable the underlying risks to be re-assessed.

82. The risk appetite would provide a baseline to monitor each risk against i.e. the residual risk will be reviewed against the risk appetite to monitor the effectiveness of controls and whether actions are being addressed to ensure that the risk remains equal to or below the tolerance level.

Communication and learning

83. Communication and learning runs through the whole process of risk management. The identification of new risks or changes in risk are important and dependent on communication coordinated by the Corporate Governance Team. Communication about risk is also important in relation to:

    - ensuring everybody in the ICB understands in a way appropriate to their role, what the organisation's risk strategy and policy is, what the risk priorities are and how their particular responsibilities in the organisation fit into the framework;

    - ensuring that transferable lessons are learned and communicated to those who can benefit from them; and

    - ensure that each level of management, including the ICB Board, actively seek and receive appropriate and regular assurance about the management of risk within their span of control. Sufficient information will be provided to allow them to plan actions in respect of risks where the residual risk is not acceptable, as well as assurance about risks which are deemed to be acceptably under control. In addition to routine communication of such assurances, there should be a mechanism for escalating important risks which suddenly develop or emerge.

84. Communication with partner organisations about risks is also important particularly where an organisation is dependent on the other organisation for direct delivery of services on behalf of the organisation.

ROLES AND RESPONSIBILITIES

Accountabilities and responsibilities

Responsibility of the ICB's Chief Executive (Accountable Officer)

85. The ICB Chief Executive is the Accountable Officer for the ICB and, as such, has overall accountability and responsibility for ensuring there is an effective risk management system in place within the ICB. This includes meeting statutory requirements and adhering to guidance issued by the Department of Health and NHS England & NHS Improvement in respect of risk and governance.

86. The ICB Chief Executive is required to sign an Annual Governance Statement on behalf of the ICB Board. This describes how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

87. On behalf of the ICB Chief Executive, Executive Directors are collectively and corporately responsible and accountable for the management of all risks in the organisation. Specific additional delegated responsibilities are set out below.

Responsibility of ICB's Executive Director Nursing, Quality and Performance

88. The ICB's Executive Director Nursing, Quality and Performance has delegated responsibility from the ICB Chief Executive for managing the strategic development and implementation of clinical governance, overseeing the handling and monitoring of patient safety incidents and complaints.

89. The Chief Nurse is also the trained and named Caldicott Guardian for the ICB.

Responsibility of ICB's Executive Director of Finance, Contracting and Corporate Governance

90. The ICB's Executive Director of Finance, Contracting and Corporate Governance has delegated responsibility from the ICB Chief Executive for managing the strategic development and implementation of organisational and financial risk management systems and processes relating to organisational financial performance management and corporate governance. This includes overseeing the handling and monitoring of corporate incidents and litigation claims arising from patient care. Responsibility also includes regularly reporting on the content of the risk registers and the ICB's Board Assurance Framework and the actions being taken to the Executive Management Team meetings, Audit Committees and Board meetings.

91. The ICB's Executive Director of Finance, Contracting and Corporate Governance is the nominated Senior Information Risk Owner (SIRO).

92. As the Senior Information Risk Owner (SIRO), the ICB's Executive Director of Finance, Contracting and Corporate Governance has responsibility to act as an advocate for information risk management and information governance on the Board. The SIRO will ensure information risk management is incorporated into the Risk Management Policy and Strategy and where required review and agree action in respect of identified information risks. Responsibility will also include the following: taking ownership of the risk assessment process for information risk, including review of an annual information risk assessment to support and inform the Annual Governance Statement; ensuring that the ICB's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff; and providing a focal point for the resolution and/or discussion of information risk issues.

Executive Director of People and Innovation

93. The ICB's Executive Director of People and Innovation has responsibility from the ICB's Chief Executive for promoting the ICB's innovation programmes within and outside the ICB. This includes the strategic development and lead for the ICB's work on digital technology, overseeing the communications and engagement work, and oversees Human Resources and organisational development.

Executive Director of Strategy and Planning

94. The ICB's Executive Director of Strategy and Planning has responsibility from the ICB Chief Executive for the short and long term strategic planning. This includes public reporting of Integrated Care System (ICS) progress, oversight of population health and data management and intelligence, policy development and implementation (commissioning and decommissioning) and joint commissioning with local authorities (Better Care Fund [BCF]).

