Joined Up Care Derbyshire

NHS Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC AGENDA

Thursday 21st September 2023 at 9am to 10.45am

Via MST

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

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

Time	Reference	Item	Presenter	Delivery
09:00	**Introductory Items**			
	ICBP/2324/064	Welcome, introductions and apologies:	Richard Wright	Verbal
	ICBP/2324/065	Confirmation of quoracy	Richard Wright	Verbal
	ICBP/2324/066	Declarations of Interest • Register of Interests • Summary register for recording interests during the meeting • Glossary	Richard Wright	Paper
09:05	**Minutes and Matters Arising**			
	ICBP/2324/067	Minutes from the meeting held on 20.7.2023	Richard Wright	Paper
	ICBP/2324/068	Action Log – July 2023	Richard Wright	Paper
09.10	**Strategy and Leadership**			
	ICBP/2324/069	Chair's Report – August 2023	Richard Wright	Verbal
	ICBP/2324/070	Chief Executive Officer's Report – August 2023	Dr Chris Clayton	Verbal
	ICBP/2324/071	NHS Derby and Derbyshire Clinical Commissioning Group Annual Report and Accounts - April to June 2022 NHS Derby and Derbyshire Integrated Care Board Annual Report and Accounts - July 2022 - March 2023	Richard Wright Dr Avi Bhatia Dr Chris Clayton Keith Griffiths	Paper / Presentation

Time	Reference	Item	Presenter	Delivery
		https://joinedupcarederbyshire.co.uk/publications/annual-reports/		
	ICBP/2324/072	ICB Annual Assessment and Development	Dr Chris Clayton	Paper
09:40	**Risk Management**			
	ICBP/2324/073	ICB Risk Register – August 2023	Helen Dillistone	Paper
09:50	**For Decision**			
	ICBP/2324/074	ICB Corporate Committees' Terms of Reference	Helen Dillistone	Paper
10:00	**Integrated Assurance & Performance**			
	ICBP/2324/075	Integrated Assurance and Performance Report • Quality • Performance • Workforce • Finance	Dr Chris Clayton Dr Deji Okubadejo / Prof Dean Howells Dr Deji Okubadejo / Zara Jones Margaret Gildea / Linda Garnett Jill Dentith / Keith Griffiths	Paper
10:20	**Corporate Assurance**			
	ICBP/2324/076	Verdict in the trial of Lucy Letby	Dr Chris Weiner/ Prof Dean Howells	Paper
	ICBP/2324/077	Finance and Estates Committee Assurance Report – July / August 2023	Jill Dentith	Paper
	ICBP/2324/078	People and Culture Committee Assurance Report – September 2023	Margaret Gildea	Paper
	ICBP/2324/079	Audit and Governance Committee Assurance Report – August 2023	Sue Sunderland	Paper
	ICBP/2324/080	Derbyshire Public Partnership Committee Assurance Report – August 2023	Julian Corner	Paper
	ICBP/2324/081	Quality and Performance Committee Assurance Report – July/August 2023	Dr Deji Okubadejo	Paper
	ICBP/2324/082	Population Health and Strategic Commissioning Committee Assurance Report – September 2023	Julian Corner	Paper

Time	Reference	Item	Presenter	Delivery
10:35	**Items for Information**			
	ICBP/2324/083	National Patient Safety Strategy – Derbyshire Position Statement – September 2023	Prof Dean Howells	Paper
	ICBP/2324/084	2022/23 Quality Account ICB Statements	Prof Dean Howells	Paper
The following items are for information and will not be individually presented				
	ICBP/2324/085	Ratified minutes of the Derby and Derbyshire Health and Wellbeing Boards • Derby City Health & Wellbeing Board - 16.3.2023 / 27.7.2023 • Derbyshire County Health & Wellbeing Board – 13.7.2023	Richard Wright	Papers
	ICBP/2324/086	Ratified minutes of ICB Committee Meetings: • Audit & Governance Committee – 8.6.2023 • People & Culture Committee – 7.6.2023 • Public Partnership Committee – 27.6.2023 • Quality & Performance Committee – 29.6.2023 / 27.7.2023	Richard Wright	Papers
10:40	**Closing Items**			
	ICBP/2324/087	Forward Planner	Richard Wright	Paper
	ICBP/2324/088	1. Did the items on the agenda address the risks in a way that we feel will mitigate them over the short and medium term. If not do we want to consider a deep dive on any items in a future agenda? 2. Did any of the discussions prompt us to want to change any of the risk ratings up or down?	Richard Wright	Verbal
	ICBP/2324/089	Any Other Business	Richard Wright	Verbal
	ICBP/2324/090	Questions received from members of the public	Richard Wright	Verbal
Date and time of next meeting in public: **Date:** Thursday, 16th November 2023 **Time:** 9am to 10.45am **Venue:** via MS Teams			Richard Wright	Verbal

*denotes those who have left, who will be removed from the register six months after their leaving date

Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Allen	Tracy	Participant to the Board for Place	Primary & Community Care Delivery Board Chair of Digital and Data Delivery Board Integrated Place Executive Meeting	CEO of Derbyshire Community Health Services NHS Foundation Trust	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Partner is a Director (not Board Member) for NHS Derby and Derbyshire ICB				✓	01/07/22	Ongoing	
				Trustee for NHS Providers Board		✓			01/07/22	Ongoing	
				Sister-in-law is Business Development Director of Race Cottam Associates (who bid for, and undertake projects for the Derbyshire system estates teams)				✓	01/07/22	Ongoing	
Austin	Jim	Chief Digital & Information Officer	Finance & Estates Committee	Employed jointly between NHS Derby and Derbyshire Integrated Care Board and Derbyshire Community Health Services NHS Foundation Trust	✓				01/11/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Spouse is a locum GP and the Local Place Alliance lead for High Peak (8 hours per week)				✓	01/11/22	Ongoing	
Bhatia	Avi	Participant to the Board for the Clinical & Professional Leadership Group	Chair - Clinical and Professional Leadership Group, Derbyshire ICS Population Health & Strategic Commissioning Committee	GP partner at Moir Medical Centre	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				GP partner at Erewash Health Partnership	✓				01/07/22	Ongoing	
				Part landlord / owner of premises at College Street Medical Practice, Long Eaton, Nottingham	✓				01/07/22	Ongoing	
				Spouse works for Nottingham University Hospitals in Gynaecology				✓	01/07/22	Ongoing	
Clayton	Chris	Chief Executive Officer	N/A	Spouse is a partner in PWC				✓	01/07/22	Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Corner	Julian	ICB Non-Executive Member	Public Partnership Committee Population Health & Strategic Commissioning Committee Remuneration Committee	As the CEO of Lankelly Chase Foundation, I may have an interest in organisations being commissioned by the JUCD if that would support a grant funding relationship that Lankelly Chase has with them.		✓			01/03/22	30/06/25	Not aware of any grant relationships between Lankelly Chase and Derbyshire based organisations, or organisations that might stand to benefit from JUCD commissioning decisions. If that were to happen I would alert the JUCD chair and excuse myself from decisions both at Lankelly Chase and JUCD.
Dentith	Jill	Interim Non-Exective Member	Audit & Governance Committee Finance & Estates Committee People & Culture Committee Quality & Performance Committee	Self-employed through own management consultancy business trading as Jill Dentith Consulting	✓				2012	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Director of Jon Carr Structural Design Ltd	✓				06/04/21	Ongoing	
Dillistone	Helen	Chief of Staff	Audit & Governance Committee Public Partnership Committee	Nil							No action required
Garnett	Linda	Interim Chief People Officer	People & Culture Committee Population Health & Strategic Commissioning Committee Finance & Estates Committee	Husband, Wynne Garnett is providing services to the ICB via Amber Valley CVS				✓	01/07/22	Ongoing	None required currently
Gildea	Margaret	Non-Executive Member / Senior Independent Director	Audit & Governance Committee People and Culture Committee Remuneration Committee Derby City Health & Wellbeing Board	Director of Organisation Change Solutions Limited	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Coaching and organisation development with First Steps Eating Disorders	✓				01/07/22	Ongoing	
				Director, Melbourne Assembly Rooms		✓			01/07/22	Ongoing	
Green*	Carolyn	Interim Chief Executive, DHcFT	People & Culture Committee Population Health & Strategic Commissioning Committee	Board Member - National Mental Health Nurse Directors Forum		✓			06/12/22	31/03/23	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Griffiths	Keith	Chief Finance Officer	Finance & Estates Committee Population Health & Strategic Commissioning Committee Integrated Place Executive	Nil							No action required
Houlston	Ellie	Director of Public Health – Derbyshire County Council (Local Authority Partner Member)	System Quality Group Integrated Care Partnership Health and Wellbeing Board - Derbyshire County Council	Director of Public Health, Derbyshire County Council	✓				01/09/22	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair.
				Director and Trustee of SOAR Community			✓		01/09/22	Ongoing	Sheffield based - unlikely to bid in work in Derbyshire
Howells	Dean	Chief Nurse Officer	Quality & Performance Committee System Quality Group Population Health & Strategic Commissioning Committee Local Maternity and Neonatal System Board Clinical and Professional Leadership Board	Honorary Professor, University of Wolverhampton	✓				13/09/23	Ongoing	Declare interest if relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair.
Jones	Zara	Executive Director of Strategy & Planning	Finance & Estates Committee Population Health & Strategic Commissioning Committee Quality & Performance Committee	Nil							No action required

Surname	Forename	Job Title	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Lumsdon	Paul	Interim Chief Nursing Officer	Quality & Performance Committee System Quality Group Population Health & Strategic Commissioning Committee Local Maternity and Neonatal System Board Clinical and Professional Leadership Board	Nil							No action required
MacDonald*	John	ICB Chair	Derby and Derbyshire Integrated Care Partnership Board	Chair at University Hospitals of Leicester NHS Trust	✓				01/07/22	Ongoing	Declare interest when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Mott	Andrew	GP Amber Valley (Primary Medical Services Partner Member)	System Quality Group Joint Area Prescribing Committee Derbyshire Prescribing Group Clinical and Professional Leadership Group Primary Care Network Delivery & Assurance Group End of Life Programme Board	GP Partner of Jessop Medical Practice	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Practice is shareholder in Amber Valley Health Ltd (provides services to our PCN)	✓				01/07/22	Ongoing	
				Medical Director, Derbyshire GP Provider Board	✓				01/07/22	Ongoing	
				Wife is Consultant Paediatrician at UHDBFT				✓	01/07/22	Ongoing	
Okubadejo	Adedeji	Clinical Lead Member	Population Health & Strategic Commissioning Committee Quality & Performance Committee Remuneration Committee	Director, Carwis Consulting Ltd – Provision of clinical anaesthetic services as well as management consulting services to organisations in the independent healthcare sector	✓				01/04/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Consultant Anaesthetist, University Hospitals Birmingham NHS Foundation Trust	✓				01/04/23	30/04/23	
				Provision of private clinical anaesthetic services in the West Midlands area	✓				01/04/23	Ongoing	
				Director & Chairman OBIC UK – Working to improve educational attainment of BAME children in the UK			✓		01/04/23	Ongoing	
Posey	Stephen	CEO UHDBFT / Chair of the Provider Collaborative Leadership Board (NHS Trust & FT Partner Member)	N/A								
Powell	Mark	CEO DHcFT (NHS Trust & FT Partner Member)	People & Culture Committee Population Health & Strategic Commissioning Committee	CEO of Derbyshire Healthcare NHS Foundation Trust	✓				01/04/23	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Treasurer of Derby Athletic Club			✓		01/03/22	Ongoing	
Rawlings*	Amanda	Chief People Officer	People & Culture Committee Population Health & Strategic Commissioning Committee	Employed jointly between NHS Derby and Derbyshire Integrated Care Board and University Hospitals of Derby and Burton NHS Foundation Trust, as Chief People Officer	✓				01/07/22	30/04/23	This position was agreed by both the ICB and UHDB. Declare interest when relevant and withdraw from all discussion and voting if UHDB is potential provider, unless otherwise agreed by the meeting chair
Smith	Andy	Strategic Director of People Services - Derbyshire County Council (Local Authority Partner Member)	Clinical and Professional Leadership Group	Director of Adult Social Care and Director of Children's Services, Derby City Council	✓				01/07/22	Ongoing	Declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Member of Regional ADASS and ADCS Groups		✓			01/07/22	Ongoing	
Stacey*	Brigid	Chief Nurse Officer and Deputy Chief Executive Officer	Quality & Performance Committee System Quality Group Population Health & Strategic Commissioning Committee	Nil							No action required
Sunderland	Sue	Non-Executive Member - Audit & Governance	Audit and Governance Committee Finance and Estates Committee Public Partnership Committee IFR Panels CFI Panels	Audit Chair NED, Nottinghamshire Healthcare Trust		✓			01/07/22	Ongoing	The interests should be kept under review and specific actions determined as required - declare interests when relevant and withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
				Audit Chair of Joint Audit Risk & Assurance Committee for the Office of the Police & Crime Commissioner and Chief Constable of Derbyshire		✓			01/07/22	Ongoing	
				Husband is an independent person sitting on Derby City Audit Committee				✓	01/07/22	Ongoing	Unlikely for there to be any conflicts to manage
Weiner	Chris	Chief Medical Officer	Population Health & Strategic Commissioning Committee Quality & Performance Committee System Quality Group EMAS 999 Clinical Quality Review Group Local Maternity & Neonatal System Board Clinical and Professional Leadership Group	Nil							No action required
Wright	Richard	Chair	N/A	Nil							No action required

SUMMARY REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

A conflict of interest is defined as “a set of circumstances by which a reasonable person would consider that an Individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold” (NHS England, 2017).

Meeting	Date of Meeting	Chair (name)	Director of Corporate Delivery/ICB Meeting Lead	Name of person declaring interest	Agenda item	Details of interest declared	Action taken

MINUTES OF NHS DERBY AND DERBYSHIRE ICB BOARD MEETING IN PUBLIC

Thursday, 20th July 2023

via Microsoft Teams

Unconfirmed Minutes

Present:		
Richard Wright	RW	ICB Chair (Meeting Chair)
Tracy Allen	TA	Chief Executive DCHSFT and Place Partnerships (NHS Trust & FT Partner Member)
Jim Austin	JA	ICB Chief Digital and Information Officer (part meeting)
Dr Chris Clayton	CC	ICB Chief Executive Officer
Julian Corner	JC	ICB Non-Executive Member
Jill Dentith	JD	ICB Interim Non-Executive Member
Linda Garnett	LG	ICB Interim Chief People Officer
Margaret Gildea	MG	ICB Non-Executive Member / Senior Independent Director
Keith Griffiths	KG	ICB Chief Finance Officer
Zara Jones	ZJ	ICB Executive Director of Strategy and Planning
Paul Lumsden	PL	ICB Interim Chief Nursing Officer
Dr Andrew Mott	AM	GP Amber Valley (Partner Member for Primary Care Services)
Dr Deji Okubadejo	DO	ICB Board Clinical Other Member
Mark Powell	MP	Chief Executive DHcFT (NHS Trust and FT Partner Member)
Sue Sunderland	SS	ICB Non-Executive Member
Dr Chris Weiner	CW	ICB Chief Medical Officer
In Attendance:		
Stephen Bateman	SB	CEO, Derbyshire Health United
Helen Blunden	HB	Interpreter
Dawn Litchfield	DL	ICB Board Secretary
Jayne Needham	JN	Director of Strategy, Partnerships and Population Health / Consultant in Public Health, DCHSFT (part meeting)
Fran Palmer	ST	ICB Corporate Governance Manager
Suzanne Pickering	SP	ICB Head of Governance
Chrissy Tucker	CT	Director of Corporate Delivery
Sam Waters	SW	Interpreter
Apologies:		
Dr Avi Bhatia	AB	Participant to the Board for the Clinical & Professional Leadership Group
Helen Dillistone	HD	ICB Chief of Staff
Ellie Houlston	EH	Director of Public Health – Derbyshire County Council (Local Authority Partner Member)
Andy Smith	AS	Strategic Director of People Services – Derby City Council (Local Authority Partner Member)

ICBP/2324/040	**Welcome and apologies** Richard Wright (RW) welcomed everyone to the meeting, his first in the role of ICB Chair. RW highlighted the industrial action currently taking place across the NHS. He acknowledged that to go on strike was a difficult decision for individuals to make, however, the effect on patients across Derbyshire was also acknowledged. Thanks were expressed to those staff doing so much to minimise the impact of the industrial action; this was acknowledged and appreciated.	

