BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Appendix B – Supporting Information

A. Joint Local Health and Wellbeing Strategies Summary
B. Mapping JFP to ICP Integrated Care Strategy
C. Health and Wellbeing Board Opinion
D. Critical Risks to delivery
E. Meeting legislative requirements
F. Assuring progress of our core delivery plans

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Appendix A: Joint Local Health and Wellbeing Strategies

Our JFP, guided by the vision set out in our ICP Strategy, aligns with and builds on the strategies, approaches and targets set out by our three local health and wellbeing strategies developed by the five Health and Wellbeing Boards across BOB.

	Berkshire West	Oxfordshire	Buckinghamshire
Promoting and Protecting Health: Creating services which build trust and collaboration across diverse and hard to reach communities	• Reduce the differences in health between different groups of people. • Use data to understand local community need.	• Protect vulnerable people from risk of homelessness, threat of violence and the reality of cold homes. • Work together to reduce demand for reactive services and shift the focus to prevention.	• Improve mental health support for adults, particularly for those at greater risk of poor mental health. • Reducing social isolation.
Start well: Easily accessible services that support healthy children and happy families across diverse communities	• Promote good mental health and wellbeing for all children and young people by early identification, improving the equality of access and school engagement. • Improve process for transition to adult services.	• Deliver responsive services that place children, young people and families at the heart of what we do. • Support the most vulnerable children to have equal opportunity to become everything that want to be.	• Improve maternity and early years and helping children be ready for school. • Improve mental health support for children and young people and address social barriers. • Reduce prevalence of obesity.
Live well: Facilitating health decisions so communities can stay healthier for longer through prevention and early diagnosis	• Promote good mental health and wellbeing for all adults.	• Identify disease early and help people to manage their long-term conditions. • Ensure all people are involved in the design and evaluation of services.	• Reduce rates of cardiovascular disease by expanding tobacco dependency and NHS Health Checks. Reduce prevalence of obesity. • Improve mental health support particularly for ethnic minorities, students, men and LGBTQ.
Age well: Helping residents maintain their independence with effective services and accessible alongside opportunities for community engagement	• Continue to recognise the importance of social connection, green spaces and understanding of different cultural contexts. • Promote wellbeing activity and physical activities.	• Identify conditions early and ensure services are effective, efficient and joined up. • Focus on prevention, reducing the need for treatment and supporting residents to manage long term conditions.	• Improve mental health support by creating social opportunities in communities as well as improving early detection and diagnosis of dementia. • Increase the physical activity of older people.

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Sources: Buckinghamshire JHWBS, Oxfordshire JHWBS & Berkshire West JHWBS

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Appendix B: Mapping JFP to ICP Strategy Aims