Executive Director of Transformation

95. The ICB's Executive Director of Transformation has responsibility from the ICB' Chief Executive for the development of primary and community integration (partnership at place and neighbourhood, place based planning). This includes primary care development and oversight of service transformation and redesign (Emergency Preparedness Resilience and Response).

Head of Corporate Governance

96. The ICB's Head of Corporate Governance facilitates risk management processes ensuring it forms an integral part of the normal management process. The Head of Governance receives and collates information on risks within the organisation, monitors new developments in risk management, develops knowledge and expertise and acts as liaison point for risk management issues, both within the organisation and with external bodies. The role includes the monitoring of proposed

developments and initiatives and checking that they are likely to be compliant with good risk management practices. The Head of Corporate Governance advises on risk management theory and practice to enable risk owners to action the controls required to treat the identified risk.

General Management Responsibilities

97. All Executive Management Team/senior managers are responsible for ensuring that appropriate and effective risk management processes are in place within their designated areas and scope of responsibility. They are also responsible for ensuring that all their staff are made aware of the risks within their work environment and of their personal responsibilities, and that all their staff receive appropriate information, instruction and training to enable them to work safely. These responsibilities extend to anyone affected by the ICB's operations, including contractors, members of the public and visitors.

98. Executive Management Team/senior managers are responsible for preparing specific directorate/departmental policies and guidelines to ensure all necessary risk assessments are carried out within their directorate/department in liaison with relevant advisors where necessary, e.g. Health and Safety, Infection Control, etc. Executive Management Team/senior managers are responsible for implementing and monitoring any identified and appropriate risk management control measures within their designated areas and scope of responsibility. In situations where extreme and high risks have been identified and where local control measures are considered to be inadequate, senior managers are responsible for bringing these risks to the attention of the Executive Management Team.

99. In respect of Information Assets, the Executive Management Team/senior managers assist the SIRO in identifying information assets in their area of responsibility and nominating each asset an Information Asset Owner. They will also ensure that risk assessments are performed and submitted in compliance with SIRO requirements with associated remediation plans to the SIRO for review. They will ensure information risk management is embedded into key controls and approval processes of all major business processes and functions.

100. All managers within the organisation are responsible and accountable for the day-to-day management of risks of all types within their areas of responsibility. They are charged with and have the authority for ensuring that risks are managed effectively and that risk assessments are undertaken throughout their areas of responsibility on a proactive basis and that preventative action is carried out where necessary. Managers are responsible for the ongoing maintenance and review of their service/area/function risks and risk registers and are required to work in accordance with the risk register management process contained within this strategy. The operational risk register and any incident reports should be reviewed at team meetings in order to raise awareness of issues and the actions required to reduce risk, and share lessons learned. Managers are also responsible for setting objectives relevant to the objectives of the ICB Board, for their own team employees, and monitoring employee achievement against them.

Responsibilities of all Employees

101. All employees are responsible for:
- Familiarising themselves and complying with the ICB's Risk Management Strategy and any relevant directorate/department risk management procedures;
- Identifying risks in relation to their working environment and role within the ICB and reporting them appropriately;
- Reporting incidents/accidents and near misses using the ICB's incident reporting procedure;
- Maintaining safe working practices;
- Being aware of their duty under legislation to take reasonable care of their own safety and the safety of others;
- Complying with all ICB's policies, procedures and guidance for the protection of the health, safety and welfare of themselves and others;
- Attending training and development events to ensure a full understanding of their risk management responsibilities.
- Be aware that they have a duty under legislation to take reasonable care for their own safety and the safety of all others who may be affected by the organisation's business; and
- Comply with all organisational rules, regulations and instructions to protect health, safety and welfare of anyone affected by the organisation's business.

102. All employees have an important role to play in identifying, assessing and managing risk. To support employees in this role, the ICB seek to provide a fair, consistent environment, encouraging a culture of openness and a willingness to admit mistakes. All employees are encouraged to report any situation where things have, or could have gone wrong in the interest of openness and learning from mistakes. However, a serious breach of health and safety regulations causing loss or injury are examples of misconduct as described in ICB's Disciplinary Policy.