Item No.	Item	Action
	The ICB as the NHS family represents more than one million people across Derby and Derbyshire and focuses on the health and care of its population. The ICB is a member of the wider Derbyshire Integrated Care Partnership (ICP) which tackles entrenched societal problems and division across society; these issues cannot be tackled as individual organisations but can together in order to make a difference. The ICB recently submitted its Five Year Plan which is the NHS's contribution to delivering on the wider ICB Strategy over the next 5 years to tackle issues through addressing the root causes of the problems. The recent 75th anniversary of the NHS was celebrated a few days ago; this helped in setting the direction of travel for the future. RW is proud of what the NHS has achieved over the last 75 years, however it has become a victim of its own success in that people are now living longer. The current long waiting lists are being dealt with by limited resources. The Forward Plan signals a move to address healthy life expectancy for all groups in society, which is very much worth chasing; the plan signals a move into delivery mode. RW introduced Paul Lumsden, as the Interim Chief Nursing Officer, and Jill Dentith, as the Interim Non-Executive Member (NEM) for finance, covering the role whilst RW undertakes the ICB Chair role; both were welcomed to the meeting and the ICB Board. RW also thanked the interpreters signing at today's meeting. Apologies for absence were noted as above.	
ICBP/2324/041	**Confirmation of quoracy** It was confirmed that the meeting was quorate.	
ICBP/2324/042	**Declarations of Interest** The Chair reminded Committee Members of their obligation to declare any interests they may have on issues arising at Committee meetings which might conflict with the business of the ICB. Declarations made by members of the Board are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the ICB Board Secretary or the ICB website at the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/integrated-care-board-meetings/ Item ICB/2324/062 – Any Other Business – Proposed amendment to the Board membership – Tracy Allen (TA) raised a conflict of interest for this item in her role as the Place Lead Executive. TA did not take part in the discussion. No further declarations of interest were made.	
ICBP/2324/043	**Minutes of the meeting held on 15th June 2023** **The Board APPROVED the minutes of the above meeting as a true and accurate record of the discussions held**	

Item No.	Item	Action
ICBP/2324/044	**Action Log – June 2023** There were no outstanding items on the action log. It was enquired when the public friendly version of the Joint Forward Plan would be available (SS); Zara Jones (ZJ) confirmed that the Communications Team is currently working on this document, and it will be available in the next month or so. **The Board NOTED the Action Log**	
ICBP/2324/045	**Chair's Report** RW presented his report, a copy of which was circulated with the meeting papers; the report was taken as read and no questions were raised. The 75th year of the NHS was acknowledged. An ICB staff event was held, with a review of what the NHS had achieved over the last 75 years provided; this emphasised the amount of change over the years. **The Board NOTED the Chair's report**	
ICBP/2324/046	**Chief Executive's Report** CC presented his report, a copy of which was circulated with the meeting papers; the report was taken as read and the following points of note were made: • The work undertaken over the last few weeks in preparedness for the junior doctors and consultants' industrial action was acknowledged; the Board will continue to be kept appraised of the ongoing situation. • Important national developments and local updates were referred to in the report, including the publication of the first ever NHS Long-Term Workforce Plan, on which a Board level discussion will be held shortly. • A new mapping tool has facilitated the first national picture of mental health service provision, enabling the integration of data from the NHS, Care Quality Commission, and VCSE Sector. • Thanks were conveyed to the colleagues who attended the Westminster Abbey service to commemorate 75 years of the NHS; DDICB was well represented. • CRHFT has now opened its new Emergency Department, offering a state-of-the-art approach to patient flow. • Investment has been made to allow five 'One-Stop-Shop' Community Diagnostic Centres to be opened in Derby and Derbyshire by 2025. • As the Lead Commissioner for EMAS, DDICB is pleased to advise that 110 new replacement ambulances are being rolled out across the East Midlands as part of a regional programme. • As part of the delegation of NHS England's direct commissioning functions to ICBs, the complaints process for all NHS Primary Care Services (General Practice, Pharmacy, Optometry and Dental) changed on 1st July 2023. The updated arrangements are described on the ICB's website. **The Board NOTED the Chief Executive's report**	

Item No.	Item	Action
ICBP/2324/047	**Corporate Risk Register – June 2023** Chrissy Tucker (CT) presented the Risk Register as at 30th June 2023 to provide assurance to the Board that robust actions are in place to mitigate the risks faced by the ICB. There are currently six very high operational risks facing the organisation, for which updates and mitigating actions were provided. Two risks have been reduced in score. <u>Questions / comments</u> • Risk 01 – Zara Jones (ZJ) advised that the A&E operational target has been reduced from 95%; however, the system is still aspiring to achieve that level, and in some instances already is. • Risk 05 – Virtual agreement has been sought to amend the narrative on this risk score. Further discussions will be held on this risk at the next Audit Committee meeting (SS). • It was queried whether the industrial action currently being undertaken will fundamentally affect the risk scores (RW). ZJ responded that the consultants strike will affect some of the risks; however, it is unclear whether it will influence the risk ratings. The highly scored risks should not change much however a view will be taken on the mitigations and action descriptions to incorporate this concern. CC advised that, in terms of the higher-level risks, the risk ratings and narrative would not be amended, as they are overarching themes with many different risks that contribute to overall risks; when managing the risk and its impact, the industrial action will be factored in, in terms of the ability to achieve the overall targets set. • The impact of industrial action has been assessed based on the services provided by Providers; it was suggested that an assessment be undertaken on the impact of the industrial action on patients (DO). • The interdependencies between the risks are important. Keeping a watching brief on the effects of the industrial action on the risks as they stand, and the themes running through them, was suggested (JD). • When looking at the effects of industrial action, it is not only on waiting time, but on the diversion of management time, resulting in people not being able to work on the areas built into the plans for this year, thus affecting other things going forward (RW). • RW enquired whether the Risk Register is a fair representation of the risks that the ICB should be looking at as the coordinators of the system. CT responded that the challenges faced are shared across all partner organisations, providing them with opportunities to have an input. There is a process for raising new risks, whereby decisions are taken as to whether the risks are significant enough to be added on to the Risk Register. Live ongoing discussions are held on all risks. **The Board RECEIVED and NOTED:** • **The Risk Register Report** • **Appendix 1, as a reflection of the risks facing the organisation as at 30th June 2023** • **Appendix 2, which summarises the movement of all risks in June 2023**	

Item No.	Item	Action
ICBP/2324/048	**Partnership Consultation for DCHSFT Organisational Strategy 2023-2028** Tracy Allen (TA) introduced Jayne Needham (JN) who has led on the development of the revised DCHSFT Organisational Strategy. JN advised that the purpose of this paper was to engage with the ICB on the development of the Strategy. The paper was taken as read and reflection on its content was requested. A depth and range of engagement has been undertaken to coproduce a Strategy with patients and colleagues; an extensive literature review was undertaken to consider the new operating context, including the formation of the ICP, and the focus of balancing personalised care and population health improvement, with a prevention focus. In developing the Strategy, DCHSFT has ensured that it is aligned with the aims of the ICP Strategy and Joint Forward Plan (JFP). One of the next steps is to work with staff to identify the actions needed to ensure that DCHSFT plays its part in the ICP. <u>Questions / comments</u> • This is a clear, concise document, providing an overarching feel for where the organisation is heading. Linking it to the JFP is key from an organisational perspective and fitting into the overall system work. The savings and financial implications of this, and how it fits into system work, were requested (JD). JN responded that the efficiencies programme sits within the focus on the future in terms of ongoing sustainability. All feedback received was thematically analysed - 'if it matters to you, it matters to us'. The theme of efficiency and effectiveness clearly ran through it, as to what needs to be done to respond to the future and ensure the NHS is as efficient as possible. There is a financial efficiencies workstream in DCHSFT for delivering against efficiency targets, which are part of the system's savings. • Relating to co-design and co-production, it was enquired how this is working across the system and what needs to be in place for it to work better (DO). JN advised that the aspiration is to get to co-production; co-design has been undertaken as part of the implementation plan with DCHFT staff, the JUCD Team and Public Health on community engagement. The individual roles within the themes are now being defined to ascertain 'what good will look like'. This was tested with DCHSFT Board Members and will be taken into teams and communities, using the valuable psychological insights resource available in the system, to define and respond to needs and expectations. • The simplicity of the report and the ease of reading were praised, as was the focus on people. Sometimes strategies do not focus on the people they are providing care for; there is a lot to learn from this (MP). • CC provided the context for receiving this report. Comments were requested on the framework of individual organisational strategies now, and what they would change to next year in the context of Provider Collaboration at Scale, Place and Primary Care Networks. Thought needs to be given as to what a singular organisational strategy looks like verses a strategy of provider collaboration. A lot of community providers work in communities, many of whom are represented on this Board. TA responded that JN and the Board have challenged themselves on this; TA considered that this is a system consisting of individual organisations, and it is not seen as inappropriate or contradictory to have individual identifies and strategies, as long as they	

Item No.	Item	Action
	are increasingly framed as the contribution that each one of the partners makes to the system's vision. The document clearly links to the overall JUCD system and vision. The implementation plan will be framed around working in partnership with healthy communities and will become a collaborative plan to underpin the overall strategy and everyone's contribution. RW advised not to get into silo thinking but to focus on patient outcomes. • One of the key reasons for the ICBs existence is to tackle health inequalities. In the interest of co-production, it would be useful to share with the wider system what has been learnt on how to engage with under-represented voices within the community, as these are where the greatest inequalities exist (CW). JN advised that the method of engagement was to link in with the insight team at JUCD level and Local Authority insight. The evidence is well known as to where the disadvantaged communities are; this will help to design and deliver services, making access as easy as possible for local communities. • DCHFT's success will be a whole system success; how this success is measured and monitored and what the outputs are will indicate whether to trial them, where to push harder or provide support to others. It was enquired how success would be measured collectively and any outputs associated with the strategy (PL). JN considered this to be work undertaken in the system strategy and planning space. If aspiring to extend healthy life expectancy and reduce inequalities, there is available data to demonstrate the starting position. Qualitative data will be used to report the experiences of receiving care. RW concluded that it was a good time to bring this paper to the Board as the JFP was also on today's agenda. DCHFT has put itself in the middle of localised care and provision; this is where healthy life expectancy and equality of access will be improved. **The Board DISCUSSED and NOTED the DCHSFT Organisational Strategy Refresh 2023-2028**	
ICBP/2324/049	**Joint Forward Plan (JFP) – Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28** ZJ advised that the JFP has now been published and is presented to the Board today as an audit trail. A condensed version will be provided for staff and members of the public. ZJ sought support to take forward the implementation of the JFP for delivery and production of the tangible actions. From an ICB organisational perspective, it needs to be ensured that the implementation of the JFP is embedded within governance structures. The ICB Chief of Staff will ensure that Committees have oversight and responsibility of the different aspects to ensure delivery of the components, and that the success is tracked and measured in a coordinated manner to demonstrate progress over the 5-year period. As much feedback as possible will be obtained from system partners; the JFP has been considered by multiple system partners and forums, the feedback from which has been fully documented. The JFP sets out a compelling pace for change; it will only be successful if it is worked on as a system and linked to the strategies of the ICP, individual organisations	

Item No.	Item	Action
	and Health and Wellbeing Boards. Clarity was provided as to how the different plans link to each other and what their contributions will be. The ICB has a massive role to play in this as the Strategic Commissioner in the system. An ICB Framework has recently been produced which will help drive delivery. Different ways of working will be required, with functions taking place in different parts of the system. Work programmes will be taken forward on this direction of travel. There are five key areas within the plan, one of which is allocating more resource into preventative activities. There are suggested work programmes for the coming months to take activities forward and provide clarity on how resources will be prioritised through a consistent methodology. Not everything can be applied to this specific framework. Consistency of value, and what needs to be disinvested in to invest in prevention, is important ahead of the next operational planning round, to allow strategy to drive the planning. Indicative timelines were suggested however the ambition is to move forward ahead of the winter. <u>Questions / comments</u> • It is good that ambitions are being set out for prevention in the coming year. It was requested that the ambitions for the next 12 months are built into the Integrated Performance Report (IPR) to demonstrate progression against the ambitions and targets set. Prevention is one of the key areas of focus; this will help to demonstrate whether an impact is being made; and if not, it will help to direct focus as to what needs to be done (SS). RW agreed that the IPR requires improvement going forward to show what needs to be reported upwards and how tackling root causes is progressing. • Having published the JFP, being able to step back and focus on the five core principles is good. The specific ambitions on the work to be done next is fine, however they are big pieces of work to be undertaken within an ambitious timetable; it was enquired whether there is available capacity and capability within the system to undertake this well (TA). ZJ responded that the worry is that if we do not push ourselves to put this in place by September/October we will end up playing catch up for another year, as an Operational Plan has been set that does not match the published strategy. Regarding the prioritisation approach, a framework could be set out for a consistent approach to be applied to Year 2 of the JFP should we be looking to make different investment decisions. ZJ does not think there is currently the capacity to take this forward to the level of detail suggested by September / October, but it will be possible to make progress on which to build. TA reframed the issue in that we cannot afford 'not' to invest the capacity to progress as far as possible before the next planning round; there is a need to ask the System's Executive partners to commit to these areas which are core enablers for translating the NHS plan. RW concurred that there is a necessity to consult with partners earlier as these are such big issues. • This echoes the enormous amount of work and diagnostics undertaken beforehand; it feels different to previous strategies. This is a public facing document that people need to see; it describes a different version of the future (AM). ZJ responded that a public friendly publication will be shared, as per the communications and engagement approach referred to. This will be worked through to ensure engagement, highlight the implementation process and receive feedback.	

Item No.	Item	Action
	• CC thanked all colleagues involved under ZJ's leadership in the coordinating role. The concept of having created a Derby and Derbyshire plan should not be underestimated; this is a significant achievement. The practical challenges of doing everything within the ambitious timescales was recognised, however there is a need to challenge ourselves to make progress and improvements year on year. The system is now in a position that it has never been in before whereby every partner organisation recognises the collective plan and is questioning it to help make improvements. • The ability to resource the activities that are the core enablers is imperative. It was enquired whether there is a resource plan to deliver the enablers and undertake extensive consultation. So much work has gone into the plan that it would be a shame if it was not delivered due to a lack of available time before October (MG). ZJ advised that there are groups coordinating the implementation plan and working it through. Due to the amount of work individual organisations have to do on a day-to-day basis, there is a risk of non-delivery; these asks could be seen as add-ons. The work done by the Core Coordination Group and Executive System Planning Group has clarified how to take things forward; it will require de-prioritising existing ways of working, improving inefficiencies and duplication, and streamlining to free people up to do other things. These will be difficult conversations. RW is energised by the fact that people are buying into the JFP as a way of implementing the vision. This is going to expose hard questions as it moves forward; if this could be resolved together, it is a healthy place to be. A plea was made to system partners that this has got to be everybody's plan; it is important that the Provider Trusts' CEOs take it through their organisations to achieve a common understanding of what is being dealt with and why certain decisions need to be made together. **The Board NOTED the Joint Forward Plan and SUPPORTED the work proposed to progress its implementation** **SUPPORT was given by the Board to map the governance requirements through the ICB sub-committees and other relevant forums to ensure oversight and assurance are in place to confirm delivery of the different elements the plan. This work will be led by the ICB Chief of Staff**	
ICBP/2324/050	**NHS Long Term Workforce Plan** Linda Garnett (LG) advised that the NHS Long Term Workforce Plan has now been published. Nationally it is seen as a significant step forward in shaping the future of the healthcare workforce. The way it has been structured around three priority areas resonates strongly with how the System wants to move forward, both within the NHS and the wider One System Workforce. As it is produced at a high level, it is currently unclear what it means for individual regions and systems; it is hoped that greater clarity will be provided on the next steps. A further update will be provided once it is better understood how the Plan will be implemented. RW considered that education is under-represented in the Anchor Institution of the ICB, as it has a massive part to play in the health agenda; it feeds into cultural and organisational development, running alongside the operationalisation of the forward plan.	

Item No.	Item	Action
	Questions / comments • It will be good to get to a place where it is clear, as a system, what needs to be done in terms of growing the workforce and understand what it does in the individual parts of the system. There is a need to reach a place whereby everyone understands and believes that they work for the system; the people who use the system are not bothered about who is paying for what – all they want is care when they need it (DO). LG responded this means in practice that everyone feels they can provide the care needed regardless of organisational boundaries and policies, delivering a person-centred approach, knowing that they are supported to do so; our job is to take away the barriers, and allow staff to think of themselves as part of a team providing seamless care. • PL added that this is much needed and offers many opportunities. There is a need to build a narrative on how it is implemented; local leadership must be rebased around a learning development culture which takes care of the welfare of its staff. This also links with the Chief Nursing Officers' Strategy. It was agreed that the Plan would return to a future Board for further discussion. **The Board NOTED the NHS Long Term Workforce Plan**	**Agenda item**

ICBP/2324/051	**Integrated Assurance and Performance Report**
	
	• **Quality** – Paul Lumsden (PL) outlined the key messages of the Operational Plan from a quality perspective, as described in the meeting papers. Three areas were particularly highlighted:
	
	  • Maternity services – There is a desire to make improvements at both CRHFT and UHDBFT. UHDBFT recognises that it is not where it needs to be, however PL is impressed with the leadership of their CNO and CEO, who have been working with the Midlands and National Team to help drive improvements forward. A walk around UHDBFT's maternity unit demonstrated investment into leadership to develop the workforce; there will be ongoing scrutiny of this. Dr Chris Weiner (CW) considered it important to recognise the strength of leadership from UHDBFT, both at Executive Team level and within maternity services, to drive improvement. There is a lot of work to be done, in conjunction with the ICB and NHSE regional/national support team, to deliver the improvement plan going forward.
	  • Infection control – This is not where it needs to be against the set trajectories; there is a national rise in clostridium difficile. An infection control summit is to be held on 28th July to focus on getting the basics right.
	  • Elmwood Medical Practice – The action plan is currently being worked upon by the practice to implement the suggested improvements. The CQC is due to revisit in September.
	
