Welcome

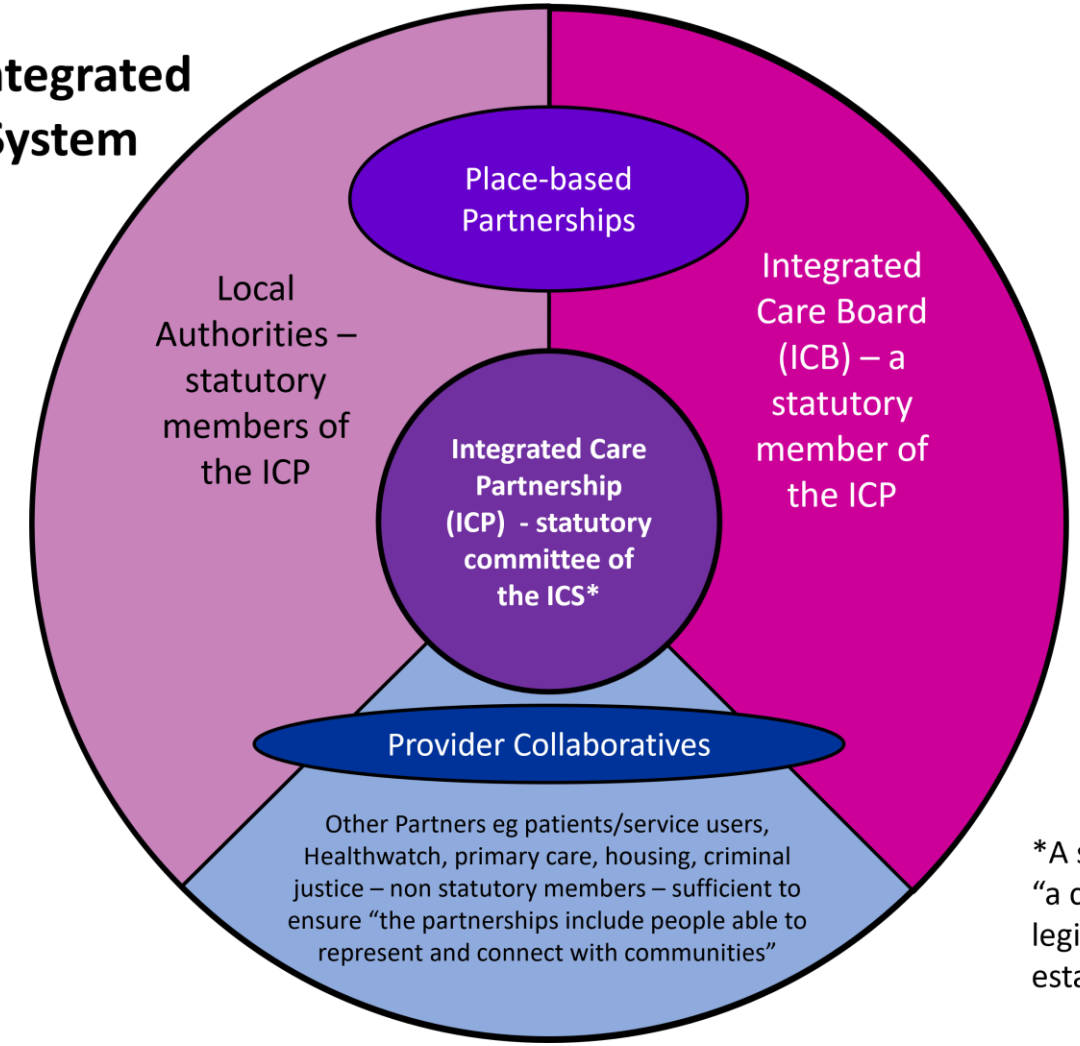
Governance across Partnerships

29 September 2022

Setting the Scene

- 42 ICSs in England
  - improving outcomes in population health and healthcare
  - tackling inequalities in outcomes, experience and access
  - enhancing productivity and value for money
  - supporting broader social and economic development.
- Bring together NHS organisations, local authorities and a number of other services and organisations (VCSE) to try and achieve these aims

The Integrated Care System (ICS)



*A statutory committee is "a committee which legislation requires to be established"

Dr Chris Clayton

Chris is the Accountable Officer and Chief Executive of NHS Derby and Derbyshire Integrated Care Board and the lead executive for Joined Up Care Derbyshire.

Joined Up Care Derbyshire

NHS Derby and Derbyshire

Governance Across Partnerships

A Derby & Derbyshire Case Study

Dr Chris Clayton

29.09.22

Joined Up Care Derbyshire

NHS Derby and Derbyshire

Agenda:

- Development approach – the why, the what & the how
- Focus on “the what” – the key strategies
- Enabling Approaches / strategies

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NHS Derby and Derbyshire

“The NHS Derby & Derbyshire Lens”

Why?

To improve overall health outcomes for the population of Derby and Derbyshire including improving life expectancy and healthy life expectancy rates

What?

What key strategies exist / will exist across the NHS, ICP & HWBBs to support delivering against “our why”?

How?

How are we going to operate as an ICB board, an ICB organisation, the NHS in D&D and as an ICS to support delivering against our why?

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Relative contribution of major determinants to health

Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Used in US to rank counties by health status

While this is from a US context it does have significant resonance with UK Evidence, though I would want to increase the contribution of housing to health outcomes from a UK perspective.

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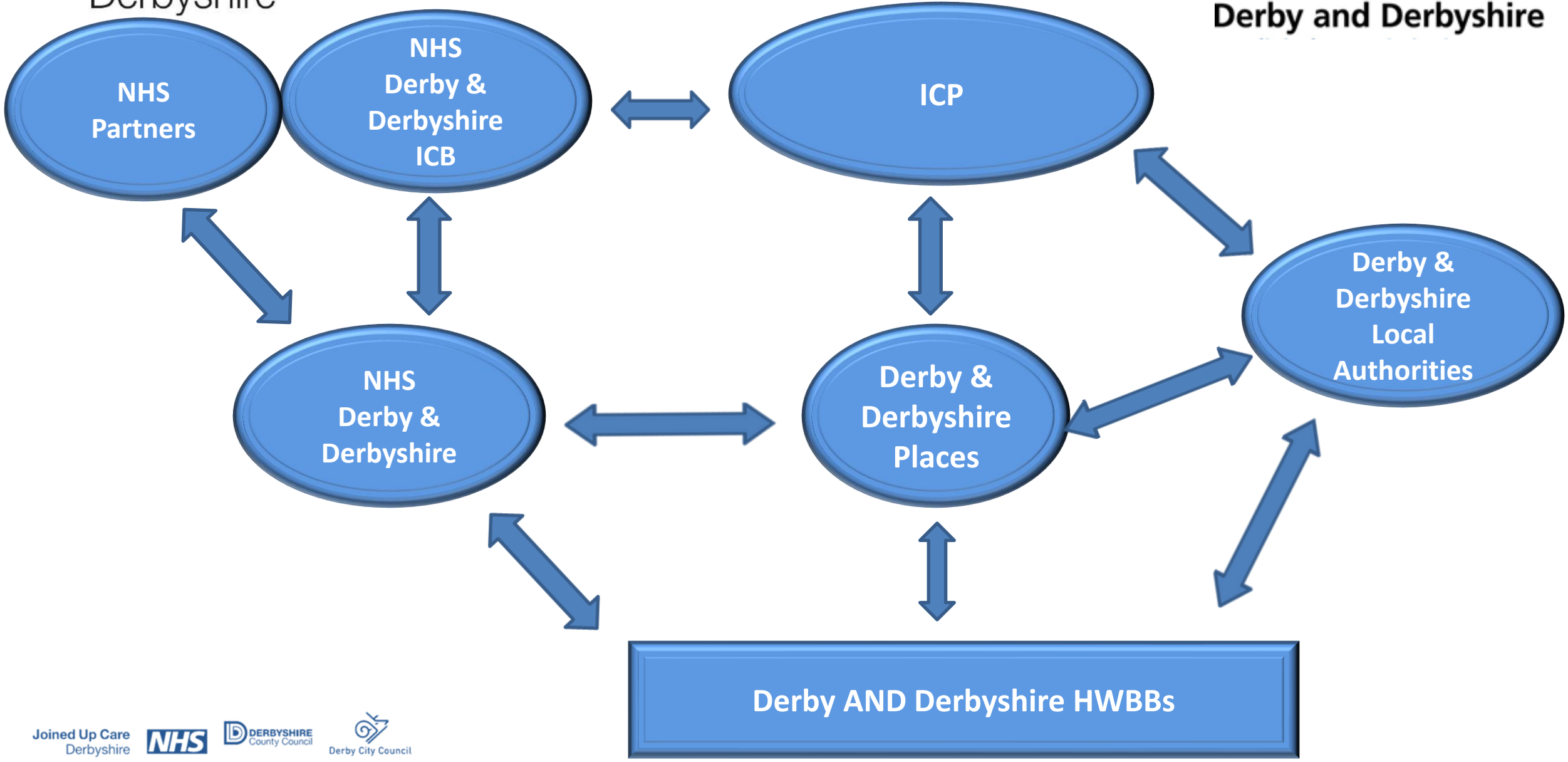
NHS Derby and Derbyshire



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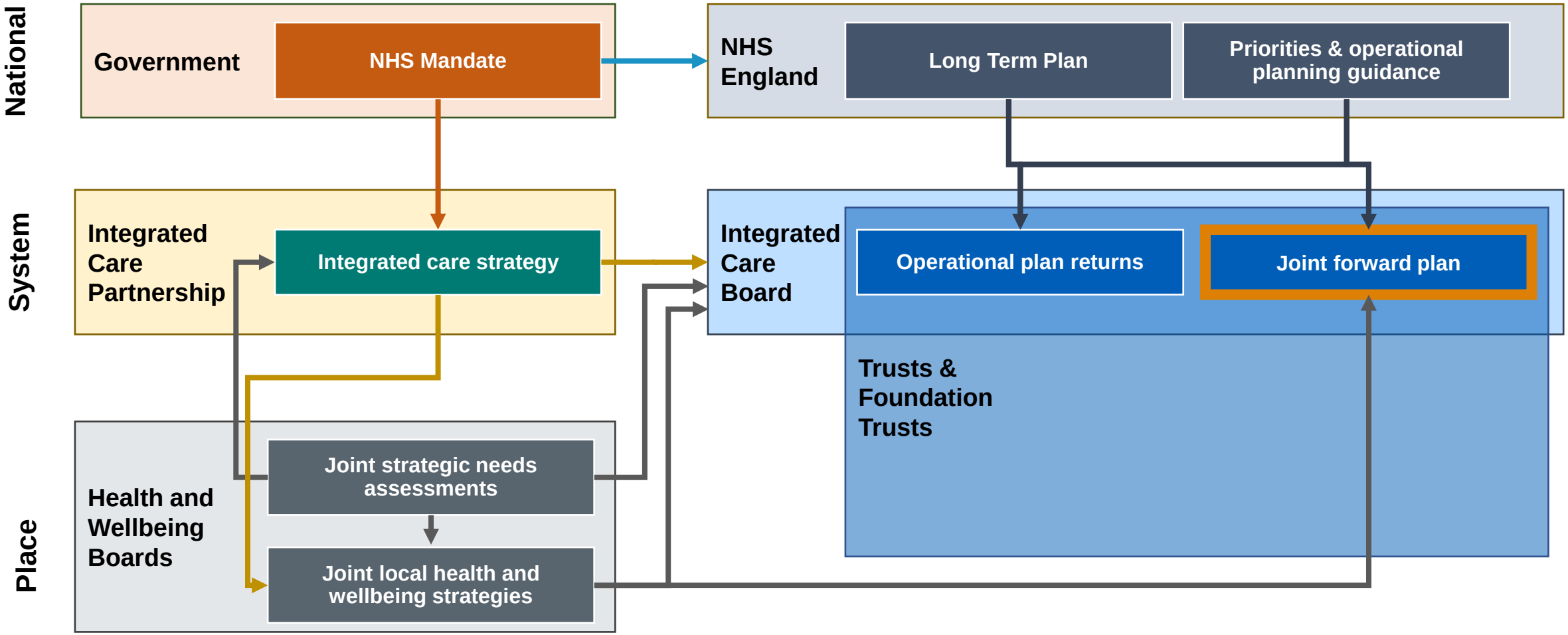
NHS Derby and Derbyshire

The Key Strategies:

- The Health & Wellbeing Strategy (JLHWSs)
- The Integrated Care Strategy (ICP)
- NHS Derby & Derbyshire Five Year Strategy

How does this all connect?



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Health & Wellbeing Board Strategies (JLHWSs)

- Explain what priorities the health and wellbeing board has set in order to tackle the needs identified in their JSNAs
- About setting a small number of key strategic priorities for action, that will make a real impact on people's lives.
- JLHWSs should translate JSNA findings into clear outcomes the board wants to achieve, which will inform local commissioning – leading to locally led initiatives that meet those outcomes and address the needs.

Systems will be required to produce an integrated care strategy, NHS planning returns and a joint forward plan in 2022/23…

Integrated care strategy
• Developed by **the Integrated Care Partnership** (ICP) • Describes how **the assessed health, care and wellbeing needs** of the local population **are to be met** by the ICB, LAs and NHSE. • Must address **integration** of health, social care and health-related services.