103. All employees are accountable for their own working practices and are required to assist with the risk management processes.

Responsibilities of Contractors

104. Contractors and agency staff working for the ICB are bound by the contents of this strategy and policy and are expected to comply with all relevant risk management policies and procedures. Information and training will be provided as necessary to enable contractors and agency staff to fulfil this responsibility.

Responsibilities of Primary Care Contractors

105. Although primary care contractors are not bound by this strategy and policy, they are required to comply with statutory obligations in the same way as the ICB (e.g. Health and Safety at Work Act, Environment Act, Control of

Substances Hazardous to Health (COSHH) Regulations etc). In addition, all clinicians are responsible to their professional bodies for their clinical practice. As such, primary care contractors need to ensure that they are managing clinical and non-clinical risks appropriately. The role of the ICB is a developmental one in relation to general practice. The ICB will work in conjunction with general practice to support improvements in quality.

Joint and collaborative working responsibilities

106. It is often at the interface between organisations that the highest risks exist and clarity about responsibilities and accountabilities for those risks is most difficult to ascertain. Only by working closely and collaboratively with a wide range of partner organisations can these risks be identified and properly managed.

107. The ICB will involve partner organisations in all aspects of risk management as appropriate. Key partners include providers of commissioned support services to the ICB, other NHS organisations (e.g. ICB, Acute Trusts, Mental Health Trusts and Community Services), the Local Authority, the Police, statutory and voluntary bodies and patient representative groups. Although the ICB currently work closely with key stakeholders around areas of identified risk (such as child protection, discharge arrangements, workforce planning) and there are a number of joint structures that already exist between agencies, more explicit systems will be developed to ensure that risk management is fully integrated in joint working and partnership arrangements

Risk Management Specialists

108. Specialist risk management support will be provided to Executive Management Team, managers and other ICB's employees. Contact details for each of Risk Management specialists are listed in Appendix 4. Where necessary, further expertise will be sourced external to the ICB.

Information Asset Owners (IAOs)

109. Individuals identified as Information Asset Owners are accountable to the SIRO and will provide assurance that information risk is being managed effectively for those information assets that they have been assigned. They will be required to:

- Understand what information is held and in what form, how it is added and removed, who has access and why;
- Approve the level and extent of transfer of data to removable media;
- Ensure that access rights to information assets are limited to the minimum needed and that usage of information is monitored;
- Ensure that best use is made of information assets, receive and respond to requests from others for access to information; and
- IAOs will be responsible for risk assessment, reduction and prevention for their information assets including ongoing evaluation and risk management.

This process includes methods of management, avoidance, mitigation, financing, and/or acceptance of the risk.

110. IAOs may be assisted in their roles by staff acting as Information Asset Administrators (IAAs) who have day-to-day responsibility for management of information risks affecting one or more assets.

Organisational structure

111. An organisational structure, to help manage the delegated responsibility for implementing risk management systems within the ICB, is illustrated and in Appendix 5.

Responsibilities of the ICB Board

112. The ICB Board have a statutory responsibility to manage risks effectively to ensure the most effective use of public money and to monitor compliance with statutory requirements of prevailing health and safety legislation, Equality Act 2010 etc. It is responsible for reviewing the effectiveness of internal controls. The ICB Board are required to produce statements of assurance that it is doing its reasonable best to manage the ICB's affairs efficiently and effectively through the implementation of internal controls to manage risk. The ICB Board will actively monitor risks and the implementation of internal controls to manage risks through its committees and specific groups, in particular, Executive Management Team, the Audit Committees, Performance, Finance and Activity Committee and the Integrated Governance and Quality Committee (or equivalent committees following any changes in governance arrangements).

Responsibility of the ICB's Board Committees

113. A comprehensive committee structure has been developed and implemented to ensure reporting and accountability for risk management within the ICB (Appendix 5). In designing the respective terms of reference, consideration has been given to establishing appropriate risk management processes and corresponding accountability arrangements. Terms of reference for these committees are subject to continuous review and assessment to focus their work to the effective achievement of the key organisational objectives.