ICP Strategic Theme	ICP strategy aims	Mapping of ICP aim in the JFP	Link To Delivery Plan
Promoting and protecting health	A reduction in the overall number of smokers in Buckinghamshire, Oxfordshire and Berkshire West, especially in our most deprived areas.	One of the ambitions in the JFP Service Delivery Plan of Inequalities, Prevention, Promoting and Protecting Health is to focus on reducing smoking prevalence and increasing tobacco dependency services in BOB. Some key initiatives: • Increase capacity of smoking cessation services across BOB and increase number of referral to those services from hospitals, embed tobaccos advisory service in all acute hospitals including mental health and maternity services, develop community pharmacy smoking cessation, and increase referrals to smoking cessation from primary care. • Smoking cessation support for those people with respiratory conditions, reducing smoking as a risk factor. • Activity will be targeted in more deprived areas and where smoking prevalence is highest.	Hyperlink to JFP – Prevention – Slide 12 Hyperlink to Respiratory – Slide 55
	Increase the proportion of people who are a healthy weight and physically active, especially in our most deprived areas and in younger people.	One of the ambitions in the JFP Service Delivery Plan of Inequalities, Prevention, Promoting and Protecting Health is to focus on reducing obesity prevalence and increase weight management services. Some key initiatives: • Target activity where prevalence is highest and ensure more people in deprived areas / cohorts are referred to weight management services. • Provide personalised care & support training to healthcare professionals so as to use every ‘teachable moment’ to deliver ‘very brief advice’ on diet and weight loss. • Increase referrals from primary care to weight management services including the National Digital Weight Management programme • Increase referrals to NHS Diabetes Prevention Programme and embed very low calorie diet pathway	Hyperlink to JFP – ambition 7 for Prevention and Adult Weight Management – Slide 13
	Reduce the proportion of people drinking alcohol at levels that are harmful to their health and wellbeing.	One of the ambitions in the JFP Service Delivery Plan of Inequalities, Prevention, Promoting and Protecting Health is to focus on reducing harmful drinking and drug behaviours and drug use. Some key initiatives: • Target activity where prevalence is highest and ensure more people in deprived areas / cohorts are referred to specialist alcohol services by their primary care team. • We will increase data collection and understanding re. alcohol consumption (AUDIT-C, progressing to full AUDIT where indicated and provide advice / referral). • Review provision of the alcohol care team (ACT) to improve care across BOB • Improve awareness and referral to alcohol pathways by integrated care teams	Hyperlink to ambition 9 of Prevention – Slide 15

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Appendix B: Mapping JFP to ICP Strategy Aims

ICP Strategic Theme	ICP strategy aims	Mapping of ICP aim in the JFP	Link To Delivery Plan
Promoting and protecting health	Protect people from infectious disease by preventing infections in all our health and care settings and delivering national and local immunisation programmes.	One of the ambitions in the JFP Service Delivery Plan of Inequalities, Prevention, Promoting and Protecting Health is to protect our population from vaccine preventable diseases through the implementation of a national immunisation strategy by 2028. Some key initiatives: • Implementation of vaccination dashboard. • Use community engagement approaches, learning from evaluation of the covid vaccination campaigns, for those groups identified as having lower uptake of immunisations, with a particular focus on the MMR and 4-in-1 pre-school booster, alongside covid and flu. • Work collaboratively to improve access to immunisations in primary care, including through enhanced access and cross-PCN working. • Effective integration and learning across organisations to deliver effective and flexible vaccination programme across BOB One of the ambitions in the JFP Service Delivery Plan of Infection Prevention and Control is to establish a system wide infection prevention and control service and network that provides quality advice to services and service users to reduce preventable infection across the system. Some key initiatives: • Fostering integration, partnership and alliances among the newly formed Integrated Care Partnership (ICP). • Reduce BOB ICS reportable Clostridioides difficile infections (CDI) and Gram-Negative Bloodstream infections (GNBSI). • Antimicrobial Stewardship to within targets set.	Hyperlink to delivery plan for Immunisations/Vaccinations - Slide 16 Hyperlink to delivery plan for Infection Prevention and Control – Slide 130

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Appendix B: Mapping JFP to ICP Strategy Aims