Five year planning exercise	
Multi-year planning returns	**Joint forward plan**
• The Long Term Plan refresh and multi-year planning guidance will be published by **NHSE** • **Detailed operational returns** will be required for **Years 1 & 2** (as per current funding settlement)	• Developed by the **Integrated Care Board** (ICB) and partner **trusts / foundation trusts** • **5-year** plan which should describe how the **NHS** will contribute to **meeting the health needs of its local population** • Will reflect **local priorities** and address the **four core purposes** of ICSs • Should be **coherent with planning returns**

The recent guidance issued by the DHSC is clear in what it expects of the ICP strategy…

Design Principles	Components
1. A core part of Integrated Care System, driving their direction and priorities 2. Rooted in the needs of people, communities and places. 3. A space to develop and oversee population health strategies to improve health outcomes and experiences. 4. Support integrated approaches and subsidiarity. 5. Be open and inclusive, involving communities and partners to utilise local data and insights.	1. Personalised Care. 2. Prevention. 3. Health Protection. 4. New approaches and mechanisms to support e.g. (shared outcomes, quality improvement, joint working and section 75)

The ICB's Joint Forward Plan will set out local ambitions with clear trajectories & milestones to be met through collaborative effort over the mid-long term…

Design Principles

1. **Owned by ICBs and trusts/FTs** and fully aligned with the ambitions of the **wider system partnership**
2. **Flexibility** that enables building on **existing local strategies and plans,** supports **subsidiarity,** and reflects **local priorities,** whilst addressing **national NHS commitments**
3. **Delivery-focused,** including measurable objectives, trajectories and milestones where appropriate
4. **Addresses system development priorities** and **ways of working**

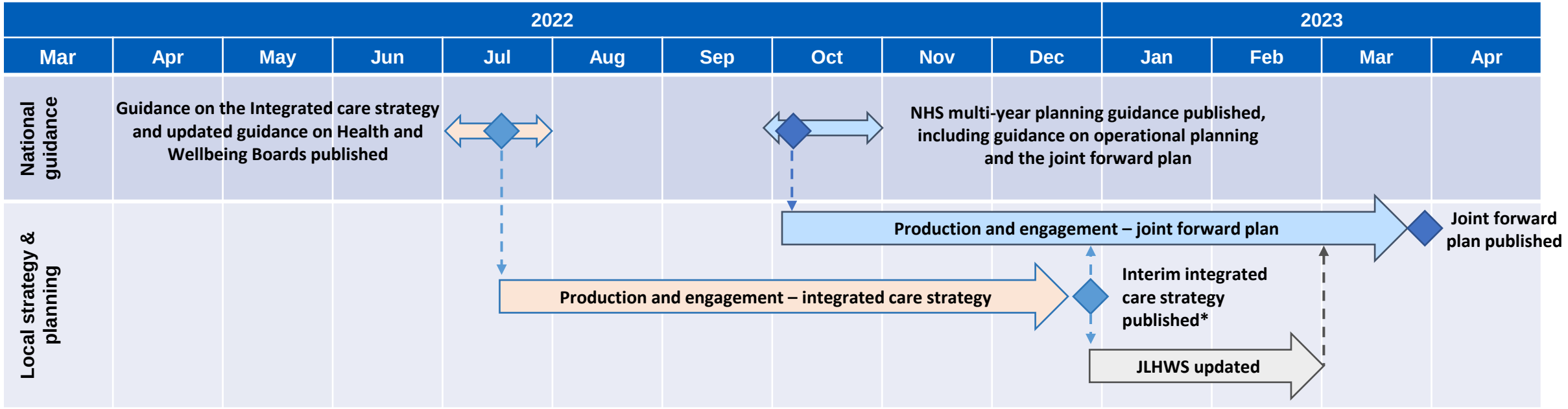
Components

1. **ICS objectives and key actions** that deliver on the **4 ambitions for an ICS**, taking into account the ICP strategy and local health and wellbeing strategies
2. Specific **delivery plans to meet the national NHS ambitions** set out in the LTP update, including trajectories and underpinning workforce and financial plans
3. **How the system will organise itself and develop** to support the above

- Linked and **fully aligned 2-year NHS operational plan returns** will be required providing supporting detail on performance, activity, finance and workforce trajectories

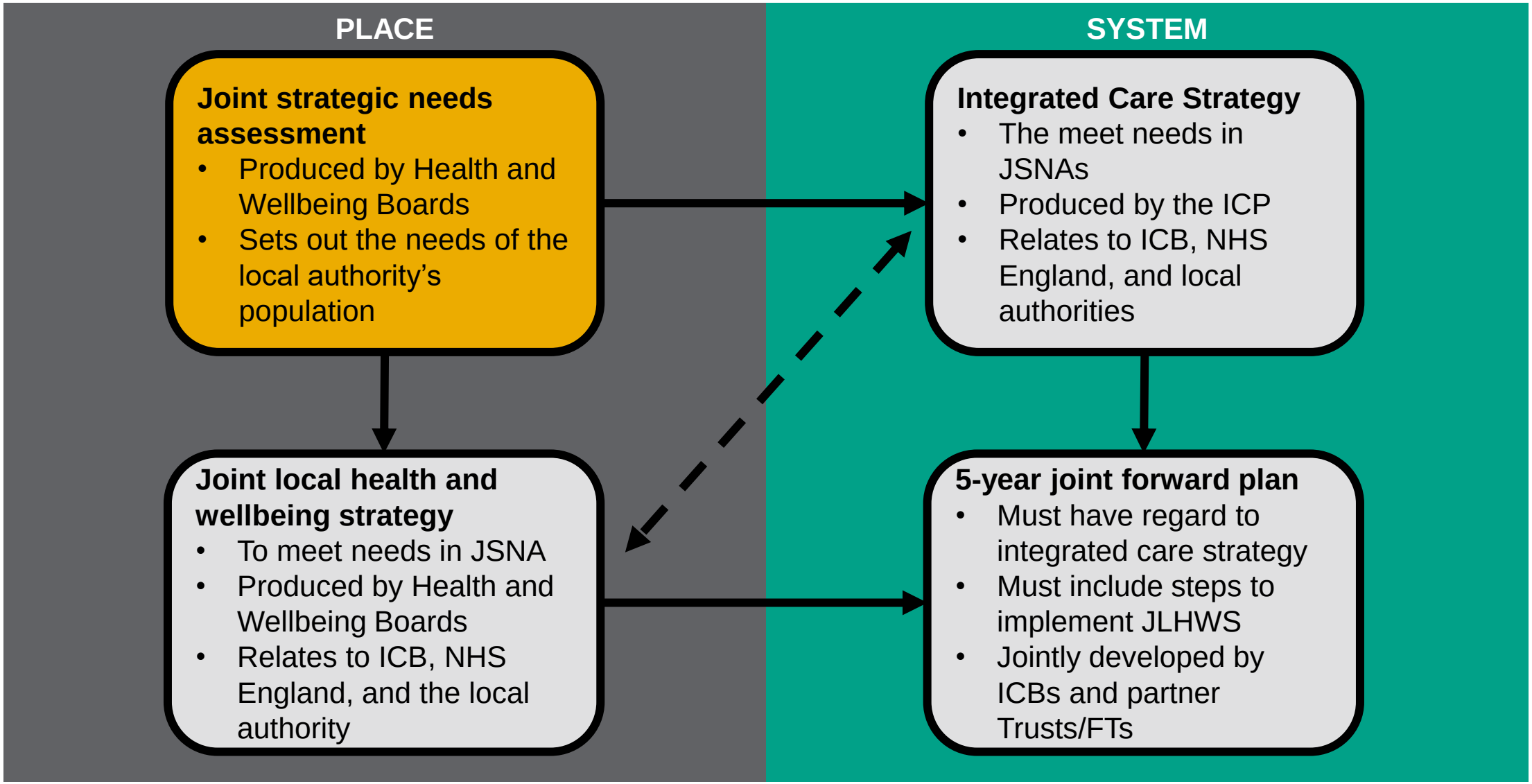
The first joint forward plan should be published before April 2023 & informed by the integrated care strategy and health & wellbeing strategies*

- Interim integrated care strategies should be available by **December 2022** if ICPs wish to influence the first joint forward plan.
- NHSE will publish **multi-year planning guidance** in **October 2022**, including planning guidance and guidance on development of the joint forward plan. The first joint forward plan must be produced before **April 2023.**
- **Joint local health and wellbeing strategies (JLHWSs)** must be updated in response to the integrated care strategy, unless if the ICB and LAs consider the current strategy sufficient. The steps that the ICB proposes to take to implement any joint local health and wellbeing strategy must be described in the joint forward plan.



*Each ICP will have to publish an interim integrated care strategy by December 2022 if it wishes to influence the ICB's first 5-year forward plan (which is to be published before April 2023).

ICS strategies and plans



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Other “enabling” strategies & approaches

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In no particular order (& not exhaustive list….):

- Planning & Coordination
- Comms, Engagement & Involvement
- “One workforce”
- Medium Term Financial Plan (Strategy)
- Data & Digital
- Transformation (inc. innovation, science & technology)
- Anchor Institution

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NHS Derby and Derbyshire

Summary:

- This is complex & complicated
- We have actions ongoing in all areas but…..
- We will need to pull this together carefully both within & without of the NHS

Aidan Rave

Principal Consultant at the GGI and NED at NHS Buckinghamshire, Oxfordshire and Berkshire West ICB. Formerly CEO at South Kesteven District Council and Deputy Mayor of Doncaster MBC.

A partnership of equals?

Systems leadership beyond integrated care

Aidan Rave
aidan.rave@good-governance.org.uk
September 2022

Before the off…

- Doncaster is home to the world's oldest classic horserace, founded by Major-General Anthony St Leger in 1776.
- The race is run each September, covering 1 mile, 6 furlongs and 115 yards (just shy of 3000 metres).
- It is the final 'classic' of the season and also the final leg of the 'triple crown' which has been won by some extremely famous horses including Ballymoss, Nijinsky and Oh So Sharp (which both won the triple crown).
- In 1953 the meeting was attended by Queen Elizabeth II and Sir Winston Churchill.

I want to cover three themes

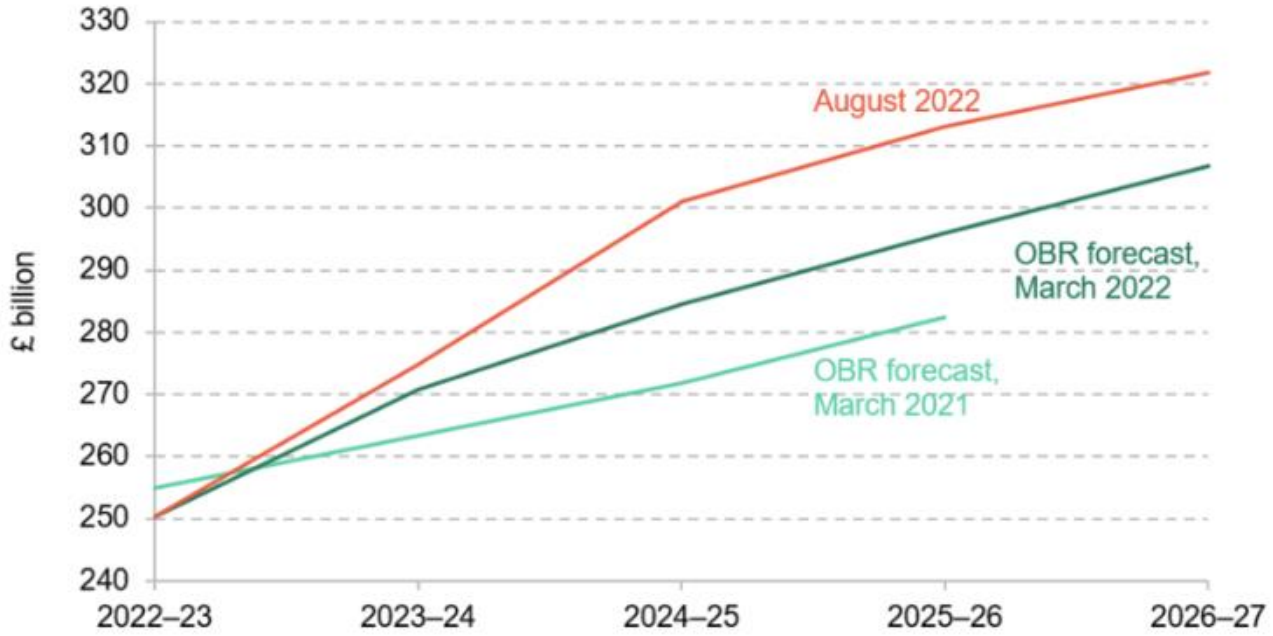
- The scale of the challenge we face
- The role of systems leadership
- Where next?

Theme 1 – framing the challenge

A perfect storm

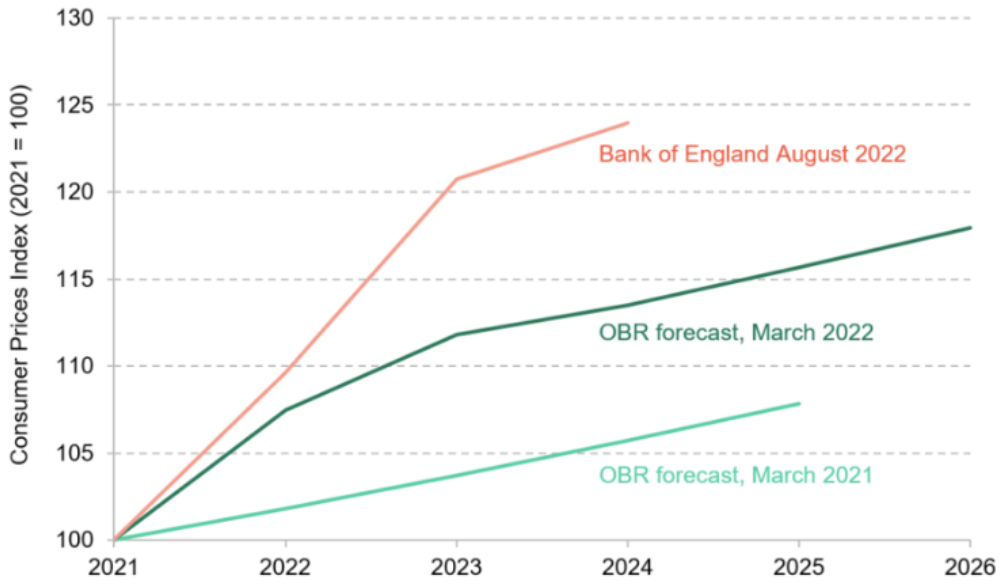
Public Finances • Historically high levels of borrowing (largely due to Covid) • Economy heading towards recession • Higher inflation and higher interest rates will automatically push up public spending and debt servicing costs	**Public Services** • Elective backlog nearing 7m and growing • Visible and 'hidden' backlog • Growing signs of staff exhaustion following a relentless 3 years – with no real end in sight • Multiple councils issuing s114 notices, affecting staff morale
Cost of Living • Inflation predicted to hit 20% or more by early 2023 • Average energy bills heading towards £5k per annum by the same period • Dramatic impact on the services sector and its ability to sustain a recovery	**Climate Emergency** • 30 per cent of the world's population is exposed to deadly heat waves more than 20 days a year. • Average temperatures for the five-year (2015-2019) and ten-year (2010-2019) periods are the highest on record. • Places need to balance economic revival with net zero

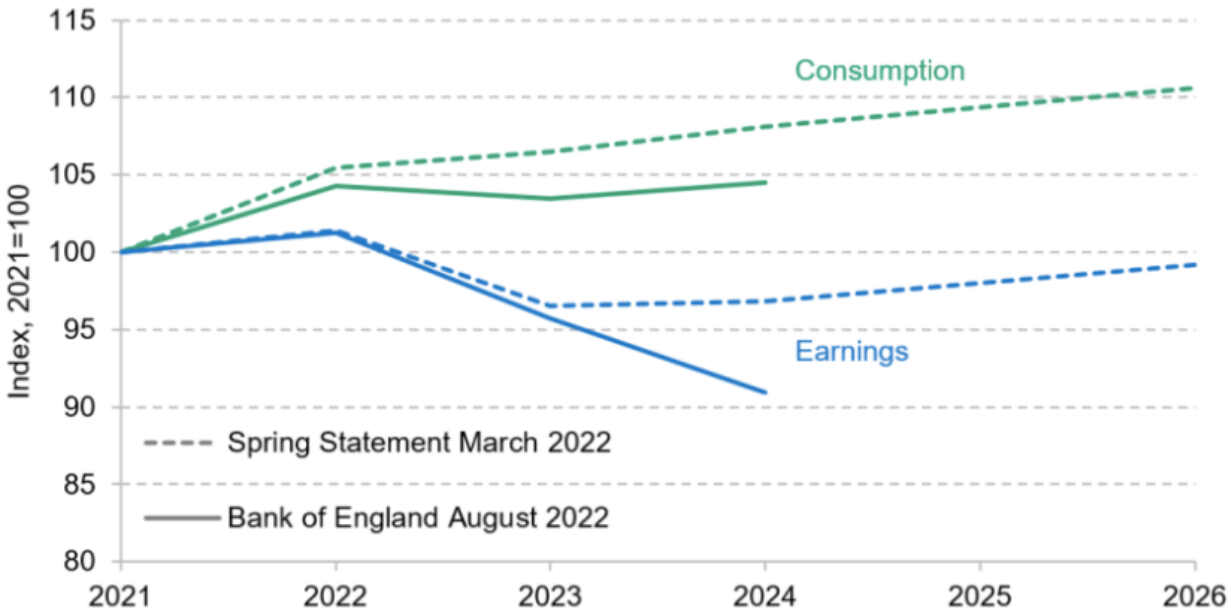
Impact on debt and benefits



Source: Office for Budget Responsibility, Economic and Fiscal Outlook March 2021 and 2022; Bank of England, Monetary Policy Report August 2022.