114. It is the responsibility of the ICB Board committees to ensure that evidence demonstrating that effective controls and reasonable assurances are in place. To ensure there is robust review and monitoring arrangements in place, the ICB's Board Assurance Framework will continue to be reviewed by the Executive Management Team on a bi-monthly basis. The Audit Committees review the effectiveness of the controls and assurances for all clinical and non-clinical risks within the Board Assurance Framework at agreed intervals in line with their work programme and provide advice to the ICB's Board.

115. The risk management structure includes the following committees.

Audit Committees

116. The Audit Committees are the committees with responsibility for reviewing and ensuring that the organisation has established and is maintaining robust and effective systems of integrated governance, risk management and internal control across all areas of its business. It is responsible for ensuring that there are appropriate and adequate links between risk management, financial risk, corporate and clinical governance. The Audit Committees will obtain assurance sufficient to enable the Annual Governance Statement to be signed off by the ICB Chief Executive.

117. The Audit Committees review the ICB's Board Assurance Framework to provide assurance to the Board that the organisation's risk management processes are effective and risks are being properly controlled. It also reviews results of audit work completed on the ICB risk management system and organisational performance. The annual audit plans for Internal Audit, External Audit and Counter Fraud are approved by the Audit Committees which are based on the ICB's Board Assurance Framework, risk registers and national guidance.

118. The Audit Committees is responsible for preparing an annual summary report to the ICB Board on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management within the organisation and the integration of governance arrangements.

Quality and Safety Committee

119. The remit of the Quality and Safety Committee [update following approval of ToR].

Finance Committee

120. The Finance Committee [update following approval of ToR].

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System Executive

121. [update following approval of ToR].

Strategic Commissioning Group

122. The Strategic Commissioning Group will be established by the ICB to exercise the primary care commissioning functions that have been delegated from NHS England as of 1 July 2022. The group will be responsible for the oversight of primary care commissioning related risks and will report to the System Executive. A summary report from the group will be presented to the System Executive and at agreed intervals to the board.

Executive Management Team

123. The Executive Management Team has delegated authority for reviewing and monitoring business risks, including health and safety risks and business continuity risks. It will establish effective links, which enable lessons learned from the risk process to be directly fed into the business planning cycle.

124. The Executive Management Team will oversee the operation of directorate level processes and ensure risk management is a key feature of the performance management process. This will assist the ICB to identify directorate risks that should be factored into wider business planning processes and then into commissioning negotiations and ensure that divisions are working collaboratively to manage risks.

Other Committees

125. In addition to the above, other committees in the governance structure will have responsibilities which include support for related risk management activities across the ICB, ensuring risk registers and action plans are kept up to date, ensuring effective arrangements for reporting, dealing with and learning lessons from incidents, complaints and claims. Other committees and groups include (this list is not exhaustive):

    - Remuneration Committee

Communication between Board' committees with responsibility for risk

126. Named independent lay members will be members of both the Audit Committees and Integrated Governance and Quality Committee etc and named Executive leads will also be in attendance at these committees, thereby ensuring regular communication and co-ordination of actions taking place between committees to ensure risk management is embedded in the organisation.

Board Assurance Framework and Directorate Risk Registers

127. At the heart of the risk management process is the risk register. A risk register is a management tool that enables the ICB to understand its comprehensive risk profile. It is a repository for all risk information. This provides the priority given to managing the risk by the organisation together with the actions needed to address the risk in question. The risk register considers all levels of risk from strategic to operational, but will concentrate on residual risks that remain after taking controls into account. These risks are then graded based on impact and likelihood and action plans completed to treat, tolerate, transfer or terminate the risk.

128. A two-tier process involving local directorate based registers and a corporate register (Board Assurance Framework) has therefore been implemented to reflect this risk profile. The aim of the two tier approach is to ensure that the bigger strategic picture does not become clouded by the day to day risk management issues that can and are dealt with as a matter of course at local level, whilst still providing a clear route for significant local issues to influence the strategic risk profile.

126. Information risk assessments completed by Information Asset Owners will be fed into the directorate risk registers.

127. The organisational structure is supported by the ICB Board Board Assurance Framework (Corporate Risk Register) and Directorate Risk Registers.