	• **Performance** – ZJ outlined the key messages of the Operational Plan from a performance perspective, as described in the meeting papers. The following key messages were highlighted:	

Item No.	Item	Action
	• Primary care – There is positive feedback from a face-to-face appointment perspective, which should be commended given the pressures being seen. Metrics are in place to work with practices to understand any issues materialising. Capacity Access Plans have been submitted to NHSE by PCNs, with help from the ICB; going forward this will help address any capacity and access challenges. This report will be developed to include the broader primary care responsibilities, including access to NHS dentistry for which there are concerns around the long waits. • Mental health/learning disabilities/autism – Despite the pressures and challenges faced in Derbyshire, the targets show delivery against plan. There is a challenge in the Transforming Care Programme for people with learning disabilities in inpatient settings; there is work ongoing to improve this performance by looking at the trajectories set and implementing actions to avoid admissions and discharging current inpatients into the community settings asap. Funding has been provided to reduce the autism assessment waiting times and increase the number of assessments available. Health checks for people with serious mental illness and learning disabilities are being undertaken to pick up any physical health care issues, as well as supporting mental health needs. • Cancer – Work is being undertaken to improve waiting times from referral to treatment; this is being driven by the current challenges and the backlog on the 62-day pathway at UHDBFT; improvements have been seen in recent weeks due to better management of referrals. DDICB remains at Tier 1, the highest level of escalation with NHSE, to manage this position; CRHFT is performing well on cancer targets. • Electives – Long waiters are still being seen in the 78-week cohort; work is ongoing to eliminate the long waiting times by the end of March 2024. • Emergency and Urgent Care – The national target for A&E performance has been lowered; improvement has been seen in the trajectories set, with Urgent Treatment Centres contributing to this. • EMAS – There has been a focus on the Category 2 response times; improvements were seen at the start of the year, with some challenges faced in June. This needs to continue to improve, as does the work to support handover delays. • **Workforce** – Linda Garnett (LG) outlined the key messages of the Operational Plan. Performance against the Workforce Plan submitted to NHSE and the actual position, as the Month 11 and 12 figures were not available when the plan was originally submitted. According to the Workforce Plan, there are 459 WTEs less than planned across all areas. Improvement has been seen in the recruitment to substantive positions; this prevents reliance on temporary staff and overtime and improves the wellbeing and effectiveness of the workforce. A further report has been developed to help understand the position in terms of establishment versus actuals; having a better focus and grip on pay costs by understanding the triangulation between people and finance will help with this. Overall, most organisations are under their expected funded establishment; however, the pay bill is overspent, primarily due to the costs associated with industrial action and the impact of pay awards not being built into the financial plans. Workforce and Finance are working closely to understand the overspends.	

Item No.	Item	Action
	• **Finance** – Keith Griffiths (KG) outlined the key messages of the Operational Plan from finance perspective as at the end of May. The final financial plans were submitted on 2nd May; this is the first understanding of the position against the plan committed to. 2023/24 is a pivotal year to stabilise the financial position for the Derbyshire system and will have big implications on the Five Year Forward Plan. It is an ambitious year, in which every organisation has committed to breakeven; to achieve this, efficiency savings of £136m must be found. A process has been undertaken to identify areas of opportunity to deliver these savings. It is recognised that the delivery of savings will take the full 12 months to realise; it is expected that, due to the speed at which they are to be delivered, more will materialise in the latter half of the year. At the end of month 2, it was planned to be overspent by £7.5m as a collective system; however, the actual overspend was £11.6m due to industrial action costs, excess inflation, pay award costs and the Cost Improvement Programme (CIP). The influence and impact that these areas will have on the commitment to breakeven will be monitored. It is important that the system delivers on everything it committed to in the plan, within its gift. The CIP is the biggest risk moving forward based on the month 2 position. CC added that there continues to be significant challenges to work through. The position at the end of Quarter 1 is as anticipated, however there were some areas which were not anticipated when framing the original plans. There is a need to appreciate the performance within our control alongside external pressures and challenges of delivery. Across many different areas, the ICB is on plan and where it is not there is a good understanding as to why and the actions that are being taken, including quality and workforce planning. Support was sought for the Board to have a conversation on how to get this report right, to ensure it has oversight of the important matters and understands the position against plan. The sub-committees need to be used to their full effect to gain assurance, whilst ensuring that governance processes are adhered to. Questions / comments • The danger of only seeing two months' data is that the wrong interpretation of the position may be taken; it would be better for trend information, highlighting any outliers, to be provided (SS). ZJ advised that the idea of this report is to demonstrate the position against plan. A high level of detail is provided at the Q&PC to demonstrate trends however should the Board wish to see this, it could be incorporated into future reports. • An ongoing concern was raised in relation to investing substantially into virtual wards, with the aim of helping flow, when utilisation has reduced. Although this is a new initiative, and actions have been implemented to ensure it is being used as much as possible, there are some issues with take up (SS). CW responded that considerable investment is being made into virtual wards which is just beginning to flow through the delivery mechanism; the digital enabler and deployed technology will continue over the next 2 to 3 months. A lull will be seen before the full benefits of the investment materialise. There is awareness that further clinical support is needed for the virtual wards; clinicians have been challenged to work in a different way and they need confidence that it	**RW**

Item No.	Item	Action
	will maintain quality of services. Stephen Posey, UHDBFT's CEO, is leading the overall programme from a U&EC Board perspective, drawing together a clinical senate in September to address the clinical concerns in the system. There is poor utilisation at this time however now that things are on the right trajectory, improvement will be seen and watched with interest. • It was enquired what the NHS is doing regarding Artificial Intelligence (AI) to improve performance (DO). CC requested that this question be picked up by Jim Austin (JA). JA attended the last Audit Committee to discuss future opportunities for AI developments. The key is being able to best prioritise to obtain the most benefit and mitigate the most risks. JA is aware of these opportunities and is already involved in many of the developments currently underway (SS). • There are three factors not within our financial control; it was enquired whether there is enough being done to prevent this affecting service provision (DO). KG emphasised that the plan submitted outlined the commitments made at that point in time, however there are additional financial pressures; it is not anticipated that the cost of these can be absorbed on top of the £136m efficiency target to be achieved. Discussions are being held with NHSE on financial respite for the NHS. These are national challenges that are not unique to Derbyshire and are separated out as unintended consequences of extra pressures. A resolution is needed quickly as it will have a cash implication later in the year for which there will be no cash in the bank to pay. **The Board NOTED the Integrated Assurance and Performance Report**	**JA**
ICBP/2324/052	**Hewitt Review – Government response** Chrissy Tucker (CT) advised that the paper sets out the points from the Hewitt Review and the response from the Department of Health and Social Care on the recommendations. The Review was discussed at the Board Development Session in May. Confirmation was provided that the ICB's Strategy aligns with this direction of travel. **The Board NOTED the key recommendations from the Hewitt Review and the Government response**	
ICBP/2324/053	**People and Culture Committee Assurance Report – June 2023** Margaret Gildea (MG) presented this report which was taken as read; no questions were raised **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/054	**Audit and Governance Assurance Report – May / June 2023** Sue Sunderland (SS) raised two areas of concern. Regarding the Section 30 referral made by the auditors, this was a consequence of the additional resource received at the end of the year. The remainder of the audit was very positive and a rating of 'unqualified accounts' was given. Secondly, there have been issues with how the Impact contract has been managed; an update will be provided at the next Audit Committee. **The Board RECEIVED and NOTED the report for assurance purposes**	

Item No.	Item	Action
ICBP/2324/055	**Derbyshire Public Partnership Assurance Report – June 2023** Julian Corner (JC) advised that the Committee is engaging in a refresh of its membership, as per the Terms of Reference. One of the guiding principles of the Five Year Plan is to give people more control over their care; this requires the Committee to be more strategic and reflect the diversity of the population. The Committee is not where the public engagement takes place however it is a vital mechanism for cultural change and overseeing the need for a compelling and consistent approach to public engagement which will drive service transformation and system efficiencies. RW added that it is important to coordinate this engagement through the ICP. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/056	**Quality and Performance Committee Assurance Report – April/May/June 2023** Dr Deji Okubadejo (DO) presented this report which was taken as read; no questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/057	**Population Health and Strategic Commissioning Committee Assurance Report – May/June/July 2023** Julian Corner (JC) presented this report which was taken as read; no questions were raised. **The Board RECEIVED and NOTED the report for assurance purposes**	
ICBP/2324/058	**Finance and Estates Committee Update – June 2023** Jill Dentith (JD) confirmed that the Integrated Performance Report highlighted all the relevant financial issues. **The Board RECEIVED and NOTED the verbal update for assurance purposes**	
ICBP/2324/059	**Ratified Minutes of ICB Corporate Committees** • Audit & Governance Committee – 23.3.2023 / 4.5.2023 • People & Culture Committee – 8.3.2023 • Public Partnership Committee – 28.2.2023 / 28.3.2023 / 25.4.2023 / 30.5.2023 • Quality & Performance Committee – 30.3.2023 / 27.4.2023 / 25.5.2023 **The Board RECEIVED and NOTED the above minutes for information**	
ICBP/2324/060	**Forward Planner** **The Board NOTED the forward planner for information**	

Item No.	Item	Action
ICBP/2324/061.1	Did the items on the agenda address the risks in a way that we feel will mitigate them over the short and medium term. If not, do we want to consider a deep dive on any items in a future agenda. CC advised that the onus of today's meeting was on assurance oversight; the risks identified are very relevant to this. The system focused meetings may need to consider other relevant risks. There is a need to be nuanced in this question depending on the subject of meeting.	
ICBP/2324/061.2	Did any of the discussions prompt us to want to change any of the risk ratings up or down?	
ICBP/2324/062	**Any Other Business** *TA declared a conflict in this item* Amendments to the ICB Constitution – Further consideration has been given to the ICB's Constitution to reference the developing importance of Provider Collaboration at Scale and Place as part of the Constitution of the ICB Board. RW has been working with FT CEOs to gauge their opinion on this. There is a consensus to change the Foundation Trust Partner Member of the ICB Board to automatically being the Chair of the Provider Collaborative Leadership Board. To ensure equity, there is a wish to have input to the Board for Place; it was therefore proposed to create an additional role of Participant to the Board for Place. A recommendation will be made to NHSE for these amendments, alongside other necessary changes, as a single application. **The Board APPROVED the proposed amendments to the ICB's Constitution**	
ICBP/2324/063	**Questions received from members of the public** No questions were received from members of the public.	

Date and Time of Next Meetings

Date: Thursday, 21st September 2023
Time: 9am to 10.45am
Venue: via MS Teams

ICB BOARD MEETING IN PUBLIC

ACTION LOG – JULY 2023

Item No.	Item Title	Lead	Action Required	Action Implemented	Due Date
ICBP/2324/050 20.7.2023	NHS Long Term Workforce Plan	Linda Garnett	It was agreed that the Plan would return to a future Board for further discussion.	Agenda item	**November 2023**
ICBP/2324/051 20.7.2023	Integrated Assurance and Performance Report	Richard Wright	Support was sought for the Board to have a conversation on how to get this report right, to ensure it has oversight of the important matters and understands the position against plan. The sub-committees need to be used to their full affect to gain assurance, whilst ensuring that governance processes are adhered to.		**November 2023**
ICBP/2324/051 20.7.2023	Integrated Assurance and Performance Report	Dr Chris Clayton / Jim Austin	It was enquired what the NHS is doing regarding Artificial Intelligence (AI) to improve performance (DO). CC requested that this question be picked up by Jim Austin (JA).	Response from Jim Austin: The NHS has a number of schemes and approaches to the use of AI in the healthcare setting, ranging from reducing the workload burden through to assistance with clinical decision making. AI has been tested in a number of settings in Derbyshire ranging from the improved prioritisation of	**Item complete**

				elective waiting lists through to (anonymised) assessment of x-rays through the EMRAD network. A full description of the national picture and the funds that can be bid for, can be found here	

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 069

Report Title	Chair's Report – August 2023							
Author	Sean Thornton, Deputy Director Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Richard Wright, ICB Chair							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Not applicable							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Not applicable							

Recommendations
The ICB Board are recommended to **NOTE** the ICB Chair's Report.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
System Strategy and Vision It has been an important year for our NHS and wider JUCD systems, with the publication of the Derby and Derbyshire Integrated Care Strategy and NHS Derby and Derbyshire Five Year Plan. The Board has reviewed these in detail, and they reflect a collegiate position across our system where we are able to agree on shared priorities for our population. We have a solid foundation, with a growing culture of mature conversation, collaboration, and agreements on many of the difficult topics that affect us today. However, I believe we can go further, faster and be more ambitious on how we set about delivery of the plans. This will require another layer of mature collaboration to overcome any remaining barriers to progress. Converting these strategies and plans into action which results in improved access and outcomes for our patients is more important than the documents themselves, which are enablers to give us permission and direction at system level. It is important that we can express what we believe patient experience, access and outcomes should look like in five years' time, and are able to continue to unite around that purpose. There is a phrase that is commonly stated, around leaving your organisational badge at the door, but that

is subtly incorrect; each organisation has a core role to play in delivery, but we all bring our different expertise to the discussion and ensure that we maximise our collective skill and ability to deliver. We may need to reflect and change the ways in which we work to better organise ourselves around the vision, where the emphasis is increasingly placed on who we work with and not for whom we work, and that will follow. We require a staff group working closer to the patient, supporting our teams to make decisions closer to the patient, with a governance and organisational development approach that supports this. The ICB plays a key role at the centre to help bind partners, so that the sum of our parts across the NHS, social care and others is greater than our individual ability. It's important that we are able to engage our staff on this journey, as well as engaging our population.

We have made great progress so far, and I am sponsoring a system workshop on 19th October 2023 to help get our system leaders aligned around this vision for delivery. We will seek to agree on the future, to bring the strategies and plans to life, agree what we are going to do and determine how we can influence that, exploring the tough questions we face, whether that be around operations, workforce, performance, finance, or policy.

ICB Board Appointments

Professor Dean Howells has joined the ICB as Chief Nursing Officer, with effect from 1 September 2023. Dean joined the ICB from Black Country Healthcare NHS Foundation Trust and has significant healthcare experience in the NHS, independent and charity healthcare sectors, both as an Executive Director of Nursing and Chief Operating Officer. Prior to working in the Black Country, Dean's most recent NHS role was as Executive Director of Nursing, Camden and Islington NHS Foundation Trust and previously as Executive Director of Nursing and Quality at Nottinghamshire Healthcare NHS Foundation Trust. Dean is an honorary Professor at Wolverhampton University and was awarded a Queen's Nurse title in 2015.

Michelle Arrowsmith has been appointed as ICB Chief Strategy and Delivery Officer, and Deputy Chief Executive. Michelle will assume post on 2 October and brings a wealth of experience from her clinical background and senior strategic and operational management roles with the NHS in England and with healthcare organisations in New Zealand and Australia. As a qualified dietitian, Michelle is passionate about the roles of allied health professionals and wider clinical teams to support and enable good health and wellbeing. Michelle will replace Zara Jones, who will be joining Doncaster and Bassetlaw NHS Foundation Trust.

Trial and Conviction of Lucy Letby

NHS England has written to all systems following the conviction of Lucy Letby for crimes committed on the neo-natal ward as the Countess of Chester Hospital. Colleagues across the Derbyshire health service share in the condemnation of her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families. The letter outlines the measures in place to strengthen governance and safety in the NHS. NHS leaders and Boards have been asked to ensure proper implementation and oversight of such measures, and specifically, Boards must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistle blowers are treated well.
5. Boards are regularly reporting, reviewing, and acting upon available data.

Industrial Action
Our system has been able to successfully manage the immediate risks posed by recent industrial action taken by junior doctors and consultants. The ICB extends its thanks to everyone who has been involved in managing the risks posed during those periods. A further ballot of junior doctors has approved a mandate to continue to take action, for a further period of six months. It is important that we fully understand the broad range of impacts that industrial action has had upon the system, to support our continued response and ongoing broader planning; Chris Weiner (ICB Chief Medical Officer) is coordinating a specific review of this on our collective behalf.

Further action from junior doctors is due to take place in September and October; consultants will take action on Tuesday 19th and Wednesday 20th September, and junior doctors will also take action on Wednesday 20th September in the first overlap of dates between the two groups, and also on Thursday 21st September and Friday 22nd September. Consultants and junior doctors will take concurrent action for 72 hours, starting on Monday 2nd October.

The BMA have said they will permit Christmas Day-equivalent levels of staffing, which enables us to consider the previously well-rehearsed plans for this level of care, but we will have to consider the broader impacts on elective care amongst other areas.

Community Transformation Programme
We commenced a diagnostic of whole system community transformation programme with Newton Europe in January. This work has reported outputs with a set of key actions and opportunities for our system to transform pathways and ensure services are running efficiently. The resulting KPIs and the potential impact on finance and workforce implications and opportunities could amount to £50m of cash-releasing and other benefits. All partners are signed up to the emerging outcomes for patients in Derby and Derbyshire and we are running an options appraisal to further progression. Should this progress, it will require universal system transformational change to improve patient outcomes, improve staff experiences and to realise the benefits that we believe exist and are achievable.

Organisational Development
A proposal for a system approach to organisational development (OD), which has been developed by a cross-system group of OD and improvement leads and most recently receiving the support from the Provider Collaborative Leadership Board. The three themes in the proposal are:

- developing a culture of system thinking
- readiness to transform, addressing enablers and ways of working
- developing collaborative and transformational capabilities across the system

One of the focus areas will be supporting system delivery, improvement, and transformation teams, including developing skills around improvement methodologies, and using data. Another priority is embedding a shared system mindset and shared purpose throughout partner organisations, recognising the needs of different interest groups including boards and executive teams, clinical leaders, and improvement teams.

Delivering the new Community Mental Health Framework across Derbyshire
Partners are currently working together to implement the national requirements of the new Community Mental Health Framework across Derbyshire by Spring 2024. A phased, codesigned approach has been in place over recent months that will provide a localised approach, whilst also delivering national requirements. One of the key outcomes of the new model is to build capacity across community mental health teams by working in partnership with voluntary and community

sector organisations, providing a single point of access to a range of services, including health but also wider social determinants such as housing and employment.

Chesterfield Careers Fair targeting inclusivity
A careers fair held at Chesterfield College was the first of its kind to have a firm focus on inclusivity and diversity in the workplace. The pioneering careers fair entitled 'Unlocking New Possibilities' was hosted by Links CVS, the local Council for Voluntary Service in Chesterfield and North East Derbyshire, on behalf of the Derbyshire Black and Minority Ethnic (BME) Forum in partnership with Derbyshire County Council, Joined Up Care Derbyshire Careers, Chesterfield College, Department of Work and Pensions and East Midlands Chamber (Derbyshire, Nottinghamshire & Leicestershire).

The partnership has worked to develop support that more closely addresses the needs of individuals within BME communities (including new refugee communities) in Chesterfield and North East Derbyshire, with the aim of improving interest and engagement in employment opportunities across a range of sectors, including hospitality, health and social care and construction. The Joined Up Care Derbyshire Careers team is involved in a broad range of activity across our system, and more information can be found in the programme's regular newsletter.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☐	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐			

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒
Details/Findings Not applicable.		**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision making process?