The squeeze

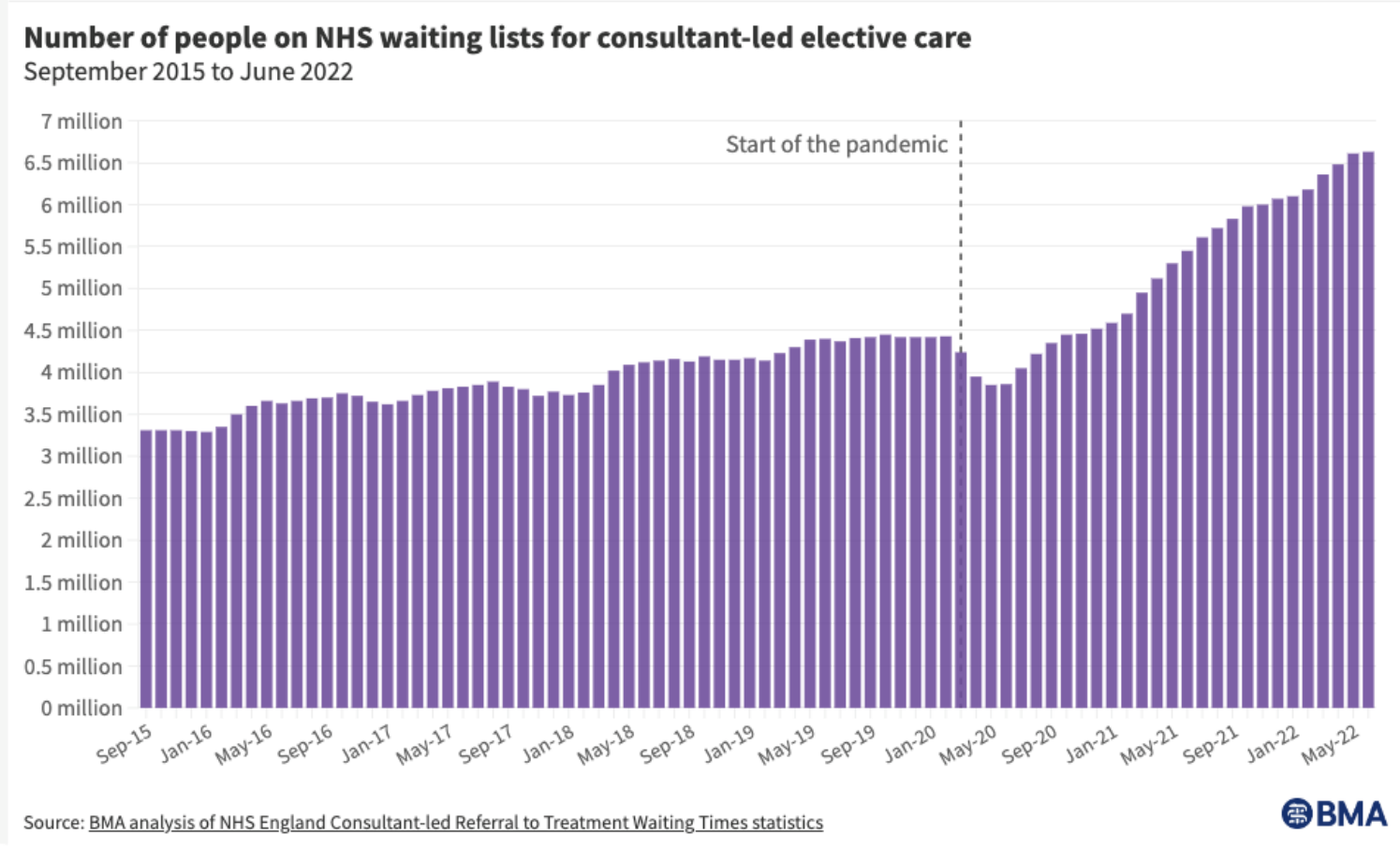




Source: Office for Budget Responsibility, Economic and Fiscal Outlook March 2021 and 2022; Bank of England, Monetary Policy Report August 2022.

Note: Earnings deflated by CPI. Bank of England series is growth in average weekly earnings; OBR series is growth in average annual earnings.

NHS demand


Number of people on NHS waiting lists for consultant-led elective care
September 2015 to June 2022
7 million
6.5 million
6 million
5.5 million
5 million
4.5 million
4 million
3.5 million
3 million
2.5 million
2 million
1.5 million
1 million
0.5 million
0 million
Start of the pandemic
Sep-15
Jan-16
May-16
Sep-16
Jan-17
May-17
Sep-17
Jan-18
May-18
Sep-18
Jan-19
May-19
Sep-19
Jan-20
May-20
Sep-20
Jan-21
May-21
Sep-21
Jan-22
May-22
Source: BMA analysis of NHS England Consultant-led Referral to Treatment Waiting Times statistics
BMA

Three potential impacts

1. People are likely to be pushed into increasingly hard choices, many of which will have a direct impact on their health and well-being, requiring some level of intervention from civic and/or civil society.
2. The people who will be expected to respond are increasingly demoralised, knackered (frankly) and suffering from many of the same pressures as those they are trying to support.
3. The short-term impact of further borrowing, additional spending and ‘promised’ tax cuts will have an impact on public-facing services, that may well last for quite some years to come.

Theme 2 – systems leadership

Let’s begin with the basics….

partnership [pahrt-ner-ship] SHOW IPA

See synonyms for: partnership / partnerships on Thesaurus.com

Elementary Level

noun

1. the state or condition of being a partner; participation; association; joint interest.
2. *Law.*
   a. the relation subsisting between partners.
   b. the contract creating this relation.
   c. an association of persons joined as partners in business.

In reality…?

"Partnership is the suppression of mutual loathing in the pursuit of public funding."

A generation of partnerships

- City Challenge
- Single Regeneration Budget/Objective 1/Objective 2 etc
- Urban Regeneration Companies
- New Deal for Communities
- Primary Care Trusts
- Clinical Commissioning Groups
- Local Strategic Partnerships
- Local Area Agreements
- Integrated Care Systems

I could go on…

But questions remain

- Have we seen a genuine shift in thinking, habits, attitudes and culture?
- A legacy that tends towards the physical?
- Deadweight issues?
- Making progress or holding the line?
- After a quarter of a century (and more) of partnership working, have we ‘moved the dial’ sufficiently to justify the level of investment?

Complicated or complex?

Complicated	Complex
Systematic	Chaotic
Predictable	Unpredictable
Linear	Dynamic
Repeatable	Unstable

Analyse →

Respond

← Probe

We are definitely complex

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““Consider the fact that for 3.8 billion years, a period of time older than the Earth's mountains and rivers and oceans, every one of your forebears on both sides has been attractive enough to find a mate, healthy enough to reproduce, and sufficiently blessed by fate and circumstances to live long enough to do so. Not one of your pertinent ancestors was squashed, devoured, drowned, starved, stranded, stuck fast, untimely wounded, or otherwise deflected from its life's quest of delivering a tiny charge of genetic material to the right partner at the right moment in order to perpetuate the only possible sequence of hereditary combinations that could result -- eventually, astoundingly, and all too briefly -- in you.”

— Bill Bryson, A Short History of Nearly Everything

Enter Integrated Care Systems

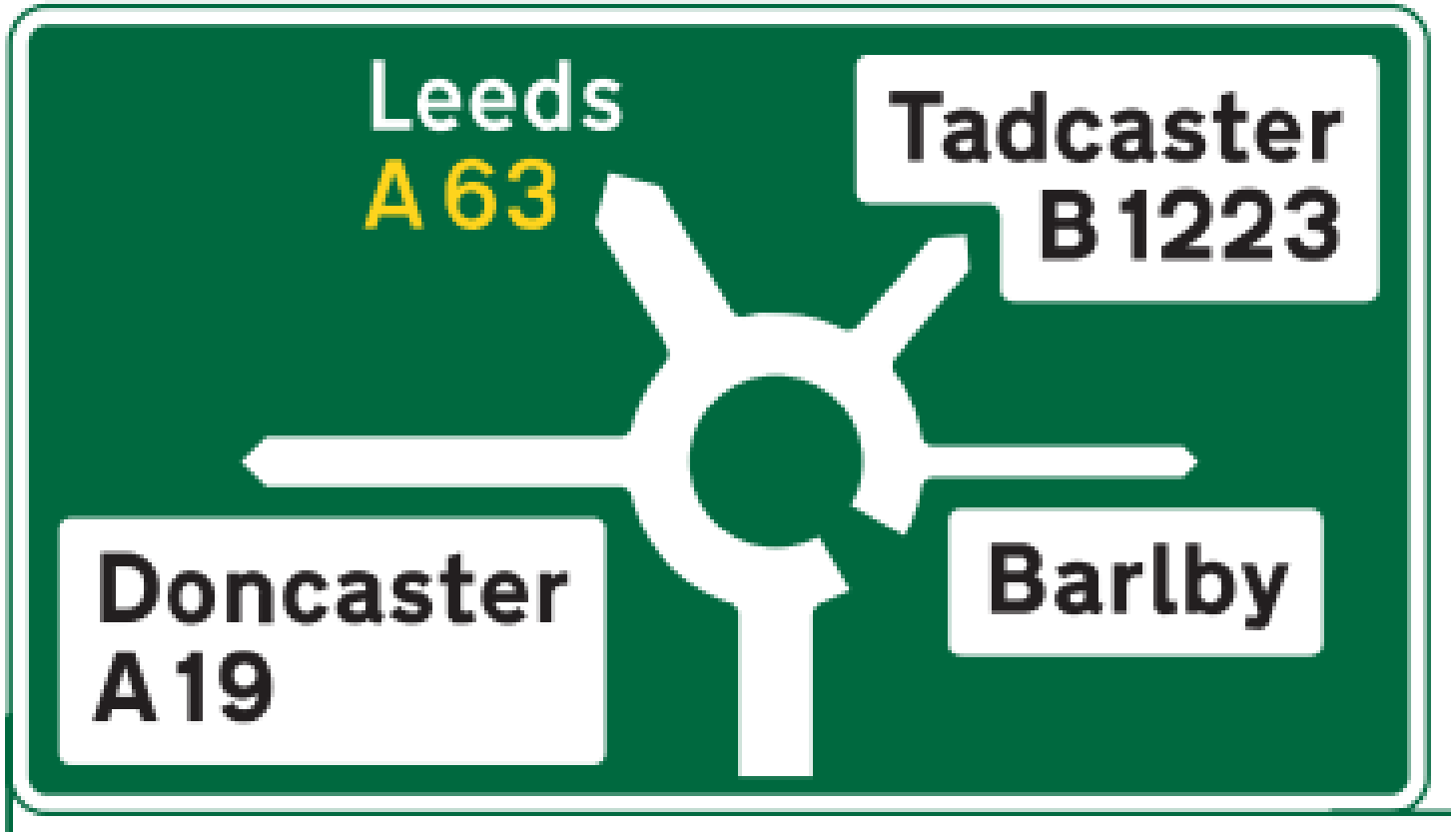
- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

So, will it be any different this time?

Despite the challenges, I'm feeling optimistic about ICSs (so long as…)

I. We place an absolute and urgent premium on the value of networks and relationships and invest in them – they are not a given.
II. The initial focus of activity is concentrated on scoping, exploring, designing and building a more comprehensive approach to partnership, with clear milestones 'baked in'.
III. We adopt a pragmatic approach to what has gone before, including the politics actively participate in truth and reconciliation.
IV. We see the ICS as a blueprint rather than a hard and fast approach.

Theme 3 – what's next?



The importance of narrative

1. The story – why does it matter?
2. The strategy – what are we going to do about it?
3. The structure – how do we organise ourselves to get it done?

“The initial challenge for an organizer—or anybody who’s going to provide leadership for change—is to figure out how to break through the inertia of habit to get people to pay attention.”

Why stories matter Professor Marshall Gantz

We must be open to learn & challenge

- We must be honest about what has worked before and what hasn't in order to avoid repetition of the same mistakes.
- That will take a degree of truth and reconciliation from all parties.
- It will also have a direct impact on organisational strategies…
- …and politics….
- …and governance.
- AND don't forget, assumptions should always be subject to challenge.

Relationships must be nurtured

- Do we view ‘networking’ as work or something that fits around work?
- How much time do leaders spend specifically developing their network?
- Do we learn enough about leadership and about emerging thinking about systems leadership?
- The nature of leadership has changed fundamentally in the last 25 – 30 years. Has our leadership kept pace?

Why stop here?

Thanks,
Stay in touch…

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Phil Robson

Phil was appointed as an Independent Member of Aneurin Bevan University Health Board in 2010. From April 2016 until May 2018 he was the Vice- Chair. He was recently appointed to the position of Special Advisor to the Board.

Mason Fitzgerald and Siân Gascoigne

Mason is a Senior Consultant at Good Governance Institute, previously holding director roles within NHS Foundation Trusts and has worked closely with the IHI.

Siân is the Head of Corporate Assurance for NHS Nottingham and Nottinghamshire ICB, working previously at NHS Nottingham and Nottinghamshire CCG for just over three years.