128. The ICB Board Assurance Framework provides the ICB with a comprehensive method for the effective and focused management of the principal risks in order to meet strategic objectives. The assurance framework is built around the corporate proactive and reactive assessment of risks that may have an impact on the achievement of corporate objectives. The organisation will operate and maintain the assurance frameworks through which the ICB' Board gain assurance from others that risks are being managed.

128. The Audit Committees will review the ICB's Board Assurance Framework at its meetings and brief the ICB's Board on changes and seek approval on any risks that should be de-escalated or closed.

129. The ICB Board are required to approve the ICB's Board Assurance Framework as a single document before the end of the financial year.

130. The ICB's Board Assurance Framework also provides a structure for the evidence to support the Annual Governance Statement that the Accountable Officer is required to sign as part of the statutory accounts and annual report. This places an emphasis on the need for the ICB's Board to be able to demonstrate that it has been properly informed about the totality of the risks, both clinical and non-clinical. This simplifies ICB's Board reporting and the prioritisation of action plans which, in turn, allows for more effective performance management.

131. Directorate/local risk registers: every directorate and has local risk registers and associated risk action plan based on a consistent approach. Each directorate will identify a risk lead responsible for coordinating the process in the directorate and an appropriate regular forum for discussing, reviewing and monitoring local risk registers and action plans on a quarterly basis.

132. Risks from the Directorate/local risk registers may require input from the Executive Management Team as a whole in order to ensure mitigation plans are in place, an opportunity to test that the correct risk has been identified/defined and the appropriate score is allocated. It is also an opportunity to identify risks that may become strategic/corporate risks and therefore need to alert the Audit Committees and the ICB's Board of these via

reporting at agreed intervals. Furthermore, directorate level risks may have an impact on the corporate/principal risks identified within the Board Assurance Framework and therefore the relevant corporate risk may need to be re-assessed in light of a risk identified at directorate level.

133. Board Assurance Framework and risk register reports - each directorate will submit its risk register to the Head of Corporate Governance, who will ensure that any significant and high level risks from Directorate Risk Registers (which includes operational and strategic risks and hence underpin the Board Assurance Framework) are escalated to the Executive Management Team via regular reports. Risks will be identified through the processes outlined within the policy, including risk information from external sources, such as enquiry reports etc.

134. A threshold for corporate risk to the Board Assurance Framework has been set using the ICB's risk rating matrix. Any risk that has an inherent risk score of 15 or above and where the residual risk score 15 or above and is higher than the risk appetite must be reported to the Executive Management Team. The Executive Management Team would evaluate the risks, and if upon evaluation the inherent risk score of 15 remains, or that the residual risk score is 15 and is higher than the risk appetite then this would be escalated to the ICB's Board Assurance Framework.

135. In the event that a risk on the Board Assurance Framework has reached the accepted target score, it will be de-escalated to the relevant Directorate Risk Register for further monitoring and review.

136. The formal process to approve the de-escalation of a risk from the Board Assurance Framework is reserved for the ICB's Board. This is likely to be based on a recommendation from the Executive Management Team.

137. It is often easier to identify specific risks at the Directorate rather than at the strategic objective level. However, it is necessary to take a strategic view to identify risks that affect all or many parts of the organisation to ensure that their total impact is assessed. It is important to ensure that the linking of risk to objectives forms an integrated part of the ICB's management activity for strategic and operational risks which will support the review, update and monitoring of the ICB's Board Assurance Framework and Directorate Risk Registers.

IMPLEMENTATION AND TRAINING

138. This strategy and policy will be circulated to all Executive Directors, Senior Managers and staff and made available on the shared drive and/or intranet. It will be the responsibility of Senior Managers to ensure that staff in their directorate read these documents and ensure attendance at relevant training programmes.

139. Managers and their staff are required to consult the strategy and follow the procedure and guidance when undertaking risk management related processes such as risk assessments.

140. This strategy and policy identifies risk management as everyone's responsibility in the ICB. The training and development of its staff is an integral part of the ICB's approach to risk management. An effective implementation of the strategy and policy requires all staff to be made aware of the ICB's approach to risk management, what their role is and the forms of support available to them. This will be achieved through staff induction training. An annual cycle of updates and learning opportunities will be a core component of the organisational development plan.