Not applicable to this report.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
	Yes ☐	No☐	N/A☒	**Details/Findings**

Quality Impact Assessment				
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable to this report

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Not applicable to this report.					

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 070

Report Title	Chief Executive Officer's Report – August 2023							
Author	Dr Chris Clayton, Chief Executive Officer							
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer							
Presenter	Dr Chris Clayton, Chief Executive Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Not applicable							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Not applicable							

Recommendations
The ICB Board are recommended to **NOTE** the ICB Chief Executive Officer's Report.
Purpose
The report provides an update on key messages and developments relating to work across the ICB and ICS.
Report Summary
Pressure in our system has been persistent for many months now. Following surges in pressure throughout last year, critical incidents in the New Year and industrial action taking place throughout 2023, we have been in a state of perpetual escalation planning. The latest planning concerned August's Summer Bank Holiday, and I am grateful to everyone who was involved in navigating the system through another managed period of risk. We know that trade unions have identified further dates for industrial action through the autumn and so our surge and pressure planning continues for now. We also continue to receive further official communication from NHS England on their expectations on formal winter planning, and have submitted our first winter plan for review. Alongside the NHS, our other public sector colleagues are experiencing operational pressures of their own as they seek to manage demand and mitigate the emerging challenges facing our population. I attend the Derbyshire Chief Executives meeting which takes place monthly to mutually work on such issues. The cost of living crisis is a common theme of discussion with impacts across different sectors and in which healthcare sector services are not immune.

The Derbyshire CEO Group has prioritised seven areas for collective attention during the early autumn months, and the NHS has a part to play in all of them:

- Preparing for Devolution in Derbyshire
- Cost of Living Crisis
- Financial Pressures
- Disabled Facilities Grant
- Skills and Training
- Young People in Care/Care Leavers
- Public Sector Recruitment and Retention

The work of our Place Alliances and Partnerships is crucial in this area, and we received a presentation from Hannah Leaton, our joint Assistant Director of Place, at one of our ICB staff Team Talks recently. Obviously Place is not charged with solving all of these issues alone, but it is the space where many of these relationships and partnerships come together to identify the most significant local challenges, working with the community.

We will continue to talk about the important 20% contribution the NHS makes to local health outcomes, after all that is the role of our ICB to plan and manage that directly, but increasingly and in parallel we will also increase the focus we can have by working with partners on housing, education, financial advice, air quality as all of these others factors have such a significant impact on the health of our population.

Our focus is in the right places and we are building the right partnerships, and I am confident that we have created the model and conditions that enable us to deliver on our Integrated Care Strategy and NHS Five Year Plan commitments. The workshop described by our Chair in his report to Board will seek to take this thinking forward.

I am pleased to report that we welcomed Professor Dean Howells into his new role as Chief Nursing Officer on 1st September. I am grateful to our Interim Chief Nursing Officer, Paul Lumsdon, for very ably covering the role since July, and will continue to work with Paul in an interim capacity until the end of the calendar year, supporting Dean's induction into the organisation and system and providing executive level operational support to the ICB in line with other changes that are occurring within the executive.

We have also announced that Michelle Arrowsmith will take up post as the ICB's Chief Strategy and Delivery Officer on 2nd October. Michelle will also be the ICB's Deputy Chief Executive. All appointments identify our desire to progress the agenda of the ICB, as set out in our five year plan. Zara Jones, Executive Director of Strategy and Planning, leaves the ICB at the end of September to take up a new position at Doncaster and Bassetlaw NHS Foundation Trust. I am very grateful for the significant role Zara has played in our system, through the pandemic and in leading our work to deliver the first NHS Five Year Plan in the ICB, and we will all wish her well for the future.

Chris Clayton
Chief Executive Officer

Chief Executive Officer calendar – examples from the regular meetings programme

Meeting and purpose	Attended by	Frequency
JUCD ICB Board meetings	ICB	Monthly
JUCD ICP Board meeting	ICB	Bi-Monthly

System Review Meeting Derbyshire	NHSE/ICB	Monthly
Quarterly System Review Meetings	NHSE/ICB	Quarterly
ICB Executive Team Meetings	ICB Executives	Weekly
Derbyshire Chief Executives	CEOs	Bi Monthly
EMAS Strategic Delivery Board	EMAS/ICB	Bi-Monthly
Joint Health and Wellbeing Board	DCC/ICB/LA	Bi-Monthly
NHS Midlands Leadership Team Meeting	NHSE/ICB	Monthly
Partnership Board	CEOs or nominees	Monthly
East Midlands ICS Commissioning Board	Regional CEOs/NHSE	Monthly
Team Talk	All staff	Weekly
JUCD Finance & Estates Sub Committee	ICB	Monthly
Midlands ICS Executive & NHSEI Timeout	ICB/NHSE	Ad Hoc
2022/23 Financial Planning	NHSE/ICB	Ad Hoc
ICB Development Session with Deloitte	ICB	Ad Hoc
Meeting with Derby and Derbyshire MPs	ICB CEO/Chair	Ad Hoc
ICB Remuneration Committee	ICB	Ad Hoc
Place & Provider Collaborative	ICB	Ad Hoc
Derbyshire Dialogue	ALL	Ad Hoc
System Escalation Calls (SEC)	ICS/LA	Ad Hoc
NHS National Leadership Event - London	NHSE	Ad Hoc
NHS Clinical Leaders Network	NHSE	Ad Hoc
Joint Emergency Services Interoperability Protocol (JESIP) Training	ICB	Ad Hoc
ICS Connected Leadership Programme – Leeds	ICB	Ad Hoc
Derbyshire Distributed Leadership Meeting	NHS Executives	Ad Hoc
East Midlands Joint Committee	East Midlands ICB CEOs	Bi-Monthly
Derbyshire LHRP Meeting	NHSE/LA/ICS	Monthly

National developments, research and reports

NHS Confederation report examines ICS progress

The NHS Confederation has published a report examining the progress of ICSs a year after they were established across England as formal partnerships under the Health and Care Act (2022). 'The state of integrated care systems 2022/23: – Riding the storm' is based on a comprehensive national survey and interviews with ICB and ICP chairs, chief executives and wider system partners. The report makes a number of recommendations for how government and national bodies can support ICSs in year two of their existence as formal partnerships, including the need for government to review the amount of capital funding available to ICSs (as well as the complex allocation process) and develop a long term plan for the social care workforce. There are recommendations too for NHS England to ensure ICBs have access to the data and capacity they need, and around setting a small number of targets based on outcomes.

NHS sets out plans for winter with new measures to help speed up discharge for patients and improve care

Care 'traffic control' centres to speed up discharge, additional ambulance hours and extra beds are part of wide-ranging plans to prepare for winter.

NHS flu and covid vaccine programmes brought forward due to risk of new covid variant

From 11 September, millions of people became eligible for a covid vaccine, in line with the latest expert guidance on the new covid variant. This change followed an announcement by the Department of Health and Social Care (DHSC) and the UK Health Security Agency (UKHSA) on the risks presented by the new BA.2.86 variant and pre-emptive measures the NHS has been asked to take. Originally, the adult covid and flu vaccination programmes had been due to start in October to maximise protection over the winter months.

Department of Health and Social Care sets out major conditions strategy

The major conditions strategy sets out how the government's approach to health and care delivery will evolve to meet population needs and tackle health disparities. The strategy makes the case for adapting the model of care to tackle the multimorbidity challenge, and identifies how ICSs can provide the infrastructure to join up health and care locally.

NHS launches first-ever sexual safety charter to help protect staff

More support will be provided to NHS staff who have suffered harassment or inappropriate behaviour, thanks to a first of its kind sexual safety charter.

Record numbers of disabled staff on NHS boards

NHS boards have more disabled members than ever before, new NHS data shows. The Workforce Disability Equality Standard (WDES) annual report shows disabled people make up 1 in 20 (4.8%) of voting members on NHS boards.

NHS to invite almost a million more people for shingles vaccine as human papillomavirus (HPV) vaccine moves to one dose

The NHS has updated two of its life-saving vaccination programmes, following the latest advice by the Joint Committee on Vaccination and Immunisation (JCVI). Almost a million more people (900,000) are now eligible for a shingles vaccination and the human papillomavirus (HPV) vaccine moves to a single dose for under 25s.

NHS rolls out world-first programme to transform diabetes care for under 40s

Tens of thousands of people in England living with early onset type 2 diabetes will benefit from more intensive and targeted care, thanks to a world-first initiative being rolled out by the NHS.

Under the ambitious new programme, named 'T2Day: Type 2 Diabetes in the Young', patients will benefit from extra one-to-one reviews as well as the option of new medicines and treatments where indicated, to help better manage their diabetes.

NHS partners with Morrisons to put vital cancer awareness messaging on underwear labels

Morrisons and the NHS are working together to put advice on underwear labels urging people to contact their GP practice if they spot potential symptoms of breast or testicular cancer. The Nutmeg-branded underwear featuring NHS advice will be in 240 Morrisons stores nationwide, initially in men's boxer shorts and followed by crop top bras in the coming months.

NHS launches lifesaving campaign to help people spot a heart attack

As admissions for heart attack return to pre-pandemic levels, the NHS has launched a lifesaving campaign to encourage people to call 999 when they are having early signs of a heart attack. The campaign will teach people about the common signs of a heart attack that are often dismissed or ignored by people.

425,000 NHS patients use online GP registration service in first year

More than 425,000 patients have used a new national online service to register with a GP in its first year. The Register with a GP surgery service, which is managed by NHS England, means NHS patients have been benefiting from easier and more convenient access to GP registration since it was launched in August 2022.

Local developments

NHS five year plan will prioritise prevention of ill health

The NHS in Derby and Derbyshire has published its five year plan. The five year plan, also referred to as the Joint Forward Plan, will prioritise the prevention of ill health. The plans sets out how NHS organisations in Derby and Derbyshire will change the way they allocate resources and work with patients so activity is more:

- Focused on preventing of ill health and reducing inequity of provision
- Personalised to individuals, so they feel more in control
- Led by intelligence – leading to better decisions
- Integrated in the way services are provided for people

The plan was agreed by the NHS Derby and Derbyshire Integrated Care Board on Thursday, 20 July.

Infrastructure Strategy

The System Strategic Estates Group will oversee a refresh of the Joined Up Care Derbyshire estates strategy, in line with national requirements and with support from NHS Property Services and Community Health Partners. The work will have a strong focus on place, with good involvement from place and primary care leads in the group. The aim is to ensure that we maximise significant opportunities to make better use of our estates and our assets more cost effectively to support integrated care across Derby and Derbyshire.

CQC Survey into Patients' Experience of Urgent and Emergency Care Shows Chesterfield Royal Hospital NHS Trust to be Amongst the Best in the Country

Information from a Care Quality Commission survey, looking at the experiences of people who

attended urgent and emergency care services, scores the Trust 8.1/10 – classed by the regulator as 'somewhat better than expected'. The survey took place between November 2022 and March 2023 and looked at the experience of thousands of people across the country.

Liver team becomes first centre in the East Midlands to gain prestigious accreditation
The Liver team at Royal Derby Hospital has been recognised nationally for providing exceptional care for patients with liver disease - becoming the first centre in the East Midlands and the eleventh centre in England, Wales, and Northern Ireland to do so.

Derbyshire NHS Trust launches first internship programme
Derbyshire Healthcare NHS Foundation Trust has partnered with the University of Derby to launch its first internship programme to help support the local NHS workforce. The internship programme helps to provide students from disciplines outside of health and social care studies to find future careers within the NHS.

Derbyshire Healthcare colleagues chosen as finalists for not one but three national NHS awards
Derbyshire Healthcare NHS Foundation Trust and two of its members of staff have been named as finalists for work carried out within the NHS at a national awards scheme run by Asian NHS professionals. Both Ade Odunlade – Chief Operating Officer and Amber Ghei – Communications Officer, are in the running for awards at the Asian Professionals National Alliance (APNA) NHS Awards.

New NHS gambling service launches across the East Midlands
A free NHS service has been launched to offer specialist treatment and support to people in the East Midlands who are struggling with a gambling problem. The East Midlands Gambling Harms Service, which is based in Derby, will provide specialist therapies, treatment and recovery to those affected by gambling addiction and gambling problems in Derbyshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire and Rutland.

Joined Up Care Derbyshire Wellbeing team named as finalist for Most Inclusive Menopause Friendly Employer Award
Joined Up Care Derbyshire's (JUCD) Wellbeing team have made the final shortlist in the Menopause Friendly Employer Awards. The awards, which are also a fund-raiser for menopause-related charities, programmes and research, work to shine a light on organisations that go above and beyond to improve support and facilities for colleagues who are experiencing menopause.

Michelle Arrowsmith appointed as Chief Strategy and Delivery Officer
Michelle Arrowsmith has been appointed as the new Chief Strategy and Delivery Officer, and Deputy Chief Executive, for NHS Derby and Derbyshire Integrated Care Board. She will take up post on Monday 2 October. Michelle brings a wealth of experience from her clinical background and senior strategic and operational management roles with the NHS in England and with healthcare organisations in New Zealand and Australia.

Professor Dean Howells appointed as Chief Nursing Officer
Professor Dean Howells became Chief Nursing Officer for NHS Derby and Derbyshire Integrated Care Board on Friday 1 September. Dean joins the organisation from Black Country Healthcare NHS Foundation Trust and has significant healthcare experience in the NHS, independent and charity healthcare sectors, both as an Executive Director of Nursing and Chief Operating Officer.

New Deputy Medical Director for Digital and Data, and Chief Clinical Information Officer at UHDB

University Hospitals of Derby and Burton have appointed Dr Nitin Kolhe as Deputy Medical Director for Digital and Data, and Chief Clinical Information Officer (CCIO). Formerly he was Deputy Divisional Medical Director for Medicine at the Trust. Dr Kolhe started in his role on Friday 1 September.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☐	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐			

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒

Details/Findings	**Has this been signed off by a finance team member?**
Not applicable to this report.	Not applicable to this report.

Have any conflicts of interest been identified throughout the decision making process?

Not applicable to this report.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable to this report.

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

Details/Findings
Not applicable to this report.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 071

Report Title	NHS Derby and Derbyshire Clinical Commissioning Group Annual Report and Accounts - April to June 2022 NHS Derby and Derbyshire Integrated Care Board Annual Report and Accounts - July 2022 - March 2023							
Author	Suzanne Pickering, Head of Governance Fran Palmer, Corporate Governance Manager							
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer							
Presenter	Dr Avi Bhatia, CCG Clinical Chair Richard Wright, ICB Chair Dr Chris Clayton, Chief Executive Officer							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☒	Information	☐
Appendices	Appendix 1 – Annual Report and Accounts Presentation							
Assurance Report Signed off by Chair	Not applicable.							
Which committee has the subject matter been through?	Audit & Governance Committee, 8 June 2023							

Recommendations
The ICB Board is recommended to **RECEIVE** the formal presentation of NHS Derby and Derbyshire Clinical Commissioning Group Annual Report and Accounts - April to June 2022; and NHS Derby and Derbyshire Integrated Care Board Annual Report and Accounts - July 2022 - March 2023.
Purpose
The purpose of the report is to formally publish the CCG and ICB's Annual Report and Accounts for the 2022/23 reporting period, and provide assurance in line with NHS England guidance.
Background
Both Clinical Commissioning Groups and Integrated Care Boards were required to prepare an Annual Report and Accounts in accordance with NHS England and Improvement directions, as outlined in the National Health Service Act (2006, as amended). The Annual Report and Accounts presented covers the financial year 2022/23 (1st April 2022 to 31st March 2023).
Report Summary
Both NHS Derby and Derbyshire CCG and NHS Derby and Derbyshire ICB's Annual Reports and Accounts for the 2022/23 financial year describe their activities, achievements, challenges, and continued response to the Covid-19 pandemic during that time. It also describes their financial performance and how they met their governance requirements. The Financial Statements are subject to a rigorous audit process and both organisations are delighted that for 2022/23 the CCG

and ICB's external auditors, KPMG, provided an unqualified audit opinion of the CCG and ICB financial statements within the reports and concluded that there were 'no significant weaknesses' in relation to use of resources.

In accordance with the CCG Audit Committee, and ICB Audit and Governance Committee Terms of References, the Committees had delegated authority from the Governing Body/ICB Board to review and approve the Annual Report and Accounts on behalf of the Governing Body/ICB Board.

The ICB Audit and Governance Committee approved both sets of Annual Reports and Accounts on the 8th June 2023. The Accountable Officer must sign the Annual Reports and Accounts to confirm adherence to the reporting framework and these were signed by Dr Chris Clayton. The signed Annual Reports and Accounts were submitted to NHS England, and External Auditors, on the 30th June 2023.

Both Annual Reports and Accounts are published in full on the ICB public website and can be accessed via the following link:
https://joinedupcarederbyshire.co.uk/publications/annual-reports/.

Summary of the Annual Report and Accounts

A three-part Annual Report and Accounts (ARA) is required to be published, which consist of the:

- Performance Report
- Accountability Report
- Financial Statements

1. The Performance Report
The purpose of the performance section is to provide information on the organisation, its main objectives and strategies and the principal risks they face.

The Performance Overview gives a synopsis of the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year, and an overall explanation of how it has discharged its functions.

The Performance Analysis provides a detailed performance summary of how the organisation measures its performance and meets its mandatory requirements as follows:

- Sustainable Development
- Improving Quality
- Engaging with People and Communities
- Reducing Health Inequality
- Health and Wellbeing Strategy

2. The Accountability Report
The purpose of the accountability section is to meet the key accountability requirements to parliament.

The Corporate Governance Report explains the composition and governance structures and how they support the achievement of the organisation's objectives. The Corporate Governance Report contains:

- Directors Report
  The report contains the details of the composition of the Governing Body/ICB Board, Audit and Governance Committee membership, Register of Interests, Personal Data Related Incidents and the Statement of Disclosure to the Auditors.