Governance across partnerships

Development of system risk management

Mason Fitzgerald, Director of Consultancy and Principal Consultant, GGI

Context

- Thinking about system risk and its management will continue to **evolve** as ICBs put risk management arrangements into practice

- Developing system risk management arrangements provides the opportunity to promote the **culture** and **practice** that is required in order to meet the ICS purpose of:
  1. Improve outcomes in population health and healthcare
  2. Help the NHS support broader social and economic development
  3. Enhance productivity and value for money
  4. Tackle inequalities in outcomes, experience and access

System risk management – Spot the difference

Organisation risk management:

- Based on organisation objectives
- Little reference to wider system issues and risks are mitigated by internal controls
- Some alignment with system partners BAFs
- Assurance drawn from internal sources

System risk management:

- Based on system objectives and system wide strategy alignment
- Requires system partners to mitigate multifactorial and complex risks
- Strong alignment with system partners BAFs
- Assurance will be drawn from a range of internal and external sources

System risk management

What it is:

- Based on collective responsibility for system objectives and outcomes
- Recognises interdependencies of system issues
- Facilitates engagement and action from system partners
- Agile and dynamic

What it isn't:

- A collation of every risk in the system
- Cherry picking red risks of system partners
- A dumping ground for risks too hard to handle

Components of system risk management

Objectives

- ICS aims
- System objectives

- Context will include the objectives of constituent members

Approach

- Principles
- Risk appetite

Tools

- ICB Board Assurance Framework
- High Level System risk register

Processes

- Policy development
- ICB and committee cycle of business
- ICB management

Structure

- Policies (e.g. escalation)
- Terms of reference for key groups, e.g. System Risk Group
- Accountability/ reporting flows

Where to start - ICS assurance principles

- **An integrated approach:** Commissioners (including specialised commissioning) and providers working together in a partnership model including local authority and voluntary sector partners where appropriate
- **Shared responsibility:** We have shared responsibility for collective resource to improve quality of care and health outcomes
- **System focus:** We have a population and system focus – with line of sight to individual organisations
- **Person-centred approach:** We have a single relationship approach; working together within a single NHS regulatory model to deliver system by default in practice
- **Transparency:** There is transparency, trust and sharing of information between constituent members and with NHSE
- **Positive behaviours:** We work with positive system behaviours towards each other and other external partners
- **Shared risk and support:** We enable joint identification and mitigation of quality, performance and financial risks and joint action on areas of actual or potential underperformance
- **Efficiency:** Assurance should be additive, not duplicative, with providers monitoring and improving performance, place providing assurance on point of intersection and system assurance focused on system-level outcomes and improvements

System risk appetite levels

Avoid	Minimal (ARAP)	Cautious	Open	Seek	Significant
Avoiding risk and uncertainty is a key organizational objective	(As little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and may only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	Willing to consider all potential delivery options while also providing an acceptable level of reward (VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

The rationale for a System BAF

A key duty of a Board is to set and monitor a strategy that ensures the long-term sustainability of the organisation and achievement of strategic objectives. Boards often struggle to maintain this strategic focus in the face of operational challenges and regulatory requirements

The BAF is recognised good practice as a tool which supports the Board to:

- **Maintain focus** on the ICB's strategic objectives
- **Identify future challenges** the system faces
- **Mitigate risks** to the ICB's strategic objectives
- **Shape Board agendas** and discussions, and also can be used to seek help from system partners
- **Enable transparency,** so stakeholders understand key issues and the future priorities of the organisation

Illustrative System BAF – example

Strategic Aim: Tackle health inequalities			Risk score
Strategic Risk No.2: **Worsening of food poverty locally**			**Xx**
If we do nothing as a partnership to address food poverty in the current crisis	**Then** we increase the likelihood of health inequalities associated with food poverty worsening considerably, including heart disease and cancer	**Resulting in** unsustainable pressure in primary, secondary and urgent care services and worsening health inequalities across all our Places in the ICS	

	Impact	Likelihood	Score
Inherent	5	4	20
Current	**4**	**3**	**12**
Target	3	3	9

Risk Trend

Sample scoring shown here only. No trend as this will be something the ICB will pick up going forward.

Risk Lead	LA Chief Executive; Lead Director of Public Health	Assurance committee	Trust Board

System Controls

Strategies and Plans
- Health inequalities strategy
- People Plan (NHS)
- Local Council plans for regeneration/levelling up

Partnerships and Services
- Place based partnerships
- Local Council Health and Wellbeing Boards
- CVS organisations

Governance & Engagement Structures
- Local councils
- Local employers (and ICB partner organisations roles as key local employers)
- Food banks
- Benefits agency local offices

Assurances reported to IC Board and committees

- Annual reports of Directors of Public Health
- Agenda discussions at Health and Wellbeing Boards
- Proxy measures across the system (tbc)

Gaps in Controls and Assurances

- No agreed way of assessing/measuring food poverty locally, and no way of properly monitoring this
- No comprehensive partnership strategy/plan for addressing food poverty

Actions and mitigations to address control / assurance gaps

- Public Health to lead work with wider system partners to develop food poverty metrics
- Councils to lead development of partnership strategy/plan for addressing food poverty

Illustrative example – risk description

Strategic Aim: Tackle health inequalities			Risk score
Strategic Risk No.2: **Worsening of food poverty locally**			**Xx**
If we do nothing as a partnership to address food poverty in the current crisis	**Then** we increase the likelihood of health inequalities associated with food poverty worsening considerably, including heart disease and cancer	**Resulting in** unsustainable pressure in primary, secondary and urgent care services and worsening health inequalities across all our Places in the ICS	

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Target	3	3	9	

Risk Lead	LA Chief Executive; Lead Director of Public Health	Assurance committee	HWB

Illustrative example – controls and assurances

System Controls	Assurances reported to IC Board and committees
Strategies and Plans • Health inequalities strategy • People Plan (NHS) • Local Council plans for regeneration/levelling up **Partnerships and Services** • Place based partnerships • Local Council Health and Wellbeing Boards • CVS organisations **Governance & Engagement Structures** • Local councils • Local employers (and ICB partner organisations roles as key local employers) • Food banks • Benefits agency local offices	• Annual reports of Directors of Public Health • Agenda discussions at Health and Wellbeing Boards • Proxy measures across the system (tbc)
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• No agreed way of assessing/measuring food poverty locally, and no way of properly monitoring this • No comprehensive partnership strategy/plan for addressing food poverty	• Public Health to lead work with wider system partners to develop food poverty metrics • Councils to lead development of partnership strategy/plan for addressing food poverty

Key steps in developing system risk management

1. Mindset
2. Process
3. Mechanics

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Nottingham and Nottinghamshire

Development of system risk management

Siân Gascoigne, Head of Corporate Assurance

Contents

- Brief introduction
- What have we done so far…
- Focus over the next six months…
- Potential challenges
- Final thoughts

Introduction

- Who am I?
  - Head of Corporate Assurance, worked in this role for just over three years, previously for a number of former CCGs prior to the ICB establishment.
  - Lead for strategic and operational risk management within the ICB.
  - Experience in aligning risk management arrangements as a result of a number of CCG mergers, prior to the establishment of the ICB.
- Who are we?
  - NHS Nottingham and Nottinghamshire ICB, established on the 1 July 2022. Brought together two predecessor CCGs (NHS Nottingham and Nottinghamshire CCG and Bassetlaw CCG).
  - Complex system ‘Our Family Portrait’

Introduction

<table>
<tr><td colspan="8">Our family portrait - Nottingham and Nottinghamshire Integrated Care System (ICS)</td></tr>
<tr><td colspan="2">Nottingham City PBP 396,000 population</td><td colspan="2">South Nottinghamshire PBP 378,000 population</td><td colspan="2">Mid Nottinghamshire PBP 334,000 population</td><td colspan="2">Bassetlaw PBP 118,000 population</td></tr>
<tr><td colspan="2">8 PCNs</td><td colspan="2">6 PCNs</td><td colspan="2">6 PCNs</td><td colspan="2">3 PCNs</td></tr>
<tr><td colspan="8">NHS Nottingham and Nottinghamshire Integrated Care Board (ICB)</td></tr>
<tr><td colspan="4">Nottingham University Hospitals NHS Trust</td><td colspan="2">Sherwood Forest NHS Foundation Trust</td><td colspan="2">Doncaster and Bassetlaw NHS Foundation Trust</td></tr>
<tr><td colspan="8">Nottinghamshire Healthcare NHS Foundation Trust (mental health)</td></tr>
<tr><td colspan="2">Nottingham CityCare Partnership (community provider)</td><td colspan="6">Nottinghamshire Healthcare NHS Foundation Trust (community provider)</td></tr>
<tr><td colspan="8">East Midlands Ambulance NHS Trust</td></tr>
<tr><td colspan="2" rowspan="2">Nottingham City Council (Unitary)</td><td colspan="6">Nottinghamshire County Council</td></tr>
<tr><td>Broxtowe Borough Council</td><td>Gedling Borough Council</td><td>Rushcliffe Borough Council</td><td>Ashfield District Council</td><td>Mansfield District Council</td><td>Newark & Sherwood District Council</td><td>Bassetlaw District Council</td></tr>
<tr><td colspan="2">Voluntary and community sector input</td><td colspan="2">Voluntary and community sector input</td><td colspan="2">Voluntary and community sector input</td><td colspan="2">Voluntary and community sector input</td></tr>
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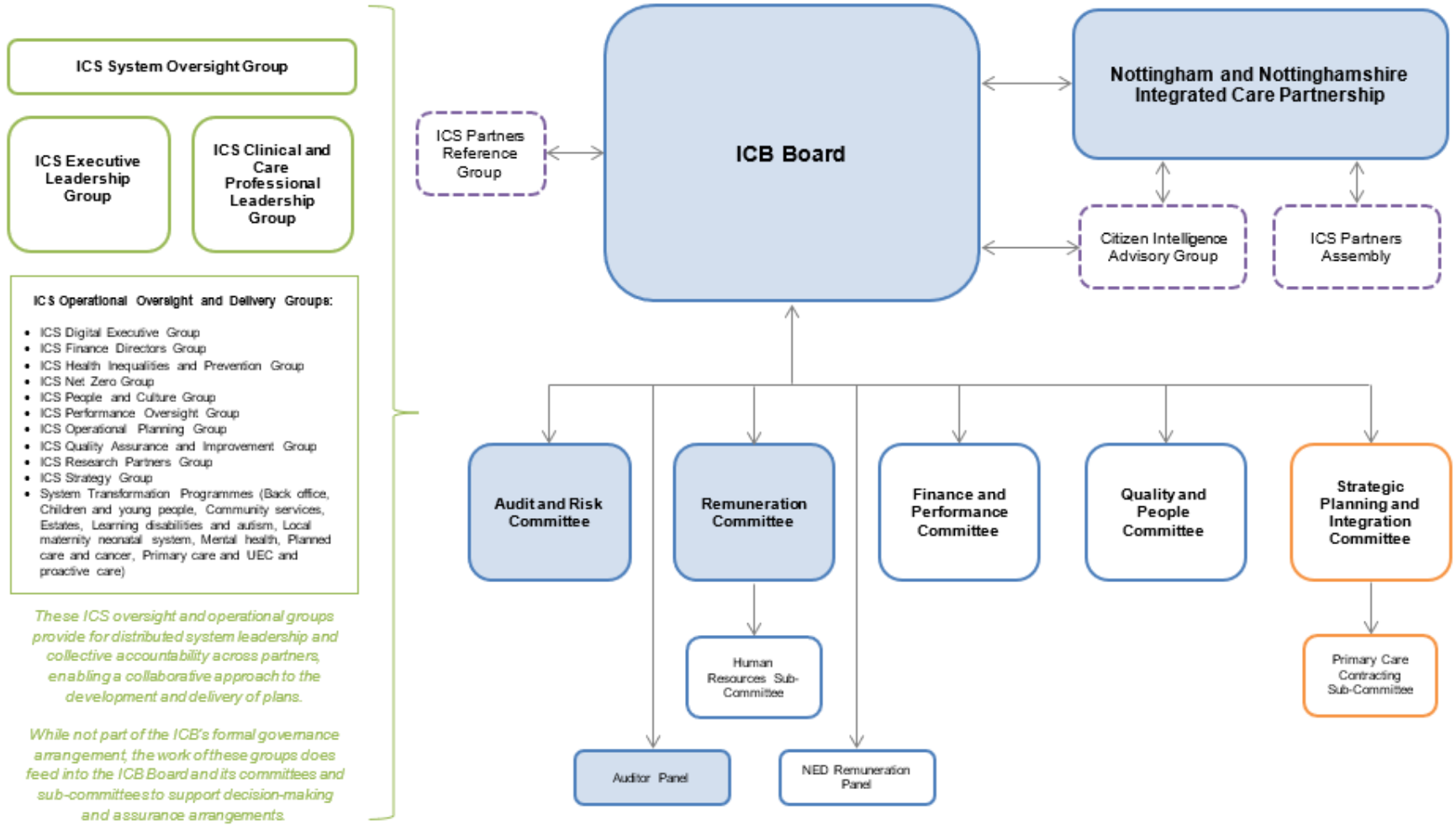
Introduction

4. ICB Board and Committee Structure

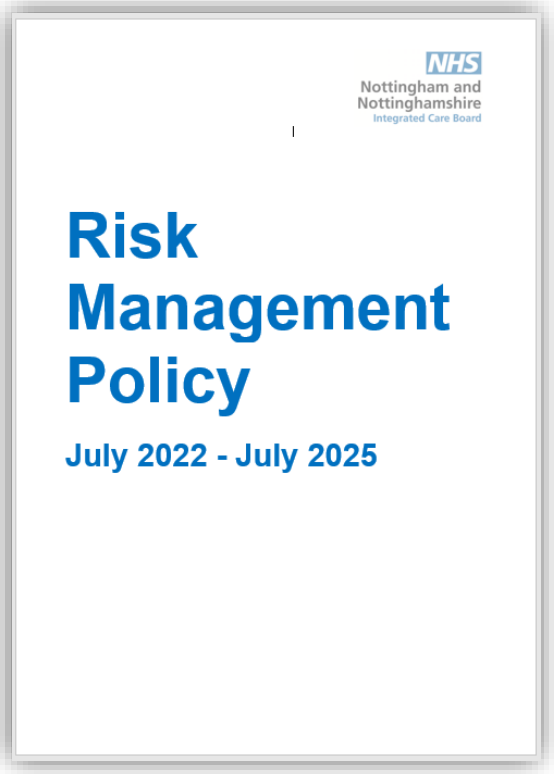


Journey so far…

- Initial engagement with NHS and Council risk leads
- Understand and define what is meant by ‘system risk management’
- Developed an ICB Risk Management Policy
- Established an ICB Board Assurance Framework
  - Exercise to review alignment of strategic BAF risks across NHS system partners
- Developed an ICB Operational Risk Register to capture both ‘corporate’ and system operational risks
- Commenced operational risk reporting to ICB committees and ICS system groups

Journey so far…

- Understand and define what is meant by ‘system risk management’
  - It is not the escalation of ICS system partner risks to the ICB; it is the collective mitigation of risks identified, and agreed, by all partners.
  - The coordination of system risk management sits with the ICB; however, it is important to recognise that the management of risks will be collectively-led and contributed to by all partners.
- Developed an ICB Risk Management Policy



Journey so far…

- Established an ICB Board Assurance Framework
  - The **unitary boards of each statutory NHS partner organisation within the ICS will continue to have their own individual Board Assurance Frameworks**, and there may be a differential approach to these by the respective organisations in line with their roles, responsibilities and requirements of individual Boards.
  - However, it has been recognised that the move towards more collaborative working, **the importance of having some alignment of key strategic risks across partners is vital for successful system working**.