141. The effective implementation of this strategy and policy will facilitate the delivery of a quality service, alongside employee training and support to provide improved awareness of the measures needed to prevent, control and contain risk. Together with this strategy, Human Resources policies relating to induction, learning and development, training needs analysis form the action plan for the delivery of identified training across the organisation.

142. The organisational learning/training needs analysis is coordinated by the Human Resources Team in order to identify the learning needs of permanent employees and temporary employees along with the frequency of any updates required. This will be documented on the individual's personal development plan, which will be monitored and reviewed as part of the annual appraisal process. Where necessary, and appropriate, they may participate in any existing risk management training programme. All training is recorded and monitored in accordance with the statutory and mandatory training requirements. Non-attendance of staff, or Senior Managers will be followed up and monitored.

143. Information Governance training provision will also cover aspects of information risk assessment. It is expected that all staff should receive annual basic information governance training appropriate to their role through the online Electronic Staff Record (ESR).

144. Training will be offered to all levels of staff in their respective roles from the Accountable Officer and the ICB's Board to local risk assessors. This will include reference to the need for risk assessment, explanation of the risk management process, description of the risk assessment form, more information about the types of risks which require assessment, and how risks are communicated throughout the organisation and the importance of feedback.

145. It is an expectation as detailed within the duties that all ICB's Board members and senior managers participate in awareness risk management training as appropriate which will support objective setting and review at personnel development review sessions.

MONITORING AND AUDITING ARRANGEMENTS

146. The risk management process is continually evolving and the systems must be reviewed in the light of changes in the ICB environment, operations, guidance, best practice and legislation. As a result this strategy and policy will be reviewed on at least an annual basis with a formal review every three years.

147. The ICB will monitor and review its performance in relation to the management of risk and the continuing suitability and effectiveness of the systems and processes in place to manage risk. The ICB will monitor and review compliance in relation to this strategy and policy by using the information it receives from external regulators and internal governance policies, systems and processes. This includes monitoring effectiveness through the organisational programme of internal audit. The ICB may also consider measuring their effectiveness in developing the maturity of the ICB's risk management framework and therefore may consider completing an annual risk maturity assessment using the HM Treasury Risk Management Assessment Framework. Risk maturity refers to where the ICB are on its risk management journey and how well established risk management is as a discipline across the organisations.

148. Furthermore, the ICB's Board sign-off the ICB's Board Assurance Framework on an annual basis and the Audit Committees will approve, on behalf of the ICB's Board, the Annual Governance Statement by the Accountable Officer.

LINKS TO OTHER POLICIES

149. The Risk Management Strategy and Policy should be read in conjunction with the following:

- Conflicts of Interest, Gifts and Hospitality and Sponsorship Policy
- Corporate Incident Reporting Policy
- Serious Incidents Policy
- Complaints Management Policy
- Claims and Litigation Policy
- Health and Safety Policy and associated policies
- Information Governance Policy and associated policies
- Information Security Policy and associated policies
- Bullying and Harassment Policy
- Whistleblowing Policy
- Fraud, Bribery and Corruption Policy

Appendix 1

Definitions

Assurance	An evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework. The more measurable, verifiable and objective an assurance is, the stronger the declaration and source of evidence it is. The assurance must also be up to date. Effective assurance needs to be at two levels, internal and external
Board Assurance Framework	The Board Assurance Framework provides evidence that the ICB have systematically identified their objectives both strategically and operationally, and manages its risks to achieving them. The framework systematically provides a vehicle for the identification of assurances and controls to risks and their effectiveness.
Cause	The reason for the risk to potentially occur.
Consequence	The results should the risk materialise.
Control	A measure put in place to mitigate a risk from occurring i.e. to prevent. Different types of control can be preventative, detective, directive and corrective.
Description	The way of explaining risk to allow consistent understanding across the Groups in a single sentence where possible i.e. think of the words preceding the risk 'There is a risk of' or There is a risk that' to put the risk in context.
Gaps in controls/ assurances	Where the residual risk does not meet the risk appetite, gaps in the controls and the assurances must be identified in order to reduce the residual risk as close as possible to the risk appetite.
Gross / Inherent Risk	Inherent risk is the effect of something that might happen before taking account of controls in place to manage or mitigate it. The higher the score, the more attention the risk will require and the more likely the ICB's Board would seek assurance as to how it was being managed whether directly or via a sub-committee.
Impact	A measurement of the effect the risk will have if it will materialise.
Issue	Issue is something that has happened, as opposed to a risk which is something that could happen.
Likelihood	A measurement of the chance that a risk will materialise.
Mitigation Actions	These are the actions the risk owners take to reduce the risk or where this is not possible limit the impact of the risk.
Net Risk	The measurement in terms of likelihood and impact on a risk after controls are considered to mitigate the risk. Used in the Groups on the Board Assurance Framework.