- Statement of Accountable Officer's Responsibilities
  The Accountable Officer must explain their responsibility for preparing the financial statements and confirm that the ARA as a whole is fair, balanced and understandable and that he takes personal responsibility for the ARA.

- Governance Statement
  The Governance Statement reflects on the circumstances in which the organisations operated during 2022/23, particularly:
  - the Governing Body/ICB Board and its Committees, and Governing Body/ICB Board Performance during the year;
  - risk management arrangements and effectiveness;
  - other sources of assurance;
  - Control Issues;
  - Significant Assurance of the Head of Internal Audit Opinion; and
  - a review of effective governance, risk management and internal control.

The Remuneration and Staff Report sets out the organisation's remuneration policy for its directors and senior managers, reports on how the policy was implemented and sets out the amounts awarded to directors and senior managers which are detailed in the Remuneration Report tables.

The Staff Report provides an analysis of staff numbers and costs, staff composition and sickness absence data.

The Parliamentary Accountability and Audit Report – there is no requirement to produce a Parliamentary Accountability and Audit report. Disclosures on remote contingent liabilities and losses and special payments are included where applicable in the Financial Statements and an Audit Certification is included after the Financial Statements.

3. The Financial Statements

The annual accounts include a set of primary financial statements, and the format of the statement must be followed precisely as per the Department of Health and Social Care Group Accounting Manual 2022/23. Auditors reviewed the Accountability Report for consistency with other information in the financial statements and provided an unqualified opinion on the disclosures detailed in the Accountability Report.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☒
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☒
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☒			

No further risks identified.

Financial impact on the ICB or wider Integrated Care System		
Yes ☐	No☐	N/A☒
Details/Findings Not applicable.		**Has this been signed off by a finance team member?** Not applicable.
Have any conflicts of interest been identified throughout the decision making process?		
None identified.		
Project Dependencies		
Completion of Impact Assessments		

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Summary:**	

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒
Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?			
Not applicable.			

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable.					

NHS Derby and Derbyshire Clinical Commissioning Group and NHS Derby and Derbyshire Integrated Care Board Annual Report & Accounts 2022/23

Introduction

- The establishment of the Integrated Care Board (ICB) on the 1st July 2022 resulted in the abolishment of the Clinical Commissioning Group (CCG) on the 30th June 2022.
- Both organisations were required to prepare an Annual Report and Accounts in accordance with NHS England directions, as outlined in the NHS Act 2006 (as amended).

<u>CCG Annual Report & Accounts</u>

- Covers Quarter 1 (1st April to 30th June) of the 2022/23 financial year

<u>ICB Annual Report & Accounts</u>

- Covers Quarters 2 to 4 (1st July to 31st March) of the 2022/23 financial year

CCG Clinical Chair's Foreword

- Thank you to health and social care colleagues – challenges of the Covid-19 pandemic still remain alongside significant system pressures, however significant progress made in terms of recovery
- Placing clinicians at the heart of decision-making has been fundamental to our achievements as a CCG
- Central role of Primary Care Networks
- Strategic decision-making role of Clinical and Professional Leadership Group

Dr Avi Bhatia
CCG Clinical Chair

ICB Chair's Foreword

- Gratitude for the commitment of health and care staff in working beyond the call of duty to keep our citizens safe and to provide the best possible care
- Formal inclusion of new partners to the ICB Board to benefit from increased expertise in our understanding of communities
- Collaboration at 'district-level' through 'Place'
- Derby and Derbyshire faced with wide variation in the health outcomes of the population
- Aim to improve health and reduce health inequalities through:
  - Integrated Care
  - Integrated Commissioning
  - Integrated Governance
- Continue to understand the sources of service pressure, and solve issues relating to discharge and backlogs of care

John MacDonald
ICB Chair

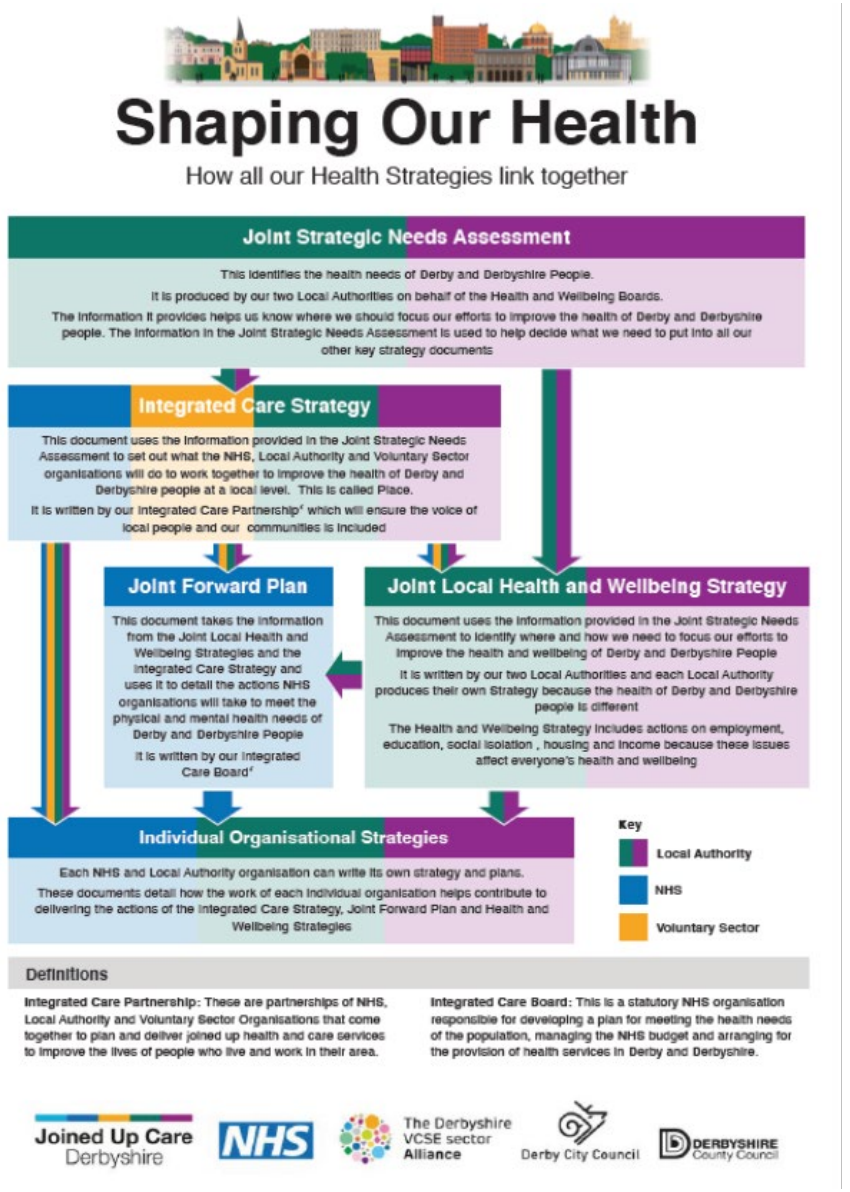
ICB Chief Executive Officer Statement

- Smooth transition from CCG to ICB with no legacy issues
- Derby and Derbyshire Together Programme – engagement with staff and external partners in setting a defined purpose and vision
- Challenges faced by health and care system managed in a consistent, careful and coordinated manner
- System pressures resulted in significant partnership working to resolve discharge challenges
- Additional planning for industrial action
- Recovery of activity positions following pandemic, in particular urgent cancer referrals and waiting times
- Development of Integrated Care Partnership, Place partnerships, Provider Collaborative, Primary Care Networks and Clinical and Professional Leadership Group
- Derby and Derbyshire NHS Five Year Plan 2023/24 to 2027/28

Dr Chris Clayton
ICB Chief Executive Officer

Bringing the System Together

- Integrated Care Strategy
- Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28
- Integrated Care Partnerships
- Health and Wellbeing Board
- Joint Working with Local Authorities
- Derbyshire Anchor Institutions
- Team Up Derbyshire
- Primary Care Networks
- Place Development and Delivery
- Integration of Glossop into the ICS and High Peak Place



2022/23 Performance

Achievements during 2022/23

- Over 70% of Mental Health constitutional standards met
- Derby and Derbyshire achieved the target for ensuring no patients were waiting longer than 104 weeks by the 31st July 2022; and no patients waiting longer than 78 weeks for treatment achieved during April 2023
- Cervical and bowel screening programmes have been fully restored in Derbyshire and waiting times are in line with national standards
- Discharge to Assess – worked with partner organisations to develop 218 temporary bedded placements across residential and nursing settings
- NHSE-directed system control centre – created to ensure the ICB has visibility of operational pressures and risks across providers and system partners
- Primary Care Networks recruited 461.95 FTEs under the Additional Roles Reimbursement Scheme, exceeding the target by 25%

2022/23 Performance (cont'd)

Improvements required for 2023/24

- Referral to treatment
- Diagnostic waits
- A&E waits/12-hour trolley breaches
- Cancer waits less than 14 days
- 28 day faster diagnosis standard
- Cancer waits less than 31 days
- Cancer waits less than 62 days
- Mental Health – IAPT waiting times (six weeks) and Dementia diagnosis
- Mixed sex accommodation
- Ambulance performance

ICB Chief Finance Officer Statement

- Total resources of £1,706.8m, including income of £9.4m (£1,697.4m of allocations from the Department of Health and Social Care). The ICB committed expenditure totalling £1,721.6m, leaving the ICB with a deficit of £14.8m
- £31.6m system deficit due to expenditure outside of ICB's control – cost of living increases, impact of the national pay award and Covid-19 related costs
- Pressures in prescribing, continuing healthcare fast track packages to support hospital discharge and Section 117 in mental health cases
- Considerable work undertaken to understand the extent of the financial challenges and the backlog of routine healthcare
- Delivery of high-level transformation to achieve financial efficiencies

Keith Griffiths
ICB Chief Finance Officer

CCG and ICB Audit Opinion

- No inconsistencies between the contents of the Accountability, Performance and Director's Reports and the financial statements
- Remuneration Reports materially accurate
- Annual Governance Statements consistent with financial statements and complied with relevant guidance
- Unqualified audit opinion of financial statements
- Concluded that there were 'no significant weaknesses' in relation to its use of resources

On behalf of the entire ICB Board we would like to extend our sincere thanks to our ICB staff, our public and voluntary sector partners and all Joined Up Care Derbyshire staff across Derbyshire for their ongoing contribution towards keeping local people healthy and well.

Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 072

Report Title	ICB Annual Assessment and Development							
Author	Chrissy Tucker, Director of Corporate Delivery							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Dr Chris Clayton, Chief Executive Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Appendix 1 – NHSE letter dated 27 July 2023							
Assurance Report Signed off by Chair	Not applicable.							
Which committee has the subject matter been through?	Not applicable.							

Recommendations
The ICB Board is recommended to **NOTE** the contents of this report.
Purpose
The purpose of this report is to inform the ICB Board of the outcome of the Annual Assessment process, including areas for improvement.
Background
NHS England has a legal duty to undertake and publish an annual assessment of Integrated Care Board (ICB) performance with respect to each financial year in line with section 14Z59 of the NHS Act 2006 and as amended by the Health and Care Act 2022. The assessment must consider how the ICB has performed against eight specific duties: 1. The duty to improve quality. 2. The duty to reduce inequalities. 3. The duty to take appropriate advice. 4. The duty to have regard for the effect of decisions. 5. The duty to use and promote research. 6. The duty to involve patients and the public. 7. The financial duties. 8. The duty to support local strategies and priorities.

It must also consider the ICB's contribution to the four fundamental purposes of the ICB, together with the way in which it has provided leadership to the system. The four fundamental purposes are:

- Improving population health and healthcare
- Tackling unequal access and outcomes
- Enhancing productivity and value for money
- Helping the NHS support broader social and economic development

The assessment included NHSE regional teams obtaining feedback from system partners, the ICP and the Health and Wellbeing Boards.

Report Summary

The attached letter (Appendix 1) provides a narrative assessment under the headings outlined above, including areas for improvement, and reflects that the ICB has been operational for only nine months of the assessment year. Progress against improvement areas will be monitored through the ICB's regular meetings with NHSE and will form part of the wider organisational development programme during its second year of operation. The development areas are:

System Leadership
Continue to develop and embed in ICB governance the NHS Oversight Framework arrangements including supporting and monitoring organisations against agreed exit criteria.

Improving Population Health and Healthcare

- Enable effective UEC flow and conduct further work to ensure that bed occupancy meets the required standard for 2023/24.
- Together with the East Midlands ICBs, focus on improving ambulance performance standards.
- Continue the recovery work relating to cancer performance standards and elective surgery waits.
- Continue focus on reducing adult inpatient care for Learning Disability and Autism patients.
- Continue work on continuity of carer in maternity services and in particular support UHDB in their response to recent serious incidents.

Tackling Unequal Outcomes, Access and Experience
No specific improvements identified.

Enhancing Productivity and Value for Money
Further consider how system wide transformation can be realised to support delivery of the efficiency plan.

Helping the NHS support broader social and economic development
No specific improvements identified.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☐	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐

SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☒			

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☒	N/A☐

Details/Findings	**Has this been signed off by a finance team member?**
No financial impact.	Not applicable.

Have any conflicts of interest been identified throughout the decision making process?

None identified.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:

Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?

Not applicable to this report.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable to this report.

Appendix 1

Classification: Official

NHS England Midlands

27 July 2023

From the office of Julie Grant
Director of Strategic Transformation

23 Stephenson Street
Birmingham
B2 4JB

T: 07876 354253
E: j.grant10@nhs.net
W: www.england.nhs.uk

By email

Richard Wright
Chair
Derby and Derbyshire Integrated Care Board

Dear Richard,

Annual assessment of Derby and Derbyshire Integrated Care Board's performance in 2022/23

As you are aware NHS England has a legal duty to undertake an annual assessment of Integrated Care Board (ICB) performance with respect to each financial year. This is in line with section 14Z59 of the NHS Act 2006 and as amended by the Health and Care Act 2022.

The annual assessment is focused on your organisation's performance against those specific objectives set by NHS England and the Secretary of State for Health and Social Care, its statutory duties as defined in the Act and the wider role within your Integrated Care System (ICS) across the 2022/23 financial year. The evidence to support the assessment has considered your ICB's annual report and accounts; available data; feedback from stakeholders and the discussions that NHS England has had with the ICB and the wider system during the year.

The assessment has also considered your role in providing leadership and good governance within your Integrated Care System as well as how you have contributed to each of the four fundamental purposes of an ICS.

Annex A contains a detailed summary of the areas where the ICB is displaying good or outstanding practice and areas which further progress is required along with support or assistance being supplied by NHS England to facilitate improvement.

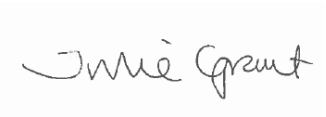
The assessment recognises the relative infancy of ICBs, having only been statutory bodies for nine months of the 2022/23 financial year, and the developing local strategic aims of ICS' set out in the Integrated Care Strategy for your system and articulated through your recently published Joint Forward Plan. 2022/23 has been a transitional year and you have had to balance the demands of establishing the new organisation with supporting service delivery.

The ICB has made significant progress in working and engaging with system partners to ensure that strategic priorities are aligned and that there is a developing approach to truly integrated health and care. Good progress has been made with leadership and governance arrangements, however there are some areas of operational and financial challenge which will require further development of oversight arrangements and focussed improvement activity in the coming year.

Please could you share the assessment with your leadership team and consider publishing this alongside your annual report at your Annual General Meeting. NHS England will also publish a summary of the outcomes of all ICB performance assessments as part of its 2022/23 Annual Report and Accounts.

Thank you for all of your work during 2022/23 in what remain challenging times for the health and care sector.

Yours sincerely,



Julie Grant
Director of Strategic Transformation, NHS England (East Midlands)

cc. Chris Clayton, Chief Executive Officer, Derby and Derbyshire Integrated Care Board
Dale Bywater, Regional Director, NHS England (Midlands)
Diane Gamble, Deputy Director of Strategic Transformation, NHS England (Midlands)

Annex A: detailed assessment

Section 1: System leadership

The ICB has made good progress with developing its approach to governance and leadership, specifically in relation to integrated care, integrated assurance and integrated commissioning. The ICB has outlined within the Joint Forward Plan (JFP) how it will address nationally mandated targets, as well as seeking to find solutions to local challenges and setting priorities and outcomes.

The ICP and ICB work in a mutually supportive manner and progress is being made on key NHS deliverables through collaboration and system working. There are positive collective working relationships with the Local Authority and good engagement between Local Authorities, the NHS, the VCSE sector and Healthwatch organisations, as evidenced in the development of the Integrated Care Strategy. The 'Team Up' programme is an example of strong partnership working which brings together nurse prescribers, occupational therapists, social care and GPs to provide care for people at home, avoiding wherever possible the need to go to hospital.

The ICB has worked collaboratively to deliver the strategic priorities, ensuring good engagement and collaboration with wider partners when developing plans such as the joint Integrated Care Strategy. The system has been advanced in developing a collaborative approach to workforce and resourcing. The JFP and annual report have demonstrated the duty to have regard for the effectiveness of strategic decisions by having a continuous theme of the 'Triple Aim' throughout the plan.

Governance, assurance and oversight arrangements continue to evolve and the NHS Oversight Framework is not yet fully embedded within the ICB governance structure. Further work is required to ensure that organisations are supported and monitored against agreed exit criteria. Further work is also required in relation to the design and implementation of the system operating model.

The approach to decision-making is highlighted throughout the annual report including the engagement and involvement of the Derby and Derbyshire residents in all elements of work, ensuring they are at the heart of decision-making processes. The ICB adopts a robust model of equality analysis and due regard which it has embedded within its decision-making processes.