Strategic risk	Risk Owner	Initial Risk Score *(I x L)*
Risk 1: Health Inequalities and Outcomes – Failure to adequately address health inequalities and improve health outcomes for the population of Nottingham and Nottinghamshire.	Medical Director	High (5 x 3)
Risk 2: System Resilience (for Managing Today) – Failure to work effectively across the system to ensure current levels of demand are met across primary, community and secondary care.	Director of Integration	High (5 x 4)
Risk 3: Transformation (for Making Tomorrow Better) – Failure to work effectively across the system to reform and improve services to ensure best possible health outcomes within available resources.	Director of Integration / Medical Director	High (5 x 3)
Risk 4: System Development (for Developing the ICS) – Failure to develop thriving 'Places' and Provider Collaboratives to ensure the best possible health outcomes for the population of Nottingham and Nottinghamshire.	Director of Integration	High (4 x 4)
Risk 5: Quality Improvement – Failure to maintain and improve the quality of services. *For 2022/23, this specifically includes the need to improve the quality of maternity services across the system.*	Director of Nursing	High (5 x 4)
Risk 6: Citizen Voice – Failure to effectively work in partnership with citizens and communities.	Chief Executive	Medium (4 x 3)
Risk 7: People and Culture – Failure to ensure sufficient capacity and capability within the local workforce.	Director of Nursing	High (5 x 4)
Risk 8: Financial Sustainability – Failure to establish a shared culture of financial stewardship to ensure financial sustainability across the system.	Director of Finance	High (4 x 4)
Risk 9: Allocation of Resources – Failure to establish robust resource allocation arrangements across the system (revenue and capital).	Director of Finance	High (5 x 3)
Risk 10: Digital Transformation – Failure to deliver digital transformation and establish effective system intelligence solutions.	Medical Director	High (5 x 3)
Risk 11: Emergency Preparedness, Resilience and Response – Failure to be adequately prepared to respond to major and/or business continuity incidents.	Director of Integration	Medium (5 x 2)
Risk 12: Equality, Diversity and Inclusion – Failure to comply with the general and specific Public Sector Equality Duties.	Director of Nursing	High (5 x 3)
Risk 13: Safeguarding – Failure to safeguard children and vulnerable adults in accordance with legislative and statutory frameworks and guidance.	Director of Nursing	Medium (5 x 2)
Risk 14: Environment Sustainability – Failure to effectively deliver on the green plan.	Director of Finance	Medium (4 x 3)
Risk 15: Research and Evidence – Failure to effectively utilise research and evidence to inform decision-making.	Medical Director	Medium (4 x 3)

Journey so far…

ICB	Trust A	Trust B	Trust C	Trust D
Health inequalities and outcomes (15)				
People and culture (20)	People (recruitment, retention and training) (20)	Workforce capacity and capability (12)	People and culture (skillset / experience/ equality and diversity) (16)	Workforce (recruitment, training and diversity) (20) / Workforce wellbeing (16) / Development of clinical model (16)
Digital transformation (15)	Infrastructure (physical and digital) (20)		Infrastructure (estate, digital, green plan and capital) (12)	Estate, infrastructure and technology (16)
Quality improvement (20)	Patients (experience and outcomes) (16)	Standards and safety of care (16)	Standards and safety of care (16)	Inability to deliver a safe service (25)
Financial sustainability (16) / Allocation of resources (15)	Financial stability (16)	Financial strategy (16)	Financial sustainability (16)	Financial targets (20) / Financial settlement (20) / Impact of external factors on supply chain costs (12)
Transformation (for making tomorrow better) (15)	Governance and strategy (16)	Working with health partners (8)	Partnership working across health and social care (12)	Transformation of UEC services (9) / Service development (16)
Research and evidence (12)	Research and education (16)	Evidence-based improvement and innovation (9)	Innovation and transformation (8)	

Journey so far…

- Developed an ICB Operational Risk Register to capture both ‘corporate’ and system operational risks
  - The Operational Risk Register includes **operational risks relevant to the ICB as a corporate body** (e.g. operational risks associated with delivery of the ICB’s statutory duties) and **operational risks associated with the delivery of system objectives/priorities** (e.g. operational risks associated with system delivery and/or the delivery of transformation programmes).
  - It contains risks inherited from the two former Clinical Commissioning Groups within the ICB’s area, as well as new risks identified by ICB officers and/or within relevant ICS forums since the 1 July 2022.
  - It enables **controls and mitigations** relating to both the ICB, and system partners, to be captured where applicable.

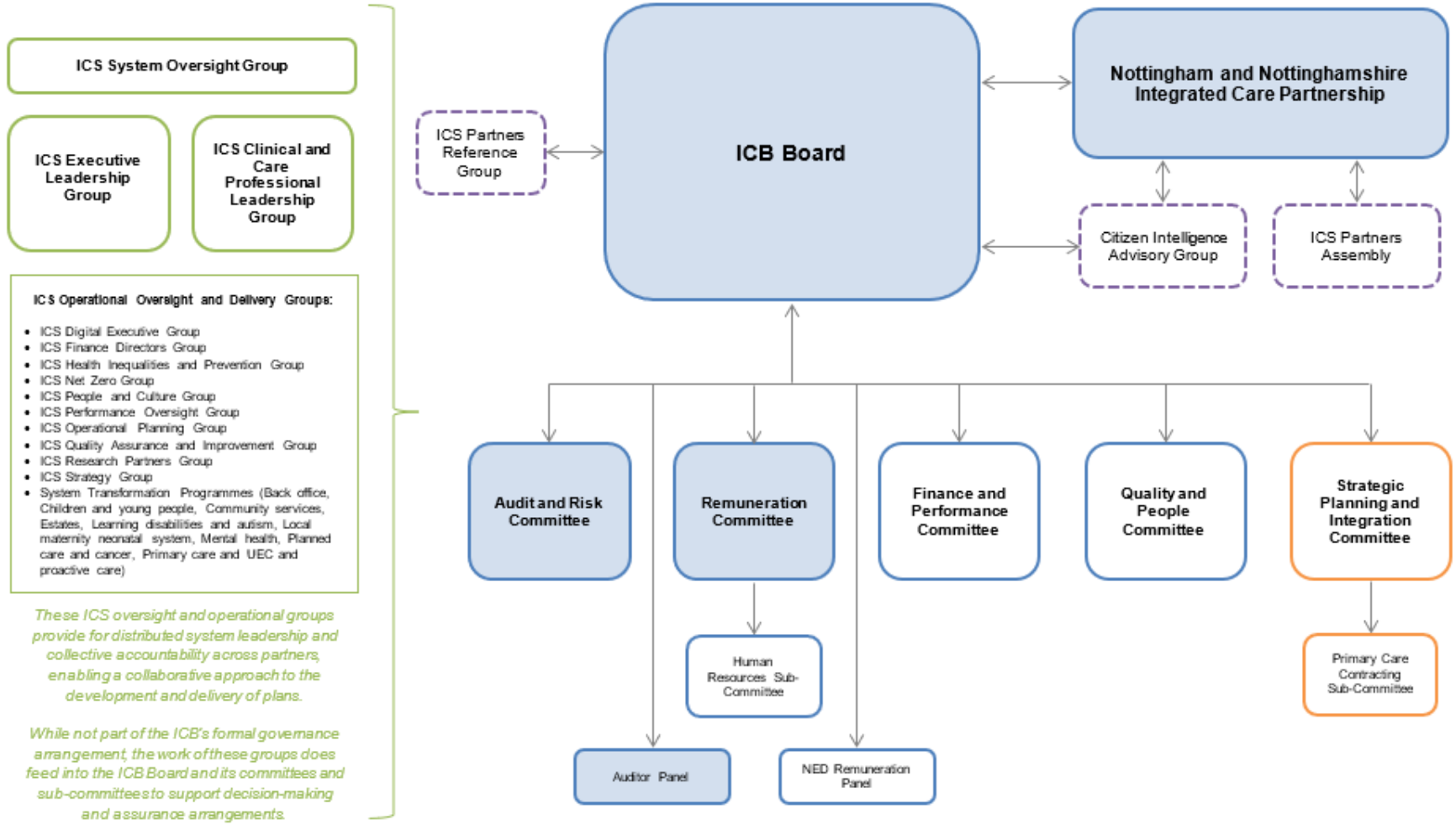
Journey so far…

- Commenced operational risk reporting to ICB committees and ICS system groups
  - Utilising the ICB ORR as the **source risk register** for system risks enables matrix reporting of relevant system risks to ICB committees, but also to other ICS forums.

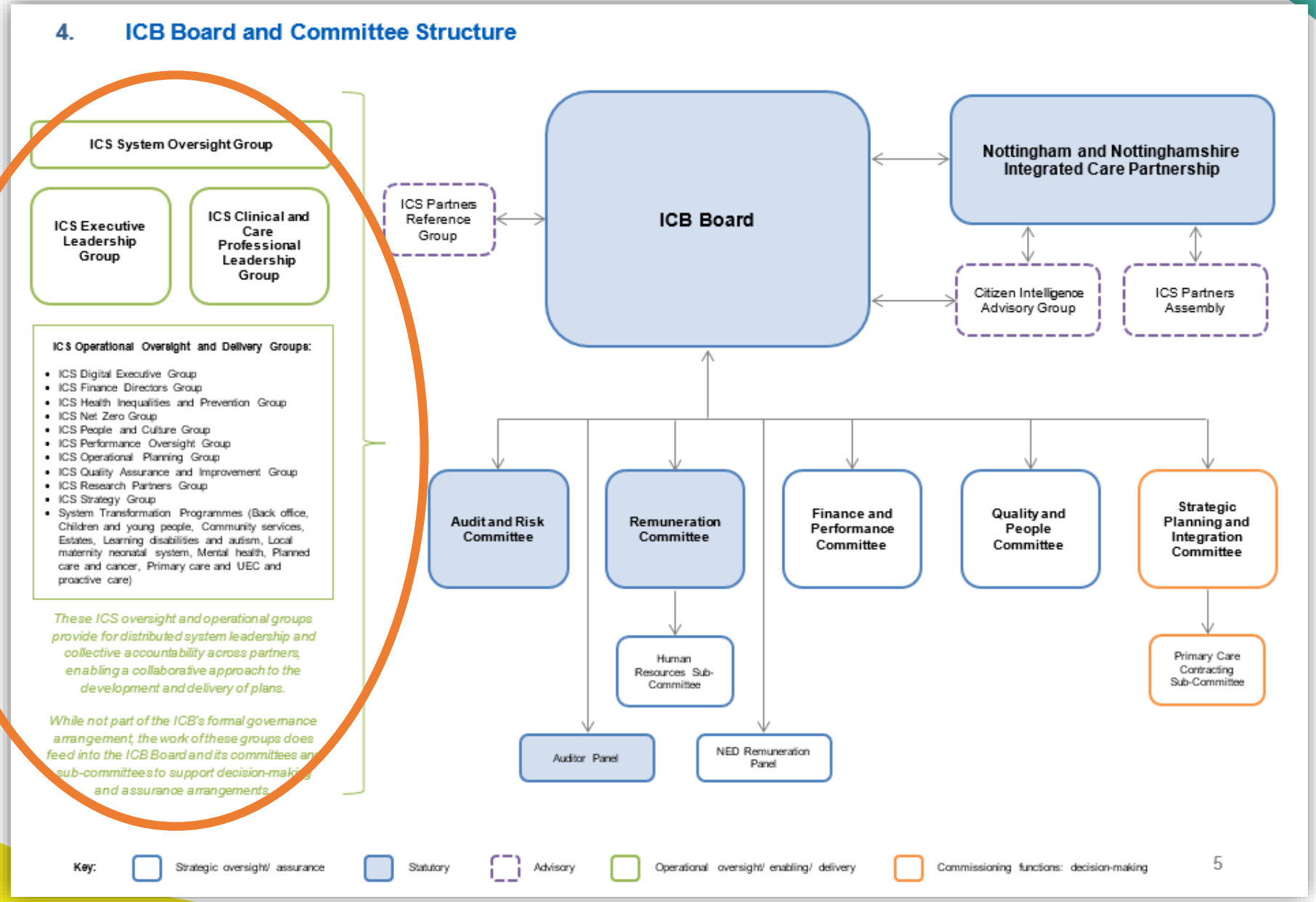
    For example, quality risks identified at the Urgent and Emergency Care (UEC) Board will be able to be reported and discussed at the UEC Board but also to the ICS System Quality Group. This process can be replicated for system finance and workforce risks to the ICS Directors of Finance Group and ICS People and Culture Group respectively.