ICP Strategic Theme	ICP strategy aims	Mapping of ICP aim in the JFP	Link To Delivery Plan
Start Well	Improve early years outcomes for all children, particularly working with communities experiencing the poorest outcomes	The Joint Forward Plan for Start Well includes service delivery plans for different areas (Maternity and Neonatal, CYP Mental Health, CYP General, CYP Neurodiversity and Learning Disabilities). These service plans have a focus in embedding early interventions for children to improve outcomes and implementing prevention initiatives to reduce health inequalities within the most deprived groups. Some key initiatives: • Focus on personalisation and co-production in improving maternity services • Implement the maternal and neonatal equity strategy, listen and co-produce services to better support minorities and health inclusion groups. • Better support for pregnant women and their partners to stop smoking – reducing percentage of women smoking at delivery	Hyperlink to Start Well – Slide 20 Hyperlink to Inequalities and Prevention – Slide 12
	Improve emotional, mental health and wellbeing for children and young people.	The Joint Forward Plan for Start Well includes service delivery plans for CYP Mental Health. The ambition is to deliver improved mental health and wellbeing outcomes for children and young people, living, learning and working in BOB. Some key initiatives: • Scoping current service models and approaches across the ICS informed by the THRIVE assessment tool, details existing variations and gaps, and deliver the necessary changes and improvements. • Engagement with participation groups to co-produce and prioritise improvements and achieve more equitable access • Develop a population health management approach to support those most at risk of mental ill health focussing on early identification, support and prevention	Hyperlink to JFP for CYP Mental Health – Slide 27
	Improve the support for children and young people with special educational needs and disabilities, and for their families and carers	The Joint Forward Plan for Start Well includes service delivery plans for CYP Neurodiversity and Learning Disabilities. The ambitions are to : • Ensure that all neuro-divergent children and young people will receive the right support, at the right time and in the right place dependant on their needs and not dependant on a diagnosis. • Deliver improved physical, mental health and wellbeing outcomes for children, young people and adults with a learning disability and their families and carers. Some key initiatives: • System review of ND referral, pre-assessment / assessment and feedback of outcome – learning to improve processes and efficiency. Deliver parity of ND care across BOB. Alternative models of support to improve access. • Focus on reducing health inequalities and improvement in quality of care for LD, improve community-based support, champion those with lived experience, ensure greater awareness of needs of people with LD in health and care services.	Hyperlink to JFP for CYP Neurodiversity – Slide 29 Hyperlink to JFP for Learning Disabilities – Slide 31
	Support young adults to move from child centred to adult services.	The Joint Forward Plan for Children's and Young People's Mental Health covers young adults and supports the shift from child centred to adult services with a specific initiative to review current transition processes across the system, working with service users to co-produce proposed improvements.	Hyperlink to JFP for CYP Mental Health – Slide 27

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Appendix B: Mapping JFP to ICP Strategy Aims

ICP Strategic Theme	ICP strategy aims	Mapping of ICP aim in the JFP	Link To Delivery Plan
Live well	Improve mental health by improving access to and experience of relevant services, especially for those at higher risk of poor mental health.	The Joint Forward Plan for Live Well includes a service delivery plan for Adults Mental Health which aims to deliver improved mental health and wellbeing outcomes for all adults and older people living, learning and working in BOB. Some key initiatives: • Develop and implement plan to increase access to IAPT for older adults • 24/7 Crisis Resolution Home Treatment functions (CRHT) for adults, operating in line with best practice by maintaining coverage to 2023/24. • Join up support for people with mental health problems including access to employment support, health care, psychological support and services led by the voluntary community and social enterprise sector.	Hyperlink to JFP for Adults Mental Health – Slide 40
	Reduce the number of people developing cardiovascular disease (heart disease and stroke) by reducing the risk factors, particularly for groups at higher risk.	The Joint Forward Plan for Live Well includes a service delivery plan for Cardiovascular services and Stroke which includes ambitions and initiatives to address the ICP aim. Some key initiatives: • Increase case finding and number of patients treated to target working with primary care and Community Pharmacy Hypertension Case Finding Service. • Working with partners to improve cardiovascular checks focused on inequalities such as people with known SMI and LD. • Support education on lipid management in primary and secondary care. • Work with system colleagues to support people with lifestyle changes - reduce smoking and obesity and increase physical activity	Hyperlink for JFP Integrated Cardiac Delivery Network plan - Slide 49 Hyperlink for JFP Integrated Stroke Delivery Network plan – Slide 59
	Increase cancer screening and early diagnosis rates with a particular focus on addressing inequalities in access and outcomes.	The Joint Forward Plan for Live Well includes a service delivery plan for Cancer which includes ambitions and initiatives to address the ICP aim. Some key initiatives: • Achieve the Faster Diagnosis Standard across all Trusts – ensuring appropriate diagnostic and treatment capacity and specific programmes on backlog reduction. • Achieve the Early Diagnosis Standard working with Public Health and other stakeholders to increase screening rates. Community Pharmacy pilot to enable suspected cancer referrals and roll our Targeted Lung Health Checks in BOB. • Work with populations identified using Core20plus5 in the Cancer Allies programme to improve overall access including collaboration with the BOB inequalities team.	Hyperlink for the JFP Cancer plan – Slide 60