Information and feedback received from Health and Wellbeing Boards and partnerships also evidences the way the ICB is working to engage and involve around decision making and building the strategy as a system.

Section 2: Improving population health and healthcare

There is an established System Quality Group in place which is mature and fully functioning and reports to the ICB Quality Committee. There is evidence that the System Quality Group is effective in managing safety concerns and ensuring actions take place. The ICB has embedded the NQB guidance on risk and escalation and there is evidence this has been utilised to escalate issues within the system and to Regional Quality Group.

The System Quality Group provides quality oversight in relation to public health outcomes and the wider determinants of health; and takes appropriate action as required to reduce Health Inequalities. The committee focuses on quality across pathways by receiving information against key performance trajectories and identifies quality issues, ensuring that they are acted upon.

The annual report provides many examples of how the ICB has improved local services. The Integrated Care Strategy identifies priorities and articulates the quality aims and objectives for the ICB. Evidence shows that services are either improving or have a clear trajectory/plan for improvement over the next 12 months. The ICB has made good progress on the continuing recovery of services following the Covid-19 pandemic. However, there were a number of areas where the ICB has faced particular challenges in making improvements over the last year.

Enabling effective UEC flow, including prompt discharge to community and social care, remains a significant challenge and further work is required to ensure that bed occupancy meets the required standard for 2023/24.

The East Midlands Coordinating Commissioning Team is hosted by Derby and Derbyshire ICB and manages the ambulance and NHS111 contracts with EMAS and DHU on behalf of all East Midlands ICBs. EMAS faced significant challenges in meeting performance standards throughout 2022/23 and this is an area of specific focus for the East Midlands ICBs in the coming year.

The ICB faced challenges in meeting cancer standards in 2022/23 and many of the recovery actions will continue to be implemented in 2023/24. It is expected that positive developments, in some areas including best practice timed pathways and transformation, will have a positive impact in the coming year.

Although the system has demonstrated significant improvement in long elective surgery waits, the ambition to have zero patients waiting more than 78 weeks by the end of March 2023 was not achieved. The ICB continues to receive support from NHS England for cancer and elective recovery.

The annual report highlights several pressures that have impacted on Mental Health performance during 2022/23. Learning Disability and Autism adult inpatient numbers were significantly over trajectory at year end and performance remains an outlier within the region.

The ICB has made progress in delivery of objectives for maternity services and there has been positive development of the equity and equality plan. Continued focus on delivering the building blocks for continuity of carer will be required, particularly for the most vulnerable groups. The ICB, in conjunction with the LMNS, is supporting University Hospitals of Derby and Burton FT with its response to a cluster of serious incidents which are undergoing review with HSIB.

There is a clear approach to working with people and communities, which satisfies the ICB's duty to conduct public involvement and consultation. The JFP highlights how critical it is to develop strategies underpinned by the view of people and communities. The ICB has developed and implemented a systematic approach to engagement which is underpinned by principles and frameworks to ensure that the experience and aspirations of local people are listened to. 'Derbyshire Dialogue' is an example of the system approach to engagement. It is a good example of engagement with the wider public and attracting people who would not otherwise engage with the NHS.

Section 3: Tackling unequal outcomes, access and experience

The ICB annual report sets out the steps being made to support the aims of improving health and reducing health inequalities. It is recognised that the NHS and its partners have faced a challenging time and the work in 2022/23 was key to developing a shared ambition to deliver a programme of health and care improvement for the people of Derby and Derbyshire.

The Integrated Care Strategy has identified indicators to reduce specific inequalities for adults by drawing on local data. This includes Hypertension case-finding to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

Through the ICS Digital and Data Programme, the ICB is engaged with the work led by the local authority through Rural Action Derbyshire and Citizens On-line to understand and mitigate challenges experienced by its citizens in accessing information and services via a digital route.

The ICB has been working on a population health management approach to understanding inequality in waiting times with the National Healthcare Inequalities Improvement Programme. Analysis relating to elective care has been completed and development of a plan is underway.

Whilst there are clear actions that the NHS is responsible for, through initiatives such as Core20PLUS5, wider system ownership and recognised importance of the prevention agenda is critical to helping the ICB in the longer-term address some of the demand and financial challenges faced by the system.

Section 4: Enhancing productivity and value for money

The ICB faced significant financial challenges in 2022/23 and reported a financial deficit of £31.3m, of which £18.6m related to an agreed technical adjustment, and £13.4m was the system's agreed stretch target.

The ICB did not deliver its efficiency plan in full and further consideration should be given to how system-wide transformation schemes can be fully realised. The ICB is clear on the risks that correlate with the triangulation between finance, activity and workforce increases.

There is evidence, within the JFP to the commitment to research, with a named ICB executive lead for research and innovation. The ICS has an established Derbyshire Research Forum and a research strategy will be developed in 2023/24 to embed an approach to research across the ICS. There is encouraging evidence of planning towards promotion and use of research including in social care as well as health care.

Section 5: Helping the NHS support broader social and economic development

The 'Anchor Charter' was formally approved in 2021/22 and was rolled out to organisations in 2022/23 to ensure that it was embedded in strategies and provided a framework for plans to benefit communities across Derby and Derbyshire. The ICB role as anchor institution within the wider anchor system is clear.

There is a well-established approach in the system with organisations seeking to use their collective influence to help address socio-economic and environmental factors, enabling and facilitating community wealth building, working together through the Derby and Derbyshire Health and Wellbeing Boards and the ICB.

The ICB and its partners have an agreed Green Plan and have established governance for delivery of the plans. The ICB has a Green executive sponsor at ICB Board level and established programme support. The ICB Annual report is exemplary in demonstrating the organisation's understanding of their role and responsibilities in climate change and the actions the organisation is taking to ensure it meets its obligations.

There is evidence provided as to how the ICB has contributed to the strategic priorities of the individual Health and Wellbeing Boards (HWBB). The annual report confirms that the ICB is fully engaged with the two HWBBs and is contributing to the delivery of the HWB strategy.

Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 073

Report Title	Integrated Care Board Risk Register Report – as at 31st August 2023							
Author	Rosalie Whitehead, Risk Management & Legal Assurance Manager							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Helen Dillistone, Chief of Staff							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – ICB Risk Register Appendix 2 – Movement in risk summary – August 2023							
Assurance Report Signed off by Chair	Not applicable.							
Which committee has the subject matter been through?	Finance and Estates Committee Population Health and Strategic Commissioning Committee System Quality Group Public Partnerships Committee Audit and Governance Committee							

Recommendations

The Board are requested to **RECEIVE** and **NOTE:**

- the Risk Register Report;
- Appendix 1, as a reflection of the risks facing the organisation as at 31st August 2023;
- Appendix 2, which summarises the movement of all risks in August 2023.

Purpose

The purpose of the Risk Register report is to appraise the ICB Board of the Risk Register.

Background

The ICB Risk Register is a live management document which enables the organisation to understand its comprehensive risk profile and brings an awareness of the wider risk environment. All risks in the Risk Register are allocated to a committee who review new and existing risks each month and agree the latest position on the risk, advise on any further mitigating actions that might be required, or approve removal of fully mitigated risks.

Report Summary

The report details the ICB's very high operational risks in order to provide assurance that robust management actions are being taken to mitigate them. It also summarises any movement in risk scores, new risks to the organisation and any closed risks.

Identification of Key Risks					
SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☒
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☒
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☒			☐

The report covers each strategic risk.

Financial impact on the ICB or wider Integrated Care System		
Yes ☒	No☐	N/A☐

Details/Findings	**Has this been signed off by a finance team member?**
Strategic risk SR4 describe the system's financial risk. *There is a risk that the NHS in Derby and Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move to a sustainable financial position and achieve best value from the £3.1billion available funding.*	Keith Griffiths, Executive Director of Finance

Have any conflicts of interest been identified throughout the decision-making process?

No conflicts of interest have been identified.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
There are no implications or risks which affect the ICB's obligations under the Public Sector Equality Duty.

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

Details/Findings
The ICB Corporate Risk register defines the risk to the achievement of Net Zero Targets and the delivery of the Derbyshire ICS Green Plan.

CORPORATE RISK REGISTER REPORT

INTRODUCTION

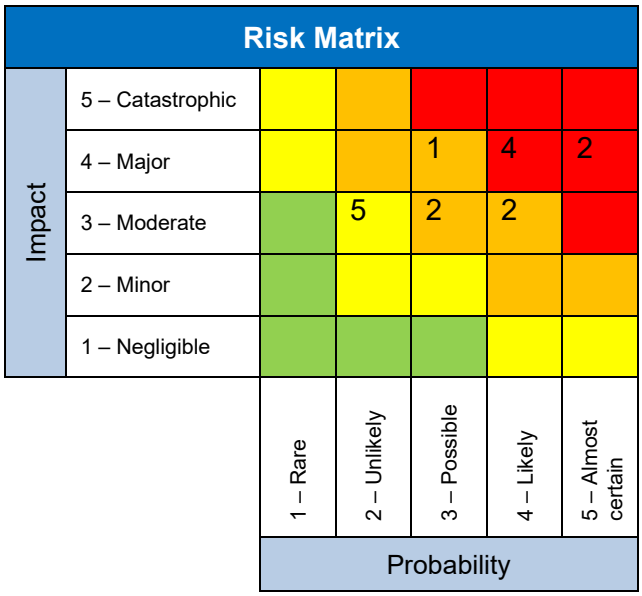
The purpose of this report is to present the ICB Board with the very high (red) operational risks from the ICB's Corporate Risk Register in order to provide assurance that robust management actions are being taken to mitigate them.

VERY HIGH OPERATIONAL RISKS

The ICB currently has 6 very high (red) operational risks in its Corporate Risk Register.

The table to the right shows the profile of the current risks scored for **all** operational risks on the Corporate Risk Register. Full details for each risk are described in Appendix 1.

A summary of the latest position regarding these risks is outlined in paragraph 2.1 below.



Very High (Red) Operational Risks

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
Risk 01	***Revised:*** *The Acute providers may not meet the new target in respect of 76% of patients being seen, treated, admitted or discharged within 4 hours by March 2024, resulting in the failure to meet the ICB constitutional standards and quality statutory duties.* **Update:** • As a result of the System Operational Resilience Group (SORG) refresh work, the weekly SORG meetings have been stood down and will be stood up when required going forward. The process for escalation has been agreed and shared. • A new specification for the Operational Co-ordination Centre (OCC) has been released by NHSE and is being worked through currently. Part of this will be improving reporting by implementing a smart system which is currently be explored by the Urgent and Emergency Care (UEC) and OCC team.	Overall score 20 **Very High** (5 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	• The OCC are also in the process of re-establishing the daily check in calls with system partners to support managing the day to day operations, improve system working and relationships as well as improve the intelligence shared from the OCC. July performance: • CRH reported 80.9% (YTD 79.3%) and UHDB reported 76.0% (YTD 73.4%). This would make both trusts compliant with the local 75% target. • CRH: The combined Type 1 and streamed attendances remain high, with an average of 235 Type 1 and 36 streamed attendances per day. • UHDB: The volume of attendances remains high, with Derby seeing an average of 208 Type 1 adult attendances per day, 101 children's Type 1s and 140 co-located UTC. • At Burton there was an average of 190 Type 1 attendances per day and 25 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average of 15 Resuscitation patients and 194 Major patients per day and Burton seeing 75 Major/Resus patients per day.		
Risk 03	***Revised:*** *There is a risk to the sustainability of individual GP practices (due to key areas detailed) across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.* **Update:** • The risk description has been refreshed, along with the mitigations and actions required to treat the risk. • The refresh considers that the risk for the ICB needs to be overarching. • Full details are provided in Appendix 1. **August update:** • A Primary Care Resilience meeting took place at the end of July 23 and a meeting is planned for September 23, this is to develop a system plan with a focus on primary care intelligence, core offer and support for practices in crisis. • Further work is taking place prior to the September meeting to develop a more advanced quality dashboard to support the early identification of practices who would benefit from additional support.	Overall score 16 **Very High** (4 x 4)	Population Health and Strategic Commissioning Committee

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
Risk 06	*Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.* **Update:** • As at month 4 the year to date (YTD) system performance was £12.9m deficit against £12.6m planned, driven by pressures not included in the plan such as industrial action, pay award shortfall, excess inflation and Microsoft licensing. There is a shortfall in efficiencies delivered YTD, which continues to be a concern. The Financial Sustainability Board has identified pay related efficiencies as a key focus area that will have a significant impact on delivering targets for 2023/24. • Delivery Board development includes commitment to objectives, receipt of and monitoring against financial allocations, proposals to strengthen accountability, workshops for September to derive medium term plans, and Public Health lead involvement to support heath inequalities. • Medium Term Financial Plans (MTFP) are currently being worked up. Task and finish groups will support alignment with workforce. Acute activity will also drive tools for triangulation of the MTFP. • The risks to delivering the 2023/24 financial plan are: o the planned rate of delivery of efficiencies increases substantially in the coming months. If the YTD shortfall continues and equally increases, the financial position will be difficult to recover. o The e-PMO is not fully populated for efficiencies, however work is underway to improve the information within ePMO including the reporting and role of Delivery Boards. o Ownership of financial plans at every level, particularly with quality, safety and risk. A Financial Sustainability Board has been established to address this. o A Capital programme is in place with risks. A strategy group is overseeing this. A strategy timeline has been agreed for December 2023. o A liquidity risk should cash releasing efficiency schemes not be delivered. A revised application to NHSE by CRH was put forward in early August, with a decision expected in late August.	Overall score 16 **Very High** (4 x 4)	Finance and Estates Committee

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
Risk 09	*There is a risk to patients on Provider waiting lists due to the continuing delays in treatment resulting in increased clinical harm.* **Update***:* • Each Provider is rated amber or green for one or more Key Performance Indicator (KPI). No indicator is rated red. The target to achieve all KPIs was Month 12 22/23. UHDB and DHcFT have previously both confirmed that the processes will be in place for each of the standards by the end of Q4, (M12 22/23). • The current risk rating remains at a very high score of 16.	Overall score 16 **Very High** (4 x 4)	System Quality Group
Risk 19	*Failure to deliver a timely response to patients due to excessive handover delays and transfer of patients to the appropriate care setting from Acute Hospitals. Risk of leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential significant levels of harm.* **Update:** • June 23 : Derby City disability direct launch scheme to support 10 Pathway Zero (P0) – return to usual place of residence discharges per week with transport and support at home. This is being well utilised. • July 23 : County LA transformation date has been delayed until January 2024. Currently reviewing options appraisal to look at alternative provision of emergency patients (P1) to support discharge through the Integrated Place Executive Board (IPE). • July 23 : Initial round of schemes to be funded through the health element of the Adult Social Care Discharge Fund (ASCDF) in July, approved schemes will be submitted to the IPE board for ratification before final approval at ICB for funding. Schemes include roles at CRH and UHDB to enable 7 day discharges, County scheme to support P0 discharges home with transport and support at home on discharge and mental health transformation to reduce length of stay in beds.	Overall score 20 **Very High** (5 x 4)	System Quality Group
Risk 20	*Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum*	Overall score 16 **Very High** (4 x 4)	System Quality Group

Risk Reference	Risk Description	Current Risk Score	Responsible Committee
	Seekers and unaccompanied asylum seekers with undertaking health assessments. **Update:** • There are ongoing challenges with contingency hotels. Hotel use continues. • Two of the city hotels are due to increase their room capacity to help met the demand of asylum seekers needing to be accommodated.		

RISK MOVEMENT

Appendix 2 details the movement of risk scores during August 2023 and the graphs detail the movement since April 2023. In summary:

One new risk was proposed in August 2023:

Risk 21: *There is a risk that contracts cannot fulfil or hand back due contracts due to the cost-of-living increases/inflation. The ICB would need to find an alternative provider and in some cases regarding health care this could be immediate, which would likely come at considerable additional cost.*

This risk is scored at a high 12 (probability 3 x impact 4) and is responsible to the Finance and Estates Committee. The Committee approved this new risk at the meeting held on 22nd August 2023.