Objective	The context in which risks are assessed i.e. Groups Aims/Objectives
Operational risks	Operational risks are bi-products of the day-to-day running of the ICB and include a broad spectrum of risks including clinical, fraud, security, financial and legal risks arising from employment law of health and safety.
Owner	Either the owner of the risk (risk owner i.e. Executive Director) or owner of an action (action owner i.e. the completer on the assigned action by the risk owner).
Principal risk	Principal risks are defined as those that threaten the achievement of the ICB's strategic objectives.
Register	A tool to capture and report on the risks identified at Directorate or Corporate level.
Residual Risk	Another term for net risk.
Risk	ISO 31000:2009 defines risk as the "effect of uncertainty on objectives" and states that "risk is often expressed in terms of a combination of the consequences of an event and associated likelihood of occurrence"
Risk Appetite	An expression of the nature and quantum of risk or uncertainty which the organisation is willing to take or accept to achieve its strategic objectives. Risk appetite score may be a different for different objectives and/or different risk categories.
Risk Management	Risk management is the process by which an organisation identifies risks, assesses their relative importance, determines the appropriate control mechanisms and ensures that the agreed action is taken. Risk management may involve judgement as well as data.
Risk Management Process	The systematic application of risk management policies, procedures and practices to the tasks of establishing the context, identifying and analysing, evaluating, treating, monitoring and communicating risk.
Risk Matrix	The tool used to as accurately as possible identify the appendix measurement of likelihood and impact of the risk identified.
Risk Tolerance	The threshold level of risk exposure which, when exceeded, will trigger an escalation.
Strategic risks	Strategic risks are those that represent major threats to achieving the ICB's strategic objectives or to its continued existence. Strategic risks will include key operational service failures, for example, failure to meet key targets or provision of poor quality care would be very damaging to the ICB's reputation.

Appendix 2

Model matrix: impact/consequence and likelihood descriptors

The information in this Appendix is based on guidance issued by the National Patient Safety Agency www.npsa.nhs.uk).

Step One:

- Choose the most appropriate domain for the identified risk from the left hand side of Table 1.
- Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the impact (i.e. consequence) score, which is the number given at the top of the column.
- See also Table 3 below which is the internal impact / consequence descriptor updated with potential financial loss at Directorate and Corporate level (for further advice relating to the assessment of impact / consequence please contact the relevant risk specialist detailed within Appendix 4).

Table 1: Impact / consequence score

Impact score	**1**	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Impact score Domains	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

Impact score / Domains	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Financial, including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

Step Two: What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency. See Table 2 below.

Table 2: Likelihood score (L)

Probability score	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Frequency How often might it/ does it happen	This will probably never happen/ recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Table 3: Internal consequences / impact descriptor table update