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Appendix B: Mapping JFP to ICP Strategy Aims

ICP Strategic Theme	ICP strategy aims	Mapping of ICP aim in the JFP	Link To Delivery Plan
Age Well	Support people to remain healthy, independent, and connected within their communities.	The Joint Forward Plan for Age well includes a service plan for Age Well Services which has an ambition and initiatives to address this aim. Some key initiatives: • Develop an approach for systematically identifying isolation / loneliness in our populations – working with PCNs, Local authorities, urgent care teams, community teams and VCSE, sharing learning from COVID. • Promote and support the five steps to mental wellbeing to older people: connect with other people, be physically active, learn new skills, give to others and pay attention to the present moment (mindfulness). • Identify and address barriers to people taking up social and physical activities such as mobility and transport issues.	Hyperlink to JFP Age Well services – Slide 73
	Provide personalised and joined up care for people as their care needs increase and become more complex.	The Joint Forward Plan for Age well includes a service plan for Age Well Services which has an ambition and initiatives to address this aim. Some key initiatives: • Early identification and diagnosis of long-term conditions and mental health issues, leading to timely care planning, education and support in the community to give patients, families and carers the best chance of managing health conditions effectively. • Personalised care and support planning is training for health and care staff for all stages of an individual's life course which is comprehensive across health and social care including mental health. This should include shared decision-making to enable informed and empowering conversation with patients and carers. • Development of a community-based MDT model of care integrating community and secondary care that addresses complexity, frailty and multiple long term conditions.	Hyperlink to JFP Age Well services - Slide 75
	Improve support for carers.	The Joint Forward Plan for Age well includes a service plan for Age Well Services which has an ambition and initiatives to address this aim. Some key initiatives: • Health and social care services to be clearly understandable and communicated effectively to staff, patients, families and carers. • Many older carers do not self-identify and register as carers, which limits access to support such as attendance allowance. Programme of communication and awareness raising combined with training for the workforce to aid in identification of carers and their registration to enable access to the full range of support and entitlements. • Cross-system review of carer support and respite care. NHS and Local Authorities develop and agree a consistent offer of support to unpaid carers, working across BOB geographies, linked with existing BOB programmes. This will include the provision of a consistent offer of respite care.	Hyperlink to JFP Age Well services - Slide 76