CONCLUSION

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

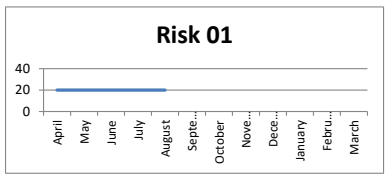
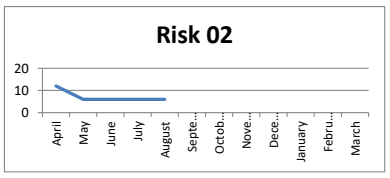
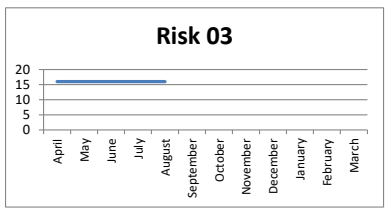
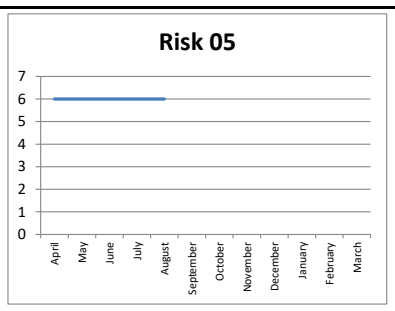
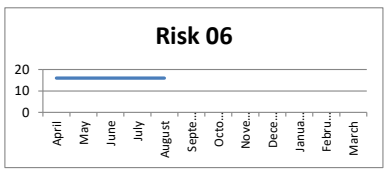
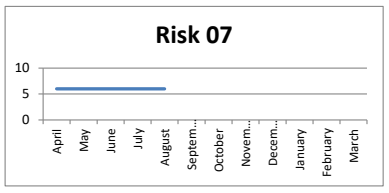
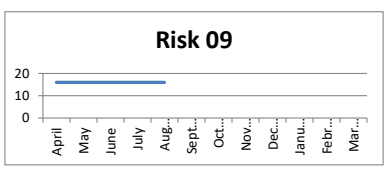
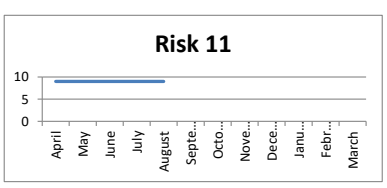
Appendix 1 - Derby and Derbyshire ICB Risk Register - as at August 2023

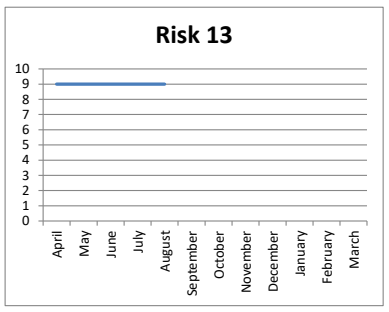
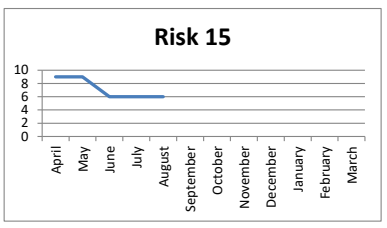
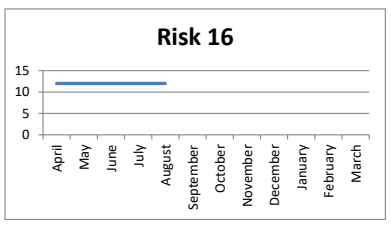
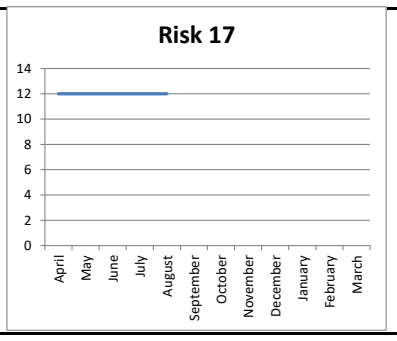
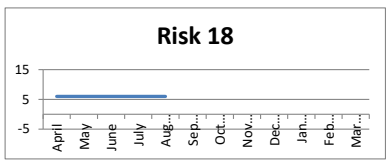
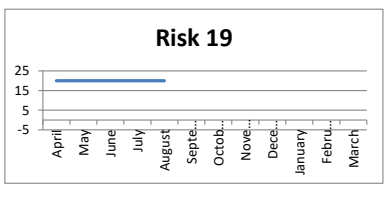
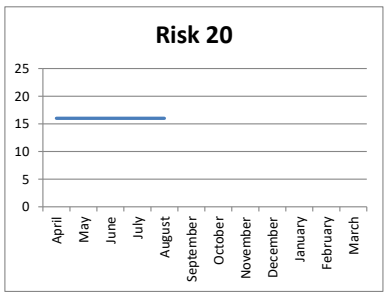
Derby and Derbyshire Integrated Care Board

Risk Reference	Year	Risk Description	Type - Corporate or Clinical	Responsible Committee	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
01	23/24	The Acute providers may not meet the new target in respect of 76% of patients being seen, treated, admitted or discharged within 4 hours by March 2024, resulting in the failure to meet the ICB constitutional standards and quality statutory duties.	Corporate/Clinical	System Quality Group	3	4	12	Governance: - The ICB are active members of the Derbyshire Urgent and Emergency Critical Care Board (UECC) which has oversight and ownership of the operational standards. The performance dashboard is under further development to allow greater scrutiny of performance and any areas of concern to be highlighted and acted upon accordingly. - Providers update the OPEL reporting website daily by 11am and can escalate concerns and requests for support via the ICB urgent care team in hours, or the on-call director out of hours. - All providers across the Derbyshire Health and Social Care System participate in the System Operational Resilience Group (silver command/tactical) and System Escalation Calls (gold command/strategic). These meetings are stood up by exception only. The purpose of this silver command level group is to co-ordinate and deliver the actions necessary to respond to significant issues which are affecting, or likely to affect, the functioning of an effective operation at a intra and inter sector level across the Health and Social Care System. This group reports into the System Escalation Group (SEC) which represents Gold Command. - The System Operational Coordination centre (OCC) was established on 1st December 2022, operation 7/7 8am-8pm with on-call cover to support out of hours. The updated Minimal Viable product for the OCC was released by NHSE on 18/07/2023 and is currently being reviewed and actioned by the UEC team. ECIST have visited the OHB site and shared their observations, expected to visit the RDH site within the next 4-6 weeks. NHSE have commissioned KPMG to review the midland systems to understand where the driving factors are, this review will help direct focus toward the improvements required in our system (if different to what our key priorities are).	Actions taken: - Review of the Directory of Services to ensure all appropriate patients go to UTCs rather than EDs - Identifying other failed pathway referrals that lead to unnecessary ambulance conveyances, forming a plan to remedy these. Use findings from the Rapid Improvement Fortnight MDT Hub to identify failed pathways and support future development of a Unscheduled Care Coordination Hub (UCCH). Next steps is to re-introduce this for the winter period as a minimum as Single Point of Access (SPoA). Awaiting a go live date. - Improving ambulance handover times through increased senior ownership within EDs and applying Releasing Time To Care principles in EMAS. The HALO role has been approved (2 x WTE), recruitment processes have commenced. - Taking a system-wide approach to Same Day Emergency Care working to increase same-day discharges to improve patient flow. - Same day emergency care (SDEC) and urgent treatment centre (UTC) pathways have been developed and continue to increase for EMAS to access, in order to reduce the number of patients directed to ED. - The OCC regularly review the OPEL dashboard to support their operational discussion and to give a full picture on their operational resilience, which supports the system to understand where the pressures are, the impact this has and actions required to support. A final version of the Opel framework has been shared by NHSE and is currently being reviewed by the OCC and UEC team. - Daily regional 10am calls continue as Operational Coordination Centre (OOC) and Regional Control Centre (RCC) calls. - As a result of the SORG refresh work, the weekly SORG meetings have been stood down and will be stood up when required going forward (process for escalation has been agreed and shared). A new specification for the OCC has been released by NHSE and is being worked through currently. Part of this will be improving reporting by implementing a smart system which is currently be explored by the UEC and OCC team. The OCC are also in the process of re-establishing the daily check in calls with system partners to support managing the day to day operations, improve system working and relationships as well as improve the intelligence shared from the OCC. - The Derby and Derbyshire Clinical Navigation Hub (DDCNH) is live. Evaluation is underway. Pilot currently due to end 30th November 2023. Winter planning for DDCNH underway. - Derby and Derbyshire Clinical Navigation Hub Plus DDCNH+) is utilised to support Industrial Action and Bank Holidays. - Review has taken place of the new draft UTC standards. Publication of the standards is awaited.	July 2023 performance CRH reported 80.9% (YTD 79.3%) and UHDB reported 76.0% (YTD 73.4%). This would make both trusts compliant with the local 75% target. CRH: The combined Type 1 & streamed attendances remain high, with an average of 235 Type 1 and 36 streamed attendances per day. UHDB: The volume of attendances remains high, with Derby seeing an average of 208Type 1 adult attendances per day, 101 children's Type 1s and 140 co-located UTC. At Burton there was an average of 190 Type 1 attendances per day and 25 per day through Primary Care Streaming. The acuity of the attendances was high, with Derby seeing an average of 15 Resuscitation patients & 194 Major patients per day and Burton seeing 75 Major/Resus patients per day.	5	4	20	5	4	20	3	3	9	On going	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Aug-23	Sep-23	Zara Jones Executive Director of Strategy and Planning	Amy Ward Interim Head of Operational Resilience and Performance Dan Merrison Senior Performance & Assurance Manager Jasbir Dosanjh
02	23/24	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the ICB.	Strategic/ Financial	System Quality Group	3	3	9	•The implementation date for Liberty Protection Safeguards (LPS) to replace DoL has been deferred by government, date for implementation not yet confirmed. The new code of practice is currently in draft and is out for public consultation until 07.07.2022 . Midlands and Lancs CSU continue to re-review and identify care packages that potentially meet the 'Acid Test' and the MCA/DoLS staff members are preparing the papers for the CCG to take to the Court of Protection as workload allows. • ICB DoL policy will be updated when the LPS Code of Practice is available. • The ICB is required to submit 100% health funded packages of care that meet the DoL threshold to the Court of Protection (CoP) authorisation, there is an agreement with the LA for the joint funded cases which the LA submit on both our behalves and charge the ICB 50% of the submission fee. There is a reputational risk to the ICB if found guilty of an unauthorised DoL for someone in receipt of CHC funding with associated compensation costs. • Due to the delay in the implementation of LPS the CCG will continue to make applications under the existing Re X process. There is still a backlog of cases that the Court of Protection have not yet processed. • The management oversight of this work is now the responsibility of the MLCSU DoL Lead following agreement between the former CCG and MLCSU. •The Designated Nurse for Safeguarding Adults sits on the CSU Operational Group where any issues in relation to this work are raised.	The Re X DoLS Options Paper was agreed by the December Governing Body meeting and is now being implemented. A further paper was taken Q & P to seek permission for the Safeguarding Adults Team and the CSU MCA/DoLS worker to submit Re X DoLS applications that are 100% funded directly to the CoP. This has been agreed and a framework for this to happen is in place. This has been agreed and a framework for this to happen is being developed and an account with the COP has been set up.	April: The government has pulled the plans for LPS to replace DoL. Therefore the ICB won't be picking up the role of responsible body under LPS so the planning that was needed for this and the risk will be able to be removed from the risk register in due course. The risk can be reviewed for closure once the ICB has seen the paper from the CSU regarding clearing the back log and the time frame for the ambers and greens to be with the court. It will be for the new government in 2024/25 to decide whether to resurrect the plans or not. Risk score probability and impact decreased accordingly for the current position. August: Further paper to be presented to SLT for a decision to be made on the options.	2	3	6	2	3	6	3	3	9	Sept 23	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Aug-23	Sep-23	Prof Dean Howells, Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding Michelle Grant, Designated Nurse Safeguarding Adults/MCA Lead
03	23/24	There is a risk to the sustainability of the individual GP practices across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care. **NEW Risk description:** There is a risk to the sustainability of individual GP practices (due to key areas detailed) across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.	Corporate	Population Health & Strategic Commissioning Committee	5	4	20	Governance processes to enable identification of potential practices requiring support. Development of Primary Care sub-group to fulfil the ICB delegation requirements in relation to Primary Medical care services. CQC and ICB summit/routine meetings to review and provide assurance re: individual practices who are due to or have had a CQC inspection resulting in a rating of requires improvement or special measures. Quality Assurance programme including development of data dashboard, triangulation of information, practice highlight report and Quality Assurance / system level framework development. Clinical Governance Leads network for sharing best practice. Primary Care Networks The Primary Care Networks will provide a way that practices can support each other in smaller groups and deliver services at scale. Over time this will provide a safe forum for practices to seek help from peers and another route for help for struggling practices. Primary Care Assurance and Delivery Board Establishment of Primary Care Assurance and Delivery Board to oversee the delivery of the Primary Care Transformation programme inclusive of estates, IT, workforce - additional roles, access. General Practice Provider Board Establishment of General Practice Provider Board to support a single, unified, appropriate representative and learned Derbyshire GP voice into the Integrated Care System.	Move existing actions across PLUS Workforce: Increasing numbers of GP's choosing salaried or locum roles rather partnership due to the additional workload and responsibilities expected. Changing population health needs: Growing population generally, as well as increasing number living over 65 with multiple complex medical conditions combined with changing public expectations around immediacy of service provision. Access: the ICB is supporting the General Practice Improvement Programme and Modernising General Practice Programmes. GPIP has an intermediate and intensive programme supported by the System Level Framework (internal quality assurance plan) ICB representative on the Midlands Region Primary Care (Access) Board. Patient expectations and the impact of modernising general practice may have a negative impact on practice stability. Estates: Development of a System Estates forum. Inadequate estates (esp. PCN). The expansion of ARRs roles is causing significant pressure on general practice estate with many practices / PCNs unable to house the number of staff employed. Information Technology: Transition funding is available to support the move to Modern General Practice Access Model (MGPAM). As per the National delivery plan for recovering access to primary care MGPAM has 3 components: Better digital telephony, Simpler online requests, Faster navigation, assessment and response Cloud Based Telephony Systems - 33 practices within DDICB have been identified as having analogue telephony systems in place .NHSE/I funding to move to CBT to support patient access (15 practices agreed to upgrade to Cloud Based Telephony, 4 practices declined to upgrade, 11 practices had already upgraded to Cloud Based Telephony and 3 practices missed deadline) Integration in general practice and system partners to use data consistently and constructively to help practices and the system understand patient need/behaviours and system response. Winter Resilience: ICB are implementing a process where PCN's are able to challenge their achievements which is in line with the commitment from the ICB to ensure that PCN income is maintained as a result of the support provided to the system during the challenging winter period, the ICB will aim to jointly understand and agree the position with the PCN. Practices ability to support winter system pressures.	August update: Primary Care Resilience meeting took place end of July 23 and a meeting is planned for September 23, this is to develop a system plan with a focus on primary care intelligence, core offer and support for practices in crisis. Further work is taking place prior to the September meeting to develop a more advanced quality dashboard to support the early identification of practices who would benefit from additional support.	4	4	16	4	4	16	4	3	12	On going	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Aug-23	Sep-23	Zara Jones Executive Director of Strategy and Planning	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care
05	23/24	If the ICB does not sufficiently resource EPRR and Business Continuity functions and strengthen emergency preparedness policies and processes it will be unable to effectively act as a Category 1 responder which may lead to an ineffective response to local and national pressures.	Corporate	Audit and Governance Committee	4	4	16	• ICB active in Local Health Resilience Partnership (LHRP) and relevant sub groups • On-call staff are required to receive Met Office Weather Alerts. These will be cascaded to relevant teams who manage vulnerable groups • Executive attendance at multi agency exercises. • Internal Audits have evaluated Business Continuity preparedness. • Derbyshire-wide Incident Plan in existence. • Joint Emergency Services Interoperability Protocol (JESIP) training made available to on-call staff • Staff member trained in Business Continuity and member of professional body • Staff member competent to train Loggists internally and there are sufficient number now trained • Derby and Derbyshire ICB represented on LHRP and LRF sub-groups including, HEPOG, Training and Exercising sub-group. Risk Assessment Working Group, LRF Tactical, Human Aspects and Derbyshire Health Protection Response Group. • On-call rota being revised to introduce two tier system with improved resilience • Comprehensive training undertaken for On-call staff to National Standards	• The On Call Forum has met regularly and has provided an opportunity to share experience and knowledge •The former CCG fully participated in the response to the COVID pandemic and submitted evidence to NHSEI as part of the 2020/21 EPRR National Core Standards • Continued collaborative working with Provider organisations and other stakeholders including the LRF and NHSEI Regional teams	May Due to the impact of Industrial Action planning and response there is a delay in updating and embedding new EPRR processes into the ICB as well as the delay to system planning due to the wider impact of industrial action on providers within Derbyshire. The resourcing of the team at the ICB is now complete with sufficient workforce to deliver the programme of work however this may be impacted upon if there is future periods of industrial action affecting the NHS June The resourcing of the ICB EPRR team is now in place however these posts are fixed term, this will lead to a risk in circa 12 months if substantive funding is not gained, re-assessment of the EPRR Core Standards will commence post 31st August 2023 with an anticipated submission of partially compliant for the ICB, this will lead into the work plan for the next 12 months to further improve/enhance the EPRR arrangements for the ICB and the system July The resourcing of the ICB EPRR team is now in place however these posts are fixed term, this will lead to a risk in circa 11 months if substantive funding is not gained, re-assessment of the EPRR Core Standards is ongoing with a confirmed unvalidated position of substantially compliant, this will be submitted on the 31st August 2023 and validated by NHS England Midlands. Following this the standards identified as partially compliant will be entered onto the Work Plan for the next 12 months, in the last month the ICB has conducted an internal BC exercise and system communications test with positive response in relation to our arrangements strengthening the assurance level of the ICB for responding to EPRR threats and Incidents. The new IRP is also out for comment encompassing all the learning since November 2022 this is to be tested in September 2023 with a target of being live by Autumn 2023 August Policies and plans approved at August meeting of Audit & Governance Committee allowing them to be submitted as evidence for the 2023 National Core Standards self assessment due by the deadline of 31 August. All relevant evidence has now been uploaded for the ICB. Providers are in the final stages of uploading theirs and dates have been set for the "confirm and challenge" process. A further out of hours test of communications took place in August with overall good response and any lessons learned forwarded to providers. Industrial action continued throughout the month with Junior Doctors and Consultants with the ICB leading actions to mitigate the impact.	2	3	6	2	3	6	2	2	4	On going	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Aug-23	Sep-23	Helen Dillistone - Chief of Staff	Chris Leach Head of EPRR
06	23/24	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.	Finance and Estates Committee	Finance	4	4	16	Aug update: Detailed risk log continues to progress to take smaller actions to mitigate the overriding risk. These include a focus on estates and digital strategies, System risk ownership, and improved reporting on ePMO. Development of the Delivery Boards' objectives, including their role in financial efficiency delivery. The System moves towards understanding its underlying position and how this impacts a triangulated Medium Term Financial Plan.	Aug update: System IYTD and forecast outturn continues to be monitored weekly. Delivery of the 23/24 is reliant on planned cash releasing efficiencies. Financial Sustainability Board has been established to support this. Improving the Delivery Boards' understanding of the financial plans, and their access to BI, to support the development of efficiency schemes alongside organisations CIPs for system benefits realisation. Ensure all relevant stakeholders included in the planning process, for triangulation and consistency.	Aug Update: At Month 4 YTD system performance was £12.9m deficit against £12.6m planned, driven by pressures not included in the plan such as industrial action, pay award shortfall, and excess inflation, and Microsoft licensing. There is a shortfall in efficiencies delivered YTD., which continues to be a concern. The FSB has identified pay related efficiencies as a key focus area that will have a significant impact on delivering targets for 2023/24. Delivery Board development includes commitment to objectives, receipt of and monitoring against financial allocations, proposals to strengthen accountability, workshops for September to derive medium term plans, and Public Health lead involvement to support heath inequalities. Medium term financial plans (MTFP) are currently being worked up. Task and finish groups will support alignment with workforce. Acute activity will also drive tools for triangulation of the MTFP. The risks to delivering the 2023/24 financial plan are: - the planned rate of delivery of efficiencies increases substantially in the coming months. If the YTD shortfall continues and equally increases, the financial position will be difficult to recover. - e-PMO not fully populated for efficiencies, however work is underway to improve the information within ePMO including the reporting, and role of Delivery Boards. - ownership of financial plans at every level, particularly with quality, safety and risk. A Financial Sustainability Board has been established to address this. - capital programme in place with risks. Being overseen by a strategy group. Strategy timeline agreed for Dec 23. - liquidity risk should cash releasing efficiency schemes not be delivered. A revised application to NHSE by CRH was put forward early August; decision expected late August.	4	4	16	4	4	16	2	3	6	On going	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Aug-23	Sep-23	Keith Griffiths, Chief Financial Officer	Darran Green, Acting Operational Director of Finance Donna Johnson Acting Assistant Chief Finance Officer
07	23/24	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	Corporate	Audit and Governance Committee	4	3	12	• Staff files from Scarsdale site are to be moved to a locked room at the TBH site. This is interim until the new space in Cardinal is available. There are still staff files at Scarsdale and Cardinal Square they are safely secured. Due to Covid-19 the work has been placed on hold as staff are all working from home. • EA's/PA's at Cardinal Square have been contacted and a list is being pulled together of names and files (current or leavers) held ensuring that these are all securely saved in locked filing cabinets. Work is being completed at Cardinal Square by staff who do regularly attend site to compile the list and confirm who may be missing. • Consider an electronic central document management system (DMS) This action remains once we are in a position to move the project forward.	• A project team has been organised to work on the risks, ensuring that a standardised format and tick list is developed of the relevant paperwork to keep in HR files. This piece of work will take a significant amount of time before the ICB can even consider looking at a document management system. • Information Governance are currently working to secure a contract for archiving, this will ensure that staff leavers files are securely archived with the correct paperwork. • Project team are obtaining guidance with other NHS organisations to consider a document management system.	January: Audit of HR files completed and the large majority of employees have an up to date electronic HR file. HR to review the paper HR files for current employees and resource required to scan any documents not held electronically onto the network. Leavers file to be sent to the ICB archive company Restore for storage. Risk score to remain unchanged. May: Limited progress due in part to absences within the HR team. June: Limited progress due in part to workload within the HR team. July: No change, work in progress. August - No change - Limited progress due in part to workload and holiday absences within the HR team.	2	3	6	2	3	6	1	2	2	Sep-23	SR8	Aug-23	Sep-23	Linda Garnett, Interim ICB Chief People Officer	James Lunn, Head of People and Organisational Development
09	23/24	There is a risk to patients on Provider waiting lists due to the continuing delays in treatment resulting in increased clinical harm.	Clinical	System Quality Group	4	4	16	• Risk stratification of waiting lists as per national guidance • Work is underway to attempt to control the growth of the waiting lists – via MSK pathways, consultant connect, ophthalmology, reviews of the waiting lists with primary care etc. • Providers are providing clinical reviews and risk stratification for long waiters and prioritising treatment accordingly.	• An assurance group is in place to monitor actions being undertaken to support these patients which reports to PCDB and SQP • Providers are capturing and reporting any clinical harm identified as a result of waits as per their quality assurance processes • An assurance framework has been developed and completed by all providers the results of which will be reported to PCDB • A minimum standard in relation to these patients is being considered by PCDB • Work to control the addition of patients to the waiting lists is ongoing	• Monthly groups are in place with all 4 providers represented • Completion of assurance framework quarterly is undertaken by all providers and reports to PCDB quarterly, and to SQG • Identified harm is reported on STEIS and all providers are monitoring this • A risk stratification tool is being piloted by providers March : More information available as Q3 paper goes to SQG in April. Propose decrease risk score - await decision at SQG. Decision following SQG held on 04.04.23: There is further work to be undertaken to standardise the process used by both acute providers and further work to be done across DCHS before risk score reduction can be considered. April: No change this month. May: No changes this month. Awaiting Qtr. 4 feedback and discussion at SQG post feedback report. June 2023: Q3 data from paper to QPC - Every Provider is rated amber for one or more Key Performance Indicator (KPI). No indicator is rated red. However, a common theme that needs exploring in future tracking is Root Cause Analysis (RCA) and Harm Review and Equal Access to All. The target to achieve all KPIs is Month 12 22/23. CRH, UHDB and DHcFT have all confirmed that the processes should be in place for each of the standards by the end of Q4, Month 12 22/23. In terms of completing all processes by Q4 DCHS have undertaken the implementation of the risk stratification and harm review process as an iterative process whereby the SOPs are being embedded in the highest priority areas first with plans to roll out to wider services over time (priority services are wound care, podiatry, and community nursing). DCHS are hopeful that the SOP implementation within the priority areas will be complete by Q1 2023-24. August 2023 Each Provider is rated amber or green for one or more Key Performance Indicator (KPI). No indicator is rated red. The target to achieve all KPIs was Month 12 22/23. UHDB and DHcFT have previously both confirmed that the processes will be in place for each of the standards by the end of Q4, (M12 22/23). Current risk rating remains 16	4	4	16	4	4	16	3	2	6	Sept-23	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Aug-23	Sep-23	Prof Dean Howells, Chief Nursing Officer	Letitia Harris Clinical Risk Manager Lisa Falconer Head of Clinical Quality (Acute)
11	23/24	If the ICB does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change	Corporate	Audit and Governance Committee	4	4	16	Helen Dillistone, Net Zero Executive Lead for Derbyshire ICS NHSE Memorandum of Understanding in place NHSE Midlands Greener Board established and meets monthly Derbyshire ICS Greener Delivery Group established and meets bi monthly NHSE Midlands regional priorities identified Derbyshire Provider Trust Green Plans approved by individual Trust Boards and submitted to NHSE Derbyshire ICS final draft Green Plan has been approved through the Derbyshire Trust Boards during March and May. The CCG Governing Body approved the Green Plan on the 7th April 2022. Approved ICS Green Plan submitted to NHSEI end March 2022 and confirmed CEO and GB sign off 7th April 2022. Derbyshire ICS Green Plan Action Plan in place and priorities identified for 2022/23. Development of Derbyshire ICS Green Plan Dash Board. Monthly Highlight Reporting to NHSE in place. Quarterly review meetings with NHSE Green Director Lead	Helen Dillistone, Net Zero Executive Lead for Derbyshire ICS NHSE Memorandum of Understanding in place NHSE Midlands Greener Board established and in place Derbyshire ICS Greener Delivery Group established and in place NHSE Midlands regional priorities identified Derbyshire Provider Trust Green Plans approved by individual Trust Boards and submitted to NHSE Derbyshire ICS final draft Green Plan will be approved through the Derbyshire Trust Boards during March and approved by the CCG Governing Body on the 7th April 2022. Derbyshire ICS final draft Green Plan has been approved through the Derbyshire Trust Boards during March and May. The CCG Governing Body approved the Green Plan on the 7th April 2022. Approved ICS Green Plan submitted to NHSEI end March 2022 and confirmed CEO and GB sign off 7th April 2022	August 2023 - MOU Funding commitments approved at the ICS Greener Group Feb 2023. Lithihare Scheme Project launched 12th June. Air Quality Project with 2 Derbyshire School in process and will be evaluated in the summer ICS Dashboard developed for measuring performance and reduction in carbon emissions Quarter 2 - August 23 Highlight Reports reported to NHSE SRO Review Meeting with NHSE took place May 2023 and take place quarterly. NHSE Memorandum of Understanding for 2023/24 detailing 23/24 priorities expected from NHSE. The current risk score 3x3 = high 9, is reasonable this cannot be reduced until the ICS starts to achieve its targets through the action plan for 2023/24. The risk does not require an escalation in risk score, the score reflects the ICB position.	3	3	9	3	3	9	3	2	6	Mar-24	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Aug-23	Sep-23	Helen Dillistone - Chief of Staff	Suzanne Pickering Head of Governance