Journey so far…

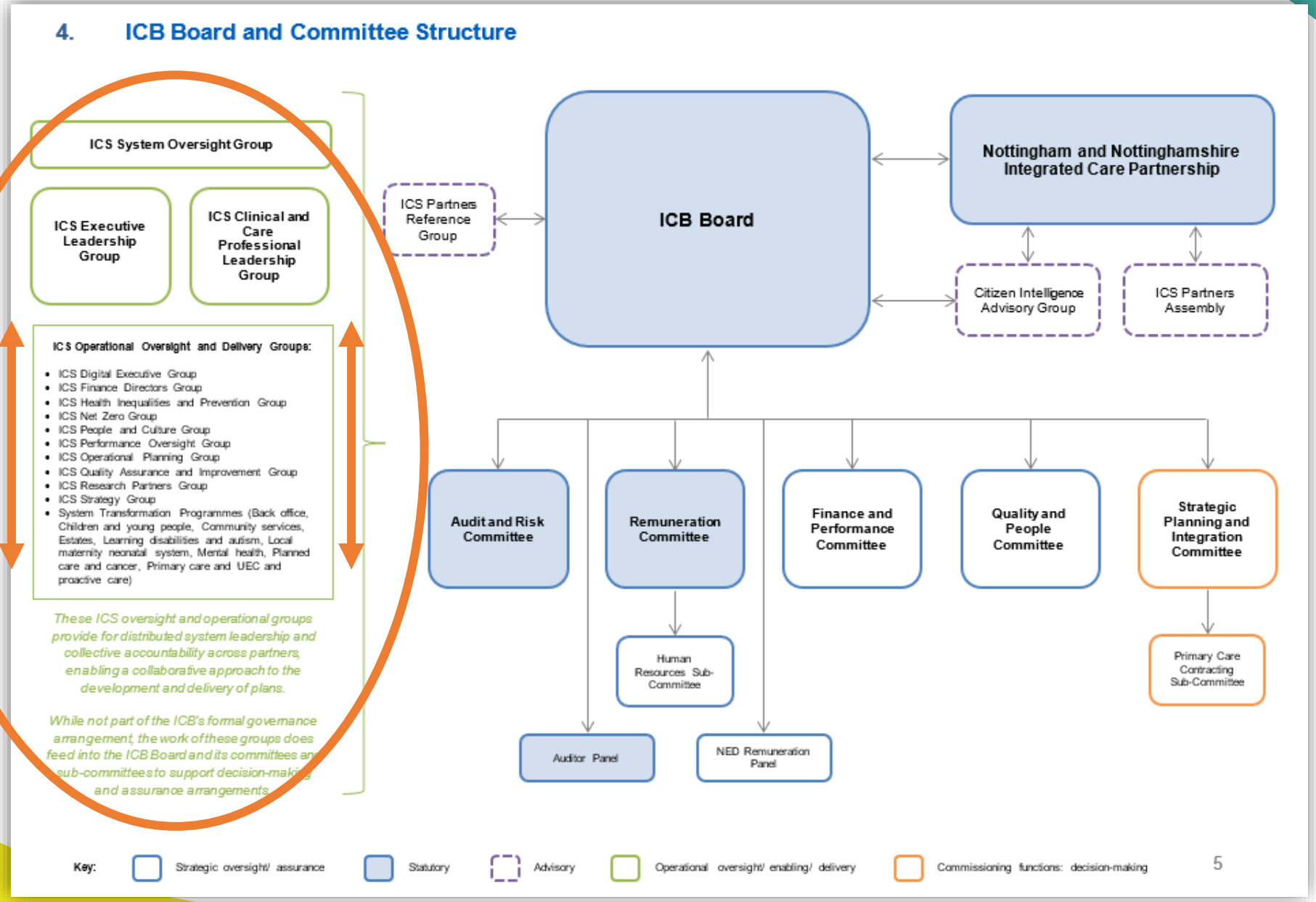
4. ICB Board and Committee Structure



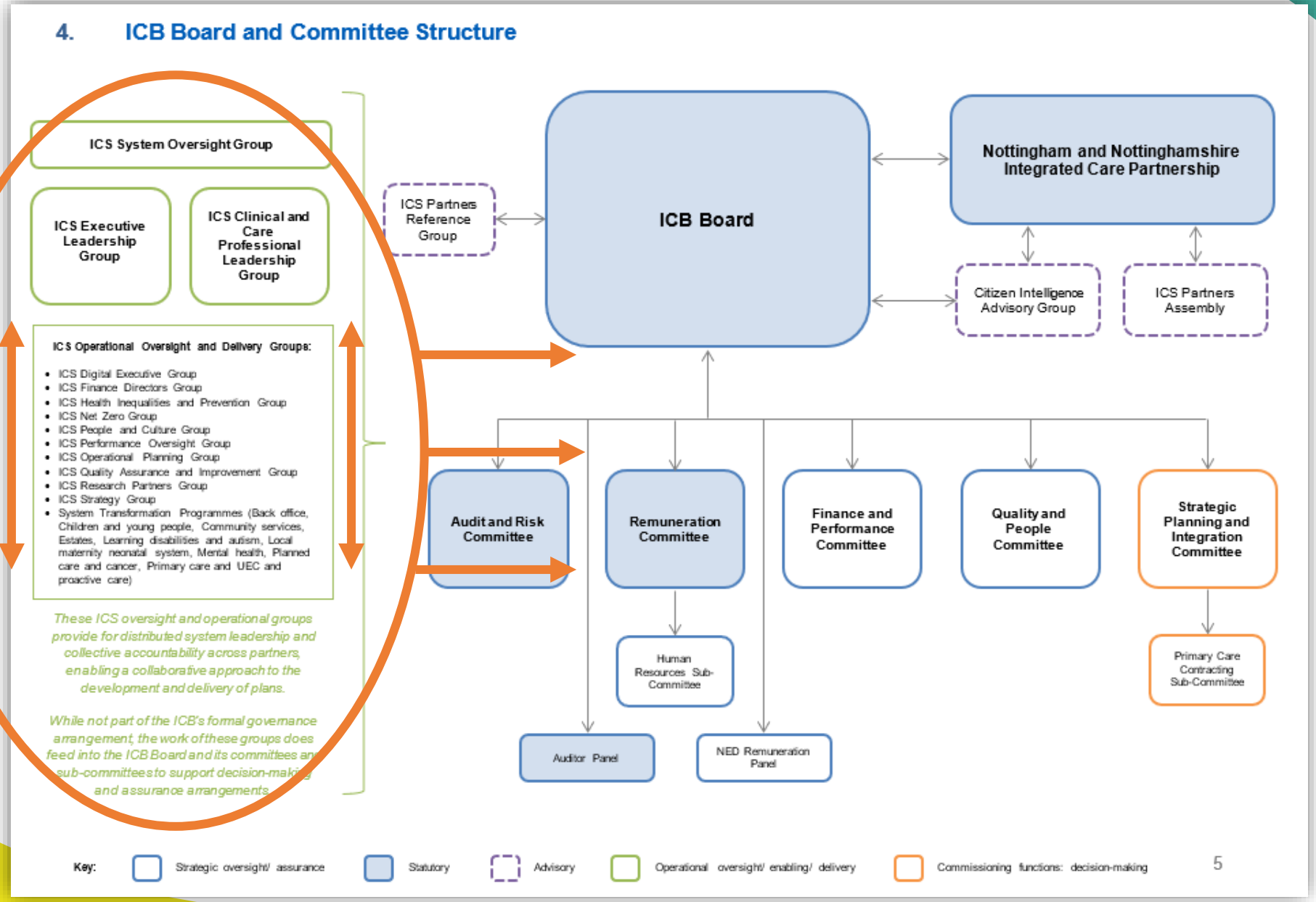
Journey so far…



Journey so far…



Journey so far…



Next six months...

- Identification of system risk controls and mitigations
- Ensuring collective ownership of mitigations
- Working with system partners to explore consistency of risk classification and language

Potential Challenges

- ‘Ownership’ of system risks and mitigations
- Maturity of systems to hold each other to account collectively in relation to the management of system risks.
- ‘Club’ vs ‘Country’

Final thoughts…

- System risk management arrangements are very early in their development and are **likely to evolve over time**.
- Initial focus is being given on ensuring risk is a regular feature across system forums and to ensure risks are being articulated through a system ‘lens’.
- Future focus will be on the system controls and mitigations, in particular, ensuring mitigating actions are ‘owned’ by the correct system partners.
- Recognise that it won’t be perfect from day one!

NHS
Nottingham and Nottinghamshire

Thank you

Contact: sian.gascoigne@nhs.net

Alex Rothwell

Alex joined the NHS Counter Fraud Authority as its Chief Executive Officer in November 2021 after a 30-year career in the Metropolitan Police and City of London Police, where he left as Detective Chief Superintendent.

Alex Rothwell

Chief Executive Officer

NHS Counter Fraud Authority

Countering fraud in the National Health Service

THE SHOCKING NUMBERS

383,132 fraud reports in UK from April 30, 2021, to May 1, 2022, resulting in losses of **£2.9bn** (National Fraud Intelligence Bureau)

£700m lost to fraudsters this April, against an average of £200m a month over previous year (Action Fraud)

40m adults in UK (around 75 per cent of population) targeted by a scammer this year (Citizens Advice)

60% of all estimated crimes last year linked to fraud and computer misuse (ONS)

2% of police in specialist fraud squads (Social Market Foundation)

1 dedicated police fraud investigator per 2,500 annual scams (Social Market Foundation)

66% of police forces in UK use generalist investigators to tackle fraud, despite lacking adequate knowledge (Police Foundation)

15% of fraud offences are reported (ONS)

1 in 1,000 reports of fraud resulted in a charge last year (ONS)

£137bn cost of fraud to economy a year (auditors Crowe UK)

40% reduction in fraud would save the economy £55bn a year (Crowe)

THE ELDERLY

£977m stolen by fraudsters from those aged 70 and over in past three years according to Action Fraud

£116m stolen from those aged between 90 and 99, an average of £6,097 each despite these victims accounting for only 19,059 of the 178,772 cases reported in over-70s group

£337m stolen from those in their 20s at an average of £2,296 each

■ **Victims in their 50s suffered the biggest total loss in every one of the past three years. Those in their 20s and 30s typically reported the most cases**

FRAUD BY COUNTRY

	UK	Canada	US	New Zealand (cyber frauds only)	Australia	France (2020 data only)
Total losses	£2.4bn	$380m (£239m)	$5.9bn (£4.73bn)	$16.8m (£8.64m)	$323.7m (£184.9m)	€1.28bn (£1.09bn)
Population	67m	38m	332m	5m	26m	67m
Fraud per capita	£36.02	£6.29	£14.25	£1.73	£7.11	£16.24

Source: Action Fraud, Canadian Anti-Fraud Centre, Federal Trade Commission, CERT NZ (New Zealand's National Computer Emergency Response Team), Australian Competition and Consumer Commission, Observatory for the Security of Payment Means

Daily Mail

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PANAMA PAPERS

The Panama Papers (Spanish: Papeles de Panamá) are 11.5 million leaked documents that detail financial and attorney–client information for more than 214,488 offshore entities. The documents, some dating back to the 1970s, were created by, and taken from, Panamanian law firm and corporate service provider Mossack Fonseca, and were leaked in April 2016.

The documents contain personal financial information about wealthy individuals and public officials that had previously been kept private. While offshore business entities are legal, reporters found that some of Mossack Fonseca shell corporations were used for illegal purposes, including tax evasion, and evading international sanctions.

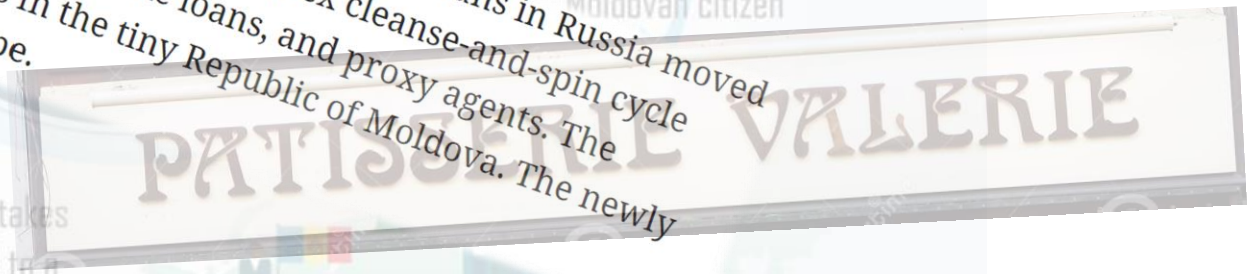
Between 2010 and early 2014, organized criminals and corrupt politicians in Russia moved US$ 20 billion in dirty funds through this laundromat's complex cleanse-and-spin cycle made up of dozens of offshore companies, banks, fake loans, and proxy agents. The process was then certified as clean by judges in the tiny Republic of Moldova. The newly cleaned funds were then spread across Europe.

The FinCEN Files

Leaked documents involving about $2tn of transactions have revealed how some of the world's biggest banks have allowed criminals to move dirty money around the world.

They also show how Russian oligarchs have used banks to avoid sanctions that were supposed to stop them getting their money into the West.

It's the latest in a string of leaks over the past five years that have exposed secret deals, money laundering and financial crime.



In October 2018, Patisserie Valerie announced to the markets that instead of having £28m in the bank, as shown in its accounts, it actually was in debt to the tune of £9.8m. This is a dramatic swing, and it ultimately caused the demise of the company, although it has now been 'rescued' from administration following its purchase by an Irish private equity firm.

News story

New crackdown on fraud and money laundering to protect UK economy

Wide ranging reforms designed to bear down on kleptocrats, organised criminals and terrorists abusing the UK's open economy have been introduced into Parliament.

From: Home Office, Department for Business, Energy & Industrial Strategy, Serious Fraud Office, HM Treasury, Ministry of Justice, and Companies House

Published 22 September 2022

The Economic Crime and Corporate Transparency Bill will strengthen the UK's reputation as a place where legitimate businesses can thrive while driving dirty money out of the UK. Through the reforms, anyone who registers a company in the UK will need to verify their identity, tackling the use of companies as a front for crime or foreign kleptocrats.

The reforms to Companies House – its biggest upgrade in 170 years – will also

Economic Crime and Corporate Transparency Bill

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Law Commission
Reforming the law

Home | About us | News and press releases | Our work | Lectures and talks

How are we doing?

We want to know how our website is working for you and where we can improve.

Give feedback

Corporate Criminal Liability

Current project status

The Law Commission has published an options paper for the Government on how it can improve the law to ensure that corporations are effectively held to account for committing serious crimes.

Options

1. Retention of the identification doctrine as at present.

2A. Allowing conduct to be attributed to a corporation if a member of its senior management engaged in, consented to, or connived in the offence.

2B. As 2A, with the addition that the organisation's chief executive officer and chief financial officer would always be considered to be members of its senior management.

3. An offence of failure to prevent fraud by an associated person.
4. An offence of failure to prevent human rights abuses.
5. An offence of failure to prevent ill-treatment or neglect.
6. An offence of failure to prevent computer misuse.
7. Making publicity orders available in all cases where a non-natural person is convicted of an offence.
8. A regime of administratively imposed monetary penalties.
9. Civil actions in the High Court, based on Serious Crime Prevention Orders, with a power to impose monetary penalties.

10A. A reporting requirement based on section 414CB of the Companies Act 2006, requiring public interest entities to report on anti-fraud procedures.

10B. A reporting requirement based on section 54 of the Modern Slavery Act 2015, requiring large corporations to report on their anti-fraud procedures.

Public Sector Fraud Authority

Working with Departments and Public Bodies to understand and reduce the impact of fraud.

Our operations are underpinned by five value principles:

Mandatory Processes

7. The PSFA will have mandatory processes for ministerial departments and public bodies. These are:

   a. The use of **Initial Fraud Impact Assessments** during the design phase pre-announcement in significant areas of new spend (in line with Managing Public Money and the Green Book);

   b. The **submission of quarterly performance data** on levels of fraud and error (as defined by the PSFA) and progress against Action Plans and Metrics;

   c. The use of, and assurance against[5], the **Counter Fraud Functional Standard**;

   d. Agreement of **annual action plans and metrics** on fraud management.