Appendix B: Mapping JFP to ICP Strategy Aims

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ICP Strategic Theme	ICP strategy aims	Mapping of ICP aim in the JFP	Link To Delivery Plan
Improving quality and access to services	Develop strong integrated neighbourhood teams so that people's needs can be met in local communities.	The Joint Forward Plan for Improving Quality and Access to Services includes a service delivery plan for Primary care which has an ambition and initiatives to address this aim. Some key interventions: • Conduct community/neighbourhood engagement events. • Define our neighbourhoods, including population and care needs. • Define the model including level of integration / collaboration and skills required. Work with providers to develop MDT ways of working and integration/embedding of community and mental health resource.	Hyperlink to JFP for Primary care – Slide 101
	Reduce and eliminate long waits for our planned services, and address variation in access across the system.	The Joint Forward Plan for Improving Quality and Access to Services includes a service delivery plan for Planned Care which has ambitions and initiatives to address this aim. Some key initiatives: • Further additional diagnostic capacity will become available through the Community Diagnostic Centres • Through the system wide Elective Care Board, continue to drive the transformation of elective care focusing initially on those specialties with the longest waits and highest volumes of patients waiting as well as through the guidance provided by the system-wide Theatres, Perioperative and Outpatients Steering Groups. • Develop elective strategy for addressing inequalities in access to elective diagnostics and treatment. Embed a process for clinical prioritisation that takes into account inequity of access to services resulting from Health Inequalities – also ensuring the order of being seen reflects patient need as well as length of wait.	Hyperlink to JFP for Planned Care – Slide 92
	Support the consistent development of our urgent care services to reduce demand and support timely access.	The Joint Forward Plan for Improving Quality and Access to Services includes a service delivery plan for Urgent and Emergency Care which has ambitions and initiatives to address this aim. Some key initiatives: • Increase Urgent Community Response (UCR) 2-hour referrals by 10% pre crisis. • Develop virtual ward/hospital at home vision – achieving 50 virtual ward beds per 100,000 population by Year 5. • Ensure Trusts have recovery plans in place to minimise delays to be seen in ED and that suitable alternatives to ED are promoted to patients to minimise inappropriate ED attendances. • Development of 24/7 Single Point of Access for BOB to ensure consistent and rapid access to clinical advice and alternative services.	Hyperlink to JFP for Urgent and Emergency Care – Slide 81
	Improve access and experience of palliative and end of life services to enable people of all ages to die well.	The Joint Forward Plan for Improving Quality and Access to Services includes a service delivery plan for Palliative and End of Life Care (PEoLC) which aims to deliver high quality, personalised, integrated 24/7 services shaped by those with lived experience of PEoLC for all ages, across the BOB ICS. Some key initiatives: • Implement a PEoLC virtual ward and a 2-year 24/7 PEoLC service model. • Work with providers and HCPs across the system to train and promote early identification and advance care planning. • Complete demand and capacity model to support redesign to integrated service models based on needs of different groups. Ensure lived experience representatives are an active partner in system-wide meetings.	Hyperlink to JFP For Palliative and End of Life Care – Slide 103

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Appendix C: Health and Wellbeing Board Opinion

HWB feedback

During the development of this JFP, we worked alongside local HWBs to share ideas and hear their feedback on our progress. We have consulted with each of the relevant HWB's on our draft JFP and sought their views on the extent to which this plan takes proper account of priorities and focus areas outlined in each JLHWB strategy.

We have included a summary of their views below.

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Appendix D – Critical risks to delivery

This JFP articulates our ambition and plans to improve and transform our services over the next five years. It is important for our system to recognise, however, that there are a number of key risks that may impact our ability to deliver our plans. Our ability to deliver on our plans is dependent on the extent to which these risks materialise, and our ability as a system to appropriately manage and mitigate these risks.

Risk	Mitigation(s)
Operations	
Our system in BOB, as is the case nationally, remains under very significant operational pressure, with record demand for our services and a large backlog. We continue to experience a number of critical performance challenges particularly across urgent and emergency care, planned care and primary care, and we expect a continued focus on recovering performance in these areas nationally. **There is a significant risk that our system's time and resources are consumed primarily in trying to manage these more immediate performance issues which will limit our ability to deliver our longer term transformation ambitions.**	• Planning over the long term through the JFP and alignment to Operational Planning process, including focus on short-term recovery • Implementation in full of key recovery plans in relation to key areas – Urgent and Emergency Care, Elective Care etc. • Establishing the right governance and delivery infrastructure at ICB level to monitor progress against longer-term goals
Workforce	
Our ability to deliver our plans relies upon having a resilient workforce, with enough staff working in the right ways. It has become increasingly difficult within the NHS to permanently recruit and retain the people needed to deliver our services and we have seen an increasing reliance on costly temporary staffing which further destabilises the workforce during this time of national pressure. National strike action has also increased our workforce shortages at certain times. **There is therefore a significant risk that workforce shortages (in both capacity and capability) limit our ability to deliver on our plans.**	• Our workforce plans as part of the JFP include a key focus on recruitment and retention of staff • Where critical workforce gaps persist, we will continue to have a flexible approach to addressing them within our financial parameters. • We have established a system-level People Committee to oversee and drive forward the workforce improvements we require,
Finance	
The delivery of our JFP is dependent on sufficient investment in improving and transforming our services. Our system is currently under significant financial pressure, with a material deficit forecast for 2023/23, and a greater understanding is needed of the drivers of this deficit. **There is a significant risk that addressing this deficit may require a reduction in spending in certain areas which may impact our ability to deliver on some of our plans**. Due to the way NHS finances are managed, it is often difficult to make firm spending commitments over a long-term timeframe, so **there is also a risk that changes to our financial position over the planning period materially impact on our plans in later years.**	• Our plans for 2023/24 are designed, as far as possible, around availability of funding for the year ahead • Our Finance plan as part of the JFP outlines some of the key areas of focus to address our financial challenges • The JFP will be revised on an annual basis to reflect changes to our plans as they develop – and this will include the impact any changes to the financial resources available to us