		A	B	C		D	E	F
Level	**Descriptor**	**Actual or Potential Impact on individuals and service**	**Actual or Potential Impact on the organisations reputation / credibility**	**The potential for financial loss** **Directorate** **Corporate**		**Quality**	**Service continuity / flexibility**	**Litigation**
1	**Negligible**	**Minimal Near misses Department / investigation**	**No immediate risk to organisation**	**Less than £500**	**Less than £10,000**	**Minor non compliance**	**No impact on services although it has potential**	**Potential for litigation**
2	**Minor**	**Short term injury / damage Cuts / bruises < 3 days absence**	**Minimal risk to organisation Local press < 1 days coverage**	**£500 - £5,000**	**£10,000 - £100,000**	**Single failure to meet internal standard**	**Minor impact on services**	**Minor cost Court attendance**
3	**Moderate**	**Semi-permanent injury / damage Significant impact on care > 3 days absence**	**RIDDOR reportable MDA reportable Need careful PR Local media < 7 days coverage**	**£5,000 - £12,000**	**£100,000 – £250,000**	**Repeated failure to meet internal standards**	**Loss of some local service**	**Civil action No defensible HSE improvement notice**
4	**Major**	**Permanent injury / damage Critical impact on care Reportable to HSE**	**Trust investigation Service closure RIDDOR reportable Long term sickness Need PR National media < 7 days**	**£12,000 – £25,000**	**£250,000 – £500,000**	**Failure to meet contract quality standards**	**Loss of service affecting more than one department**	**Civil action No defensible HSE improvement notice**
5	**Catastrophic**	**Life threatening Fatality**	**Trust investigation Regulator investigation National media > 7 days coverage HSE investigation MP Concern**	**> £25,000**	**> £500,000**	**Failure to meet National and Profession al standards**	**Major disruption to Trust**	**Criminal prosecution**

Appendix 3

Summary of Risk Appetite and Acceptable Risk Score

Risk Category	Appetite Level	Acceptable Risk Score	Rationale
Clinical Quality & Patient Safety (clinical risks)	Low	3	We hold patient and staff safety in the highest regard and will not accept any risks that threaten this. The ICB will commission high quality services for their patients. They will only rarely accept risks which threaten that goal.
Provider Performance (clinical risks)	Moderate	6	The ICB accept that provider performance is challenged and the ICB have little ability to affect change over the performance of another part, other than to influence and encourage.
Statutory and mandatory compliance and governance (organisational and information risks)	Low	3	The ICB will comply with all applicable legislation and will not accept any risk which (if realised) would result in non-compliance.
Financial Statutory Duties (financial risk)	Low	3	Achieving financial balance both within the ICB and in the wider local health economy is both a strategic priority and a statutory duty. Therefore the ICB will not accept any risk that (if realised) will threaten this.
Fraud & Negligent Financial Loss (organisational or financial or reputational risk)	Low	3	The ICB will not tolerate financial losses from fraud and negligent conduct as this represents corporate failure to safeguard public resources.
Commissioning & Contracting (organisational or financial or reputational)	Moderate	6	Innovative approaches for commissioning incorporate an inherently high level of risk, which can impact on the delivery of outcomes.

Risk Category	Appetite Level	Acceptable Risk Score	Rationale
Collaborative Working (organisational risks)	Moderate	6	The ICB will work with their member practices and other organisations (including but not restricted to other ICB and Local Authorities) to ensure the best outcome for patients and communities. They are willing to accept the risks associated with a collaborative approach.
Innovation (organisational or reputational risks)	High	8	The ICB encourage a culture of innovation and are willing to accept risks associated with this approach where they do not threaten risk areas. The ICB are not prepared to accept (as defined above e.g. quality patient care/safety)
National Policy and Direction (organisational risk)	Low	3	The ICB will follow national policy.
Reputation (organisational or financial risks)	Low	3	The ICB will maintain high standards of conduct and will not accept risks that may cause reputational harm because it could undermine public and stakeholder confidence.
Clinical Engagement (organisational or reputational)	Low	3	The ICB place importance on the positive effects of clinical engagement and will endeavour to manage issues that risk this.

Appendix 4

Contact Details for Risk Management Specialists

Name	Contact details
Caroline Trevithick **Executive Director Nursing, Quality & Performance** Director lead for clinical governance and patient safety	
Nicci Briggs **Executive Director of Finance, Contracting and Corporate Governance** Director lead for organisational risk management, financial governance and corporate governance.	
Daljit K. Bains **Head of Corporate Governance** Operational lead for non-clinical risk management, corporate governance, the Board Assurance Framework and Risk Registers.	
Matthew Curtis **Anti-Crime Team Manager** – provision of specialist counter fraud advice.	

Appendix 5

Functions and decisions map (to be inserted once approved in July 2022)

Appendix 6

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