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Fraud and Corruption Framework

Department of Health and Social Care's 5 Principles of Fraud and Corruption framework

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Reactive Activity 2021-2022 (England only)

Fraud identified – 76%
of organisations recorded no fraud identified from reactive work during 21/22

Fraud recovered – 87%
of organisations recorded no funds recovered from reactive work during 21/22

Sanctions action - 78%
of organisations recorded no sanctions actions of any type during 21/22

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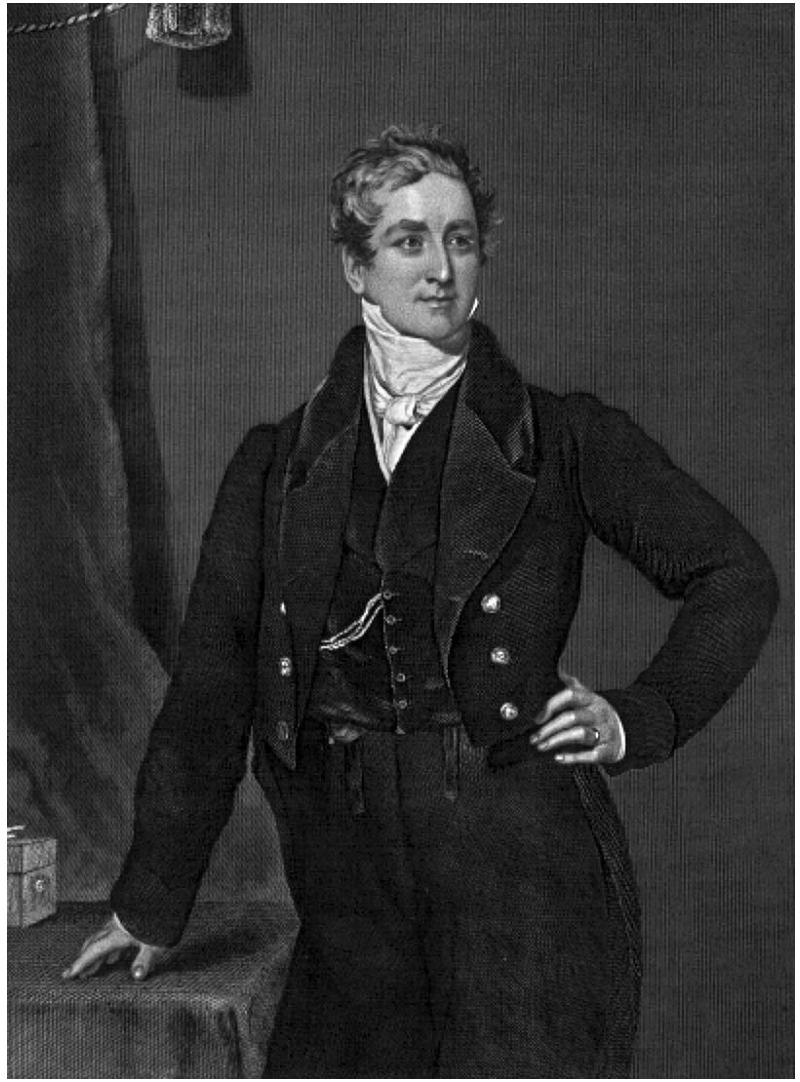
Peelian Principles 1829

‘The test of efficiency is the absence of crime not the actions of police in dealing with it’



Timeline of NHS Counter Fraud Authority

1998

2023

1998

Directorate of Counter Fraud Services (DCFS) created and assigned with overall responsibility for all the work to counter fraud and corruption undertaken in the NHS

1999

Inclusion of the Counter Fraud Operational Service (CFOS) providing a regional investigative capacity

2003

NHS Counter Fraud and Security Management Service (NHS CFSMS), set up as a special health authority an arm's length body of the Department of Health, to protect the staff, assets and resources of the NHS in England and Wales

2005

NHS CFSMS was amalgamated into the NHS Business Services Authority (BSA) to be part of a single special health authority

2011

The CFSMS division of the NHSBSA is renamed NHS Protect with its counter fraud function aligned to the development and delivery of the DHSC anti-fraud strategy

2014

NHS Protect achieves its first million pound recovery with Dentist Joyce Trail required to pay back £1.4million she had defrauded from the NHS

2015

NHS Finance Manager Barry Cosson ordered to pay back £2.1 million defrauded from his NHS employer.

2016

Four NHS Clinical specialists ordered to pay back £520,000 they had conspired to defraud from the NHS.

2017

the NHS Counter Fraud Authority (NHSCFA) is created as a new special health authority charged with identifying, investigating and preventing fraud and other economic crime within the NHS and the wider health group (removing responsibility for the protection of staff in the NHS)

2017-2020

First NHSCFA strategy
Organisation establishes itself as a leader in counter fraud.

£126m financial benefit achieved (2019-20)

2019

The NHSCFA increased their profile with 'Fraud Squad NHS' BBC One TV documentary series

2020

Covid-19 starts.

NHSCFA remit renewed by Parliament for another three years

2020-2023

Current strategy
Target of £400m overall financial benefit.

£54m achieved in 2020-21 (against target of £50m)

2021

Appointment of new Chief Executive, Alex Rothwell

2021-2022

Evolution Programme starts

Stakeholder Engagement programme launched

Clue implemented across NHS

2022-2023

Ongoing evolution
Development of new NHSCFA strategy

NHS Requirements:

Key Functions:

Standard setting and assurance

Intelligence

Fraud Prevention

Analytical Capability

Enforcement and Digital Forensics

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Covid-19 Post Event Assurance outcomes

Data collection in 2021: 91% response rate

"Good" assessment of NHS organisations' management of fraud risk on procurement spend

Recommendations

Proactive savings of £10 million

NHS Counter Fraud Authority

Cost of fraud to the NHS

£1,198,000,000

Thematic fraud areas and values

Strategic Priority Area	2021 – 2022 financial vulnerability estimate
Procurement and Commissioning fraud	£336.4m
Data Manipulation fraud	£249.1m
Patient Exemption fraud	£214m
Community Pharmaceutical Contractor fraud	£122m
GP Contractor fraud	£101m
Dental Contractor fraud	£61m
Optical Contractor fraud	£38.7m
NHS Staff fraud	£22.6m

Extract from Executive Summary – Strategic Intelligence Assessment

The response to fraud within the NHS in England is now split into three categories;

- Strategic priority: ensure that counter fraud activity is proactively pursued with threats, vulnerabilities, enablers, risk and financial vulnerability reported on an annual basis.
- Intelligence collection: intelligence resources are assigned to improve the intelligence picture with threats, vulnerabilities, enablers, risk and financial vulnerability assessment reported on an annual basis through the strategic intelligence assessment.
- Strategic oversight: fraudulent activity is monitored through trend analysis and horizon scanning to determine any fluctuations or depreciation in effectiveness of counter fraud functions. These areas will no longer be reported on an annual basis within the SIA, however a combined notional financial vulnerability figure will be provided for transparency.

Thematic fraud areas and values

Intelligence collection	2021 – 2022 value
Fraudulent access to secondary care from overseas visitors	£39.3m
Reciprocal Healthcare fraud	£1.94m

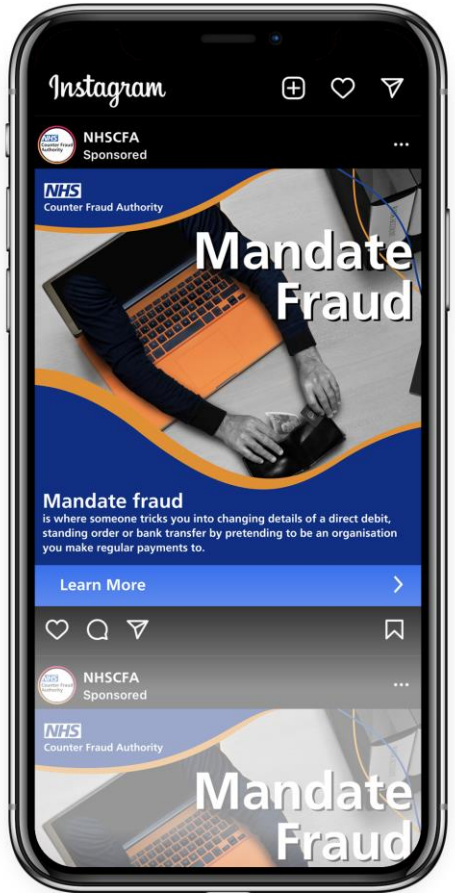
Strategic oversight	2021 – 2022 value
Additional area (NHS Bursaries and NHS Pension fraud)	£12.7m

The NHSCFA launched the **Mandate Fraud Corporate Project** in April this year.

To support this campaign, the NHSCFA will shortly launch a Mandate Fraud Prevention Resource Pack on Ngage to help facilitate LCFS engagement with finance teams.

These resources will include:

- Mandate fraud guidance/quick guides
- Social media assets
- PowerPoint presentations (for delivery to finance teams)
- Aide-memoirs
- Reporting guide
- Supplier guide



If anyone has any questions, **please email the Mandate Fraud Project Team:**

mandatefraud@nhscfa.gov.uk

Covid-19 Post Event Assurance outcomes

Data collection in 2021: 91% response rate

"Good" assessment of NHS organisations' management of fraud risk on procurement spend

Recommendations

Proactive savings of £10 million

NHS Counter Fraud Authority

PO vs non-PO outcomes

Baseline assessment in 2019: 81% response rate

Comparable assessment in 2021: 90% response rate

NHS organisations initiated 5,753 proactive measures as a result of fraud prevention campaign

A reduction of £156.8 million of financial vulnerability exposure in the risk of procurement fraud.

Positive behavioural change as a result of prevention activity that was implemented at a local level (undertaken during Q2 2019-2020). Significant shift of non-PO spend to PO spend.

Actions for NHS provider organisations

Review NHSCFA recommendations

Lead an internal risk-based discussion on vulnerability to procurement fraud within their organisation.

Local risk-based discussions on procurement could result in risk assessments and where necessary local proactive exercises.

Review and update (where necessary) local procurement and finance policies, procedures, and SOPs to reduce vulnerability and fraud risk with procurement and finance systems.

NHS
Counter Fraud Authority

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linkedin.com/in/nhscfa

Steve Connor

Steve is a NED / Audit Committee Chair at Wirral Community Health & Care NHS FT and former NHS Executive Director.

Assurance in a changing governance environment

Steve Connor

Former MD MIAA.

NED / Audit Committee Chair, Wirral Community Health & Care NHS FT.

29th September 2022

Todays Agenda

- Background
- The changing environment
- What does this mean in terms of governance / assurance?
- Potential barriers
- What does this all mean for the Audit Committee?
- Any questions

The old day job: supporting across 3 systems

Healthier Lancashire & South Cumbria

5 Trusts
8 CCG's
14 LA's
5 Places

Greater Manchester Health and Social Care Partnership

10 Trusts
10 CCG's
10 LA's
10 Places

Cheshire and Merseyside Health and Care Partnership

18 Trusts
9 CCG's
9 LA's
9 Places

Assurance: The NHS Perspective

"How do you equate the total accountability of the board with the physical impossibility of knowing everything that is being done in the board's name"

Sir Stuart Burgess, 1995

A Changing Environment in the NHS

- ICB / ICS / ICP
- Place / Locality
- Provider collaboratives
- PCN's
- Collaboration & Partnership
- Governance beyond boundaries
- Impetus for integrated governance activity
- Shift in the balance of trust & scrutiny

ICS Design Framework

Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a 'system financial envelope' set by NHSEI.

Integrated Care Systems: design framework NHSE June 2021

Governance: Two sides of the same coin

Organisational Governance

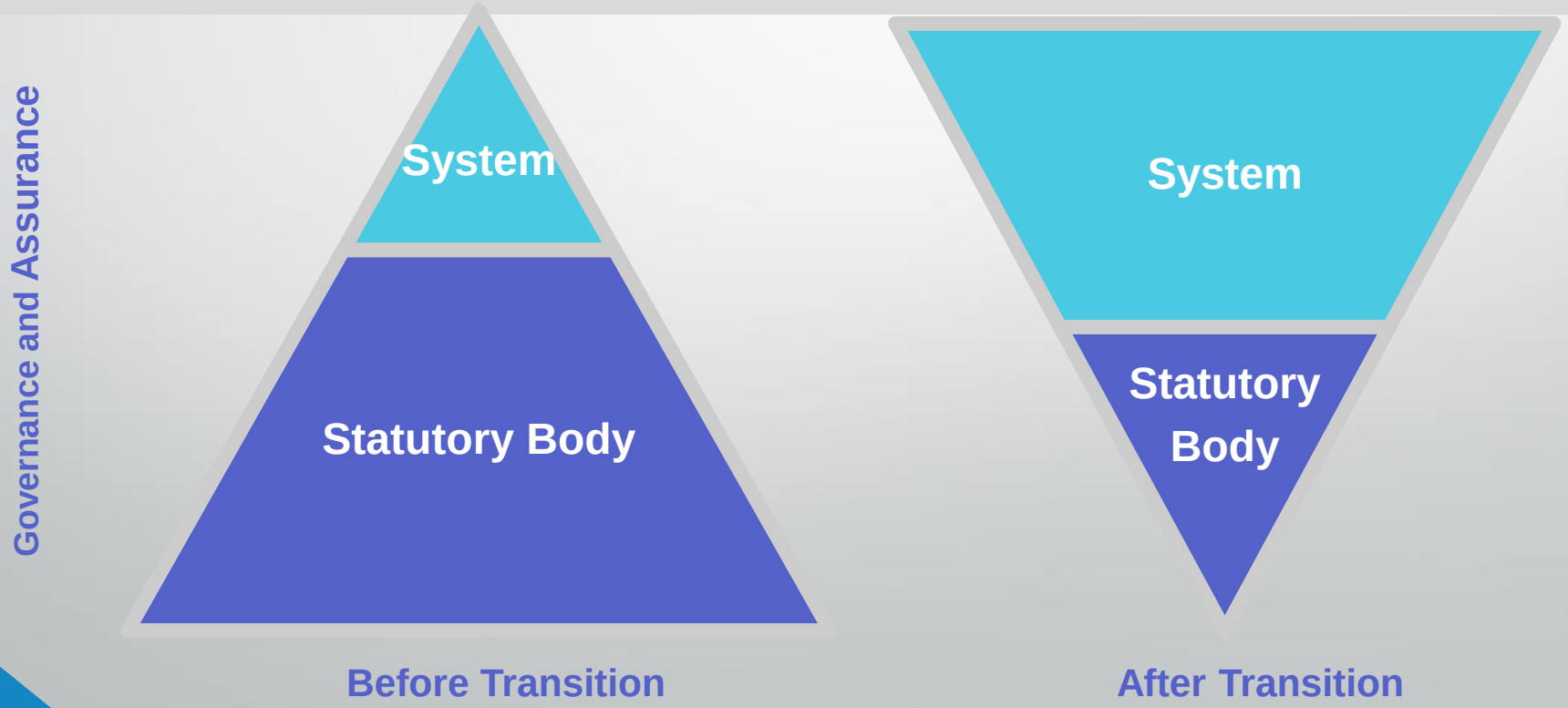
System Governance

Principles for Effective System Working

Governance and Assurance

Statutory duties and the assurance needs of sovereign bodies will remain unchanged. However, effective system working means that there will be a change in where the activity is undertaken. (I.e. a move from it being undertaken directly by the statutory body to be undertaken by the system).