Appendix E – JFP legislative requirements

Legislative requirements	Our response
The plan should set out how the ICB will meet its population's health needs.	Section 2.1 sets out the unique characteristics of BOB's population and our understanding of their health needs. BOB's population demographics have been central to the development of the ICP's strategy and strategic priorities set out in the strategy. Section 2.1 also provides an overview of our population health management approach and how this will be developed alongside partners. Each of the service plans included in this document provides an overview of key context on the population's health needs for example our service plan for Inequalities and Immunisations/Vaccinations.
Duty to promote integration across health services, social care and health-related services.	See sections 1.4, 1.5 and 1.6 which provide an overview of progress so far by the system to promote integration of services alongside plans for how future ICS architecture will continue to promote and facilitate integration. Our Place Based Partnerships are a delivery mechanism at a local level, driving transformation and integration. This is also reflected across our service plans such as in Age Well Services.
Duty to give due regard to wider effects of decisions, for example how the triple aim was considered its development.	The 'triple aim' was considered in various parts of the JFP. Aim 1) health and wellbeing of the people of England is reflected in section 2.1, aim 2) quality of healthcare services can be referenced in service plans for Inequalities and the plan for Quality as an enabling service and aim 3) sustainability and efficient use of resources has been considered in the plans for Finance and Workforce in Section 4 – Supporting and Enabling Delivery.
The JFP must describe how financial duties will be addressed (including ensuring that the expenditure of the ICB and its partner trusts does not exceed the aggregate of any sums received by them in a year).	See section 4 – Supporting and Enabling Delivery – Plan for Finance.
The JFP must set out the steps taken to deliver on relevant JLHWBSs, including identified local target outcomes, approaches and priorities.	See section 1.2 for an overview of each JLHWB strategy. The ICP Strategy aligns and builds on the outcomes, approaches and priorities set out in each local strategy. The Integrated Care Strategy has been built to align with the JLHWB strategy as shown in appendix A. There is also a detailed mapping of the JFP to the ICP strategy as seen in Appendix B. Appendix C reflects the Health and Wellbeing Board Opinion.
Duty to improve the quality of services (including clearly aligned metrics, outcomes and should be aligned with National Quality Board principles.	See section 4 – Supporting and Enabling Delivery – Plan for Quality. Additionally, quality has been referenced across service plans for example in Start Well – plans for Women's, Maternity and Neonatal and Learning Disabilities.
Duty to reduce inequalities.	Our ICP strategy outlines our commitment to working with partner organisations to improve people's health and wellbeing and reduce the inequalities in health experienced by people across our populations. Each service plan has a specific focus area on reducing inequalities as part of their 5-year plan for example in Live well – Adult's Mental Health and the service plan for Planned Care.

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Appendix E – JFP legislative requirements

Legislative requirements	Our response
Duty to promote involvement of each patient.	See section 1.4, 1.5 and 1.6 which explains how we will promote involvement of each patient through our partnerships.
Duty to involve the public (including how the public and communities have been engaged in the development of this plan and how future partnerships will be built with people and communities, particularly those who face greatest health inequalities).	See section 1.4, 1.5 and 1.6. The development of the JFP included Healthwatch representatives and we also conducted some citizen experience research which reflects what people in BOB think about their experience of our services.
Duty to patient choice and how patient choice has been considered when developing and implementing commissioning plans and contracting arrangements.	See section 4 – Supporting and Enabling Delivery – Personalised Care. The principle of patient choice is reflected across service plans for example CYP Mental Health and the plan for Cardiovascular services.
Duty to obtain appropriate advice.	Through the development of the JFP we have sought expert advice when necessary, through liaising with our system partnerships and collaborations. Service plans have been led and developed by the Subject Matter Expert in the area and working across system networks for example our focus on prevention plans were informed by our work with Public Health.
Duty to promote innovation.	See section 4 – Supporting and Enabling Delivery – Research, Innovation and Quality Improvement. This is also reflected in service plans for example the plan for Respiratory Services.
Duty to promote research.	See section 4 – Supporting and Enabling Delivery – Research, Innovation and Quality Improvement. This is also reflected within service plans for example in the plan for Planned Care in Improving Quality and Access.
Duty to promote education and training.	See section 4 – Supporting and Enabling Delivery – Workforce plan.
Duty as to climate change and how the ICB and its partners will deliver against the targets and actions in ‘Delivery a Net Zero’ NHS.	See section 4 – Supporting and Enabling Delivery – Net Zero plan.
Addressing the particular needs of children and young persons.	See section 3 and strategic theme titled ‘Start Well’.
Addressing the particular needs of victims of abuse.	See section 4 – Supporting and Enabling Delivery – Safeguarding.

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Appendix F - Assuring progress of our core delivery plans

1 Delivery plans will be regularly monitored through existing system / ICB groups

The detailed service delivery plans (appendix A) set out the 5 year ambition and supporting plans for BOB-wide services. In almost all cases these plans build on current activity that is already managed and assured through existing System or ICB level governance groups.

It is therefore proposed that relevant delivery plans will monitored and assured through these existing governance groups.

In many of these groups there will be system wide representation to allow for transparency of progress.

2 All delivery plans have a named accountable ICB executive

To ensure clear accountability for delivery and to provide oversight, each of the delivery plans will have a named accountable ICB executive, responsible for delivery. The identified executive lead role will align with existing responsibilities and accountabilities

3 Accountable ICB executive will provide assurance report to the ICB Board

In addition to the local reporting, it will be necessary to provide the ICB Board with necessary assurance of delivery progress.

- The Director of Strategy and Partnerships will coordinate a progress reports for the ICB via the relevant accountable executives.
- ICB Exec Leads will be accountable for producing a short highlight summary for each of their services.
- Suite of progress reports will be shared and single progress paper twice a year at ICB Public Board.

Example high level Board summary – Report details TBC:

[Service Area Name e.g. Integrated Respiratory Delivery Network]				Delivery Risk / Issue
Qualitative Update	*(Refer to delivery plan for proposed commitments)* *Describe:* • *Progress made since previous report* • *Progress against plan*			*There is a risk that… (Describe risk)*
Quantitative update	*Metric description*	*Baseline (YE 22/23)*	*Current performance*	*Delivery Risk / Issue*
1				
2				
3				

Example governance arrangements:

Service Delivery Plan(s)	Governance
Integrated Cardiac Delivery Network	• ICB Executive Lead: **Chief Medical Officer** • All integrated Delivery Networks report into the ***ICB Clinical Programme Board***
Integrated Respiratory Delivery Network	
Integrated Stroke Delivery Network	
Integrated Diabetes Delivery Network	

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