In order to continue to be assured that they are meeting their statutory duties sovereign bodies will require regular, reliable assurance that this governance activity is well designed and operating effectively.



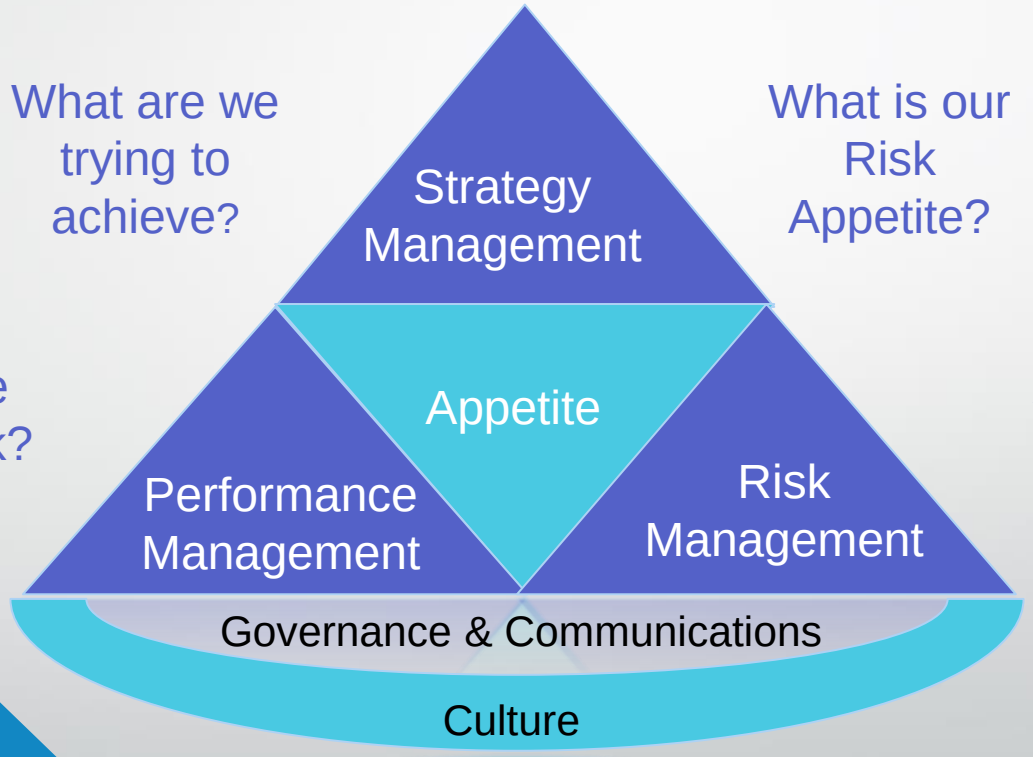
Integrated Governance

What are we trying to achieve?

What is our Risk Appetite?

Are we on track?

Are we operating within our appetite?



Implications of 'system' on organisation risk management

Risk management and appetite

- Strong governance arrangements and risk management are an ***enabler to collaboration***
- There needs to be ***alignment at each level*** (e.g. org, Place, ICS).

Organisation BAF & System Risk

- As the 'system' develops there will be ***risks that are not within the control of the organisation*** but still pose a significant threat to the delivery of strategic objectives.
- System will start to be *more* ***integral to all risks*** rather than as a separate risk.

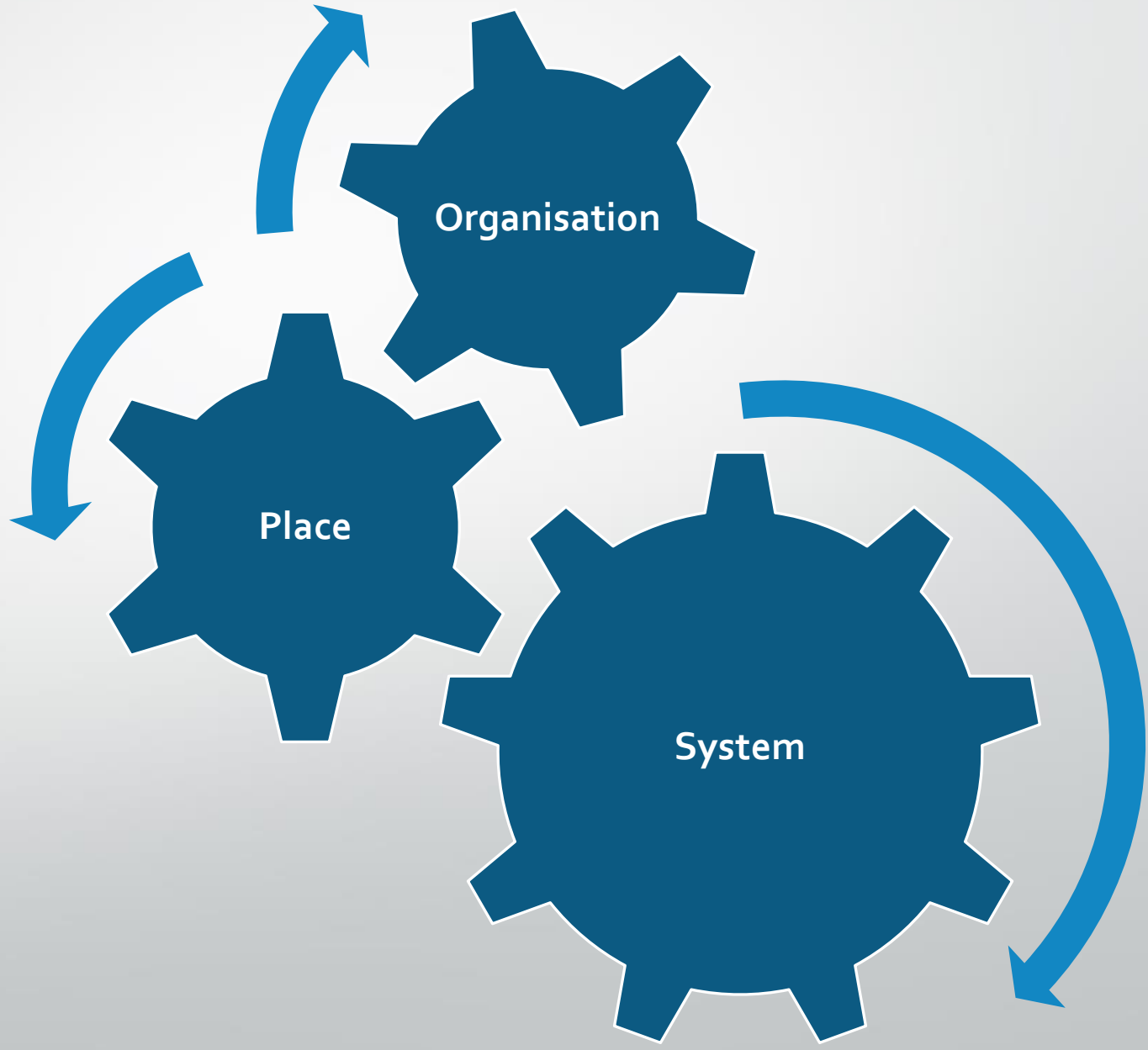
Escalation and understanding

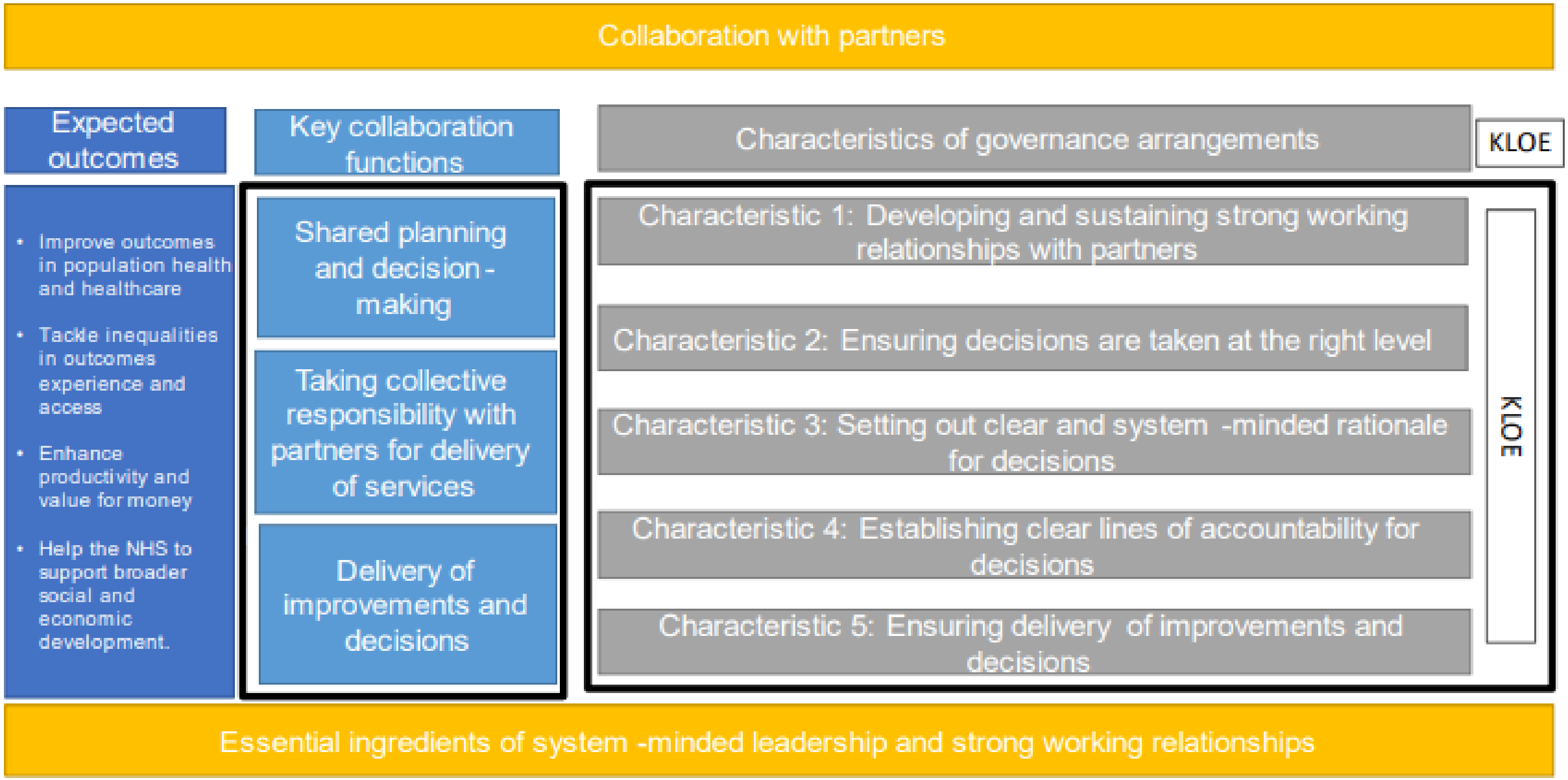
- Trust risk registers and BAFs are the key mechanisms internally.
- We need to understand how the ***chain of escalation and management of risks will work with the 'system'*** whether through provider collaboratives, place or the ICB.
- ***Transparency*** of strategic priorities, risk, governance and decision making will be key to effective risk management at all levels.

Getting everyone on the same page

Aligned BAF's providing clarity, focus and one version of the truth.

Each BAF built on individual strategic objectives.




Collaboration with partners
Expected outcomes
Key collaboration functions
Characteristics of governance arrangements
KLOE
Improve outcomes in population health and healthcare
Tackle inequalities in outcomes experience and access
Enhance productivity and value for money
Help the NHS to support broader social and economic development.
Shared planning and decision-making
Taking collective responsibility with partners for delivery of services
Delivery of improvements and decisions
Characteristic 1: Developing and sustaining strong working relationships with partners
Characteristic 2: Ensuring decisions are taken at the right level
Characteristic 3: Setting out clear and system -minded rationale for decisions
Characteristic 4: Establishing clear lines of accountability for decisions
Characteristic 5: Ensuring delivery of improvements and decisions
KLOE
Essential ingredients of system -minded leadership and strong working relationships

Provider Collaboratives- points for consideration:

Boards, committees & links to partners

- What boards, committees and links to partners are needed to carry out the collaboratives work?
- What board structure and reporting structure is needed to ensure that leadership has appropriate oversight, assurance and challenge?
- What are the chairing arrangements and how often should the board meet?
- Should sub-groups be established to oversee specific programmes of work? Who will sit on and lead these?
- Should there be advisory committees, such as strategy or clinical advisors? Who will sit on and lead these? How often will they meet?
- How will the collaboratives governance structure link with those of the ICS and other partners to exchange input and ensure alignment of objectives?

Decision Making

- Under each trust's governance, can individual trust boards delegate decision-making to their representative on the collaborative? Or do decisions of the collaborative need to be ratified by the boards?
- How will decisions be taken? Will unanimity be required or will trusts agree that they will each take the decision that a majority of providers have agreed to take?
- Are there different types of decisions that may be taken and do all members need to be involved in all decisions?
- How will the collaborative resolve any disagreements among members? Or otherwise ensure that disagreements do not de-rail progress

Potential barriers to be overcome

- Workforce
- Number of organisations / partners and complexity
- Current annual planning cycle
- Financial pressures
- Working across more than one ICB
- Waiting list pressures
- Historical arrangements

What does the Audit Committee need to focus on?

- Do we understand how governance will work in the changing environment?
  - What boards, committees & links to partners will be needed?
  - What decision making arrangements need to be established?
  - How will risk be managed?
  - What agreements will be needed?
  - Are we clear what we are accountable for?
- How do we provide appropriate challenge as arrangements are developing?
- Is our Internal Audit plan fit for purpose to provide assurance on collaboration / systems working?
- Do we need to establish an Audit Committee Chairs / members meeting at a system level?
- Is our organisational BAF aligned to the system BAF?

And finally- when things go wrong

- Insufficient evidence of scrutiny and challenge.
- Lack of clarity over which issues that come to the board for consideration & decision.
- Risks and assurances unclear
- Information incomplete or inaccurate
- Insular / internally focused

- What, how and where will we challenge?
- Have we defined what we want to see and decide upon?
- Have we identified our strategic risks and how we will be assured?
- How will we know if information complete & accurate
- How do we ensure we adopt systems thinking?

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Thank you