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
13	23/24	Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties.	Public Partnerships Committee	Corporate	4	4	16	• Detailed work programme for the engagement team • Clearly allocated portfolio leads across team to share programmes * Assessment of transformation programmes in ePMO system underway to quantify engagement workload. January: Ongoing assessment of ePMO programmes nearing conclusion. January: System comms leads have agreed distributed leadership approach to assessing work programmes within delivery boards and other system groups. Mapping to take place January & February, with review session planned for 2 March.	•Implementation of planning tool to track and monitor required activity, outputs and capacity •Links with e-PMO to embed PPI assessment and EIA processes into programme gateways •Distributed leadership across system communications professionals being implemented to understand delivery board and enabler requirements •Establishment of workstream approach to main programme areas to take place July/August 2022 to ensure prioritisation of projects is clear across system.	•Wrike planning tool in training phase (31.5.22); implementation during July/August 2022 •Agreement (8.6.22) on positioning of PPI assessment and EIA tools within e-PMO gateway processes, for implementation July 2022. Access to system granted to engagement team; training on system and assessment of activity to start August 2022. •Distributed leadership agreement among system communications group; paper to System Leadership Team (8.7.22) to confirm arrangements and flag risks deferred to future meeting. PPI Guide agreed at Engagement Committee, Senior Leadership Team and presented at Team Talk - will be developed into training programme with the aim of standardising the approach to engagement progression and equipping project teams to progress their own schemes with technical expertise provided from the engagement team. Revision and refresh of Communications and Engagement Team portfolios and priorities undertaken July 2022. April: Mapping due to take place January & February has been delayed due to other system communications priorities, including industrial action. This will be revisited at the System Communications Group meeting on 4th May. May: Distributed comms leadership reviewed, updates on progress received for P&C Committee, Children's, Planned Care & Digital. Further discussions within ICB on strategic long term conditions priorities. Discussions to assess priorities continue through May with stock take in June. May: ICB structure conversations continue in line with running cost allowance requirements. Protection of existing resource likely, no scope for growth. May: Working with regional ICB colleagues to confirm resource options for delivery of POD communications and engagement and region-wide engagement exercises. June: Workshop with regional ICB communications leads looking at best practice resourcing models and comparing impact of RCA reductions, seeking to focus on collaborative/do once approach. July/August 23: Ongoing assessment of priorities, in line with newly emerging 5-year plan and IC strategy. Ongoing anticipation of ICB structure outcomes to seek to stabilise team and confirm roles. Temporary appointments within the engagement team risk adding to the capacity challenge, with ongoing instability due to delays with the ICB structures development. There is a risk of loss of staff in the autumn/winter 2023 period which will compound the capacity risk. Similarly, vacancies arising within the Communications Team cannot be advertised whilst the ICB structure discussions continue, further compounding capacity risk. The combination may result in the need to increase the score of this risk.	3	3	9	3	3	9	2	2	4	Jan-24	SR5 SR6 SR7 SR8 SR9	Aug-23	Sep-23	Helen Dillistone - Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement
15	23/24	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	Audit and Governance Committee	Corporate	4	4	16	The former CCG team worked closely with the NHSEI team to understand current and future operating model, the work transferred, the staff required and the governance arrangements. This work enabled understanding of the detail of the transfer and shaped the transfer so that capacity could be ensured or better understand and plan for any gap. If a gap was identified, this would be escalated within the ICB for further discussion. Discussing were taking place around the possibility of the existing team remaining as presently - as a centrally managed team. This would limit the risk that the team fragments and any loss of economy of scale.	Pre-delegation assurance framework process September 2022. It is likely that the NHSEI East/West Midlands team will be retained but risks remain re potential contractual costs and capacity. Derbyshire is not required to take on delegated functions until 2023.	March: Joint Working Agreements have been drafted and are due to be signed by the end of this month, one to reflect arrangements between NHSE and ICBs and a second to reflect working arrangements between ICBs in the East Midlands. Discussions are taking place between NHSE and host ICBs, however the operational details of how the host will work with each ICB have not yet been confirmed. April: The operational details of the working relationship between the East Mids. ICBs are not yet confirmed in order to be able to assess any impacts on capacity or resource. Risk score remains the same. June: Probability decreased to 2, on the basis that Notts ICB will be the host organisation and a Standard Operating Framework has been shared. The current understanding is that our ICB will not require additional resource as a result of the delegation of pharmacy, optometry and dental services. However, specialised services are due to be delegated in April 2024 and work is currently underway to understand any impacts from that. The score will increased at that time if appropriate August : Position remains the same.	3	2	6	2	3	6				Apr-24	SR4 SR5 SR6 SR7 SR9	Aug-23	Sep-23	Helen Dillistone - Chief of Staff	Chrissy Tucker - Director of Corporate Delivery
16	23/24	With the review of ICB structures there is risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being.	Audit and Governance Committee	Corporate	4	3	12	Regular communication with staff. Sharing information with staff as soon as this became available. Continuation of regular 1 to 1 wellbeing checks. Compliance with Organisation Change & Redundancy Policy.	No significant change in sickness absence.	May: Continued promotion of wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider - Confidential Care. Promotion of new NHS Looking after your team's health and wellbeing guide, Mental Health Awareness week (including activities to improve mental wellbeing and free apps/resources). Sickness absence levels have continued to reduce again in April to around 1.6%. June: Continued promotion of wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider - Confidential Care. Sickness absence levels increased in May to 2.65%. July: Promotion of JUCD wellbeing self care pack, Body MOTs as well as wellbeing offers, activity timetable, mental health first aiders and access to our employee assistance provider - Confidential Care. Sickness absence levels reduced to 2.3%. August: Promotion of wellbeing offers and activity timetable at Team Talk. Continued promotion of mental health first aiders and our employee assistance provider - Confidential Care. Sickness absence levels increased in July to 2.86%.	4	3	12	4	3	12	3	2	6	Sep-23	SR4 SR5 SR6	Aug-23	Sep-23	Linda Garnett Interim ICB Chief People Officer	James Lunn, Head of People and Organisational Development
17	23/24	Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised.	Public Partnerships Committee	Corporate	4	3	12	The system has an agreed Communications & Engagement Strategy which continues to be implemented. This includes actions supporting broadening our communications reach across stakeholders, understanding current and future desired relationships and ensuring we are reaching deeper into the ICB and components parts to understand priorities and opportunities for involvement. The Public Partnership Committee is now established and is identifying its role in assurance of softer community and stakeholder engagement. Communications and Engagement Team leaders are linked with the emerging system strategic approach, including the development of place alliances, seeking to understand the relationships and deliver an improved narrative of progress. April: Engagement approach in IC Strategy underway with sessions during May. JFP engagement and stakeholder management approach now in development. August: JFP engagement approach remains in development.	*- Continued and accelerated implementation of the Communications and Engagement Strategy actions plan priorities across stakeholder management, digital, media, internal communications and public involvement. *- Continued formation of the remit of the Public Partnership Committee *- Key role for C&E Team to play in ICB OD programme *- Continued links with IC Strategy development programme *- Continued links with Place Alliances to understand and communicate priorities	April: JFP engagement planning now underway, as routine member of JFP Working Group. April: IC Strategy engagement underway, with sessions being promoted in May for each area of focus. May: IC Strategy engagement sessions being delivered. Summary version of strategy in production, along with public relations plan to share strategy among stakeholders. May: Partner engagement and governance routes being plotted for Joint Forward Plan. June: Briefing to City HOSC secured; progression on stakeholder management database; CEO MP briefings to recommence summer 2023. Ongoing engagement planning to support IC Strategy and NHS JFP. July/August: JFP published; engagement approach in development with aim to commence foundation discussions on change with wider stakeholder groups in autumn. Place Alliance communications and engagement approach progressing with case study development. Engagement frameworks development progressing, most notably insight framework pilots to inform change programme and strengthen decision-making.	4	3	12	4	3	12	3	2	6	Jul-24	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8	Aug-23	Sep-23	Helen Dillistone - Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement
18	23/24	There is a risk of patient harm through existing safeguarding concerns due to patients being able to pro-actively view their medical record from 1st November 2022. This is a result of national changes to the GMS contract required by NHSEI.	Population Health & Strategic Commissioning Committee	Primary Care	4	3	12	Information cascaded to all practices detailing processes needing to be put in place before 1st November. Signposting to National webinars and hosting of local webinar. Local Information cascaded including contact details for support through NECS CSU. Work with Derbyshire LMC & FAQs circulated including a range of options for practices prior to 1st November including the application of a system code which if applied prior to the 1st of November can block patient access - to no records (practice ready for go live date) /to all records/ to patients were records still need to be reviewed. Linked with JUCD Communications team and patient facing information developed.	The GMS Contract has included Patient access to medical records since 2019, this has not been enforced, NHSEI communicated with systems during September 2022 to inform that this would go live on1st November 2022. Nationally, patients registered with practices using System One and EMIS IT Systems will have full access to their prospective medical records from the 1st of November 2022 (Access to retrospective records will be sought through existing processes). All records where there is a potential for patient harm to occur as a result of viewing the record need to be reviewed before the 1st of November 2022; all records where there is an existing safeguarding concern need to be reviewed There remain a number of uncertainties re; what will be viewable and when including Secondary Care Communications/ Local Authority Communications A survey has been circulated asking for practices to inform which option they have adopted in order to target support to those practices who require support. To continue to communicate updates to general practice. Working with communications - circulate information to support patients and practices.	November/December: Surveyed all General Practice and as of 25th November 17 practices have applied the code not to share for over 80% of their patient population. As part of the survey practices have submitted a plan to support increasing the level of access for their patients. January 2023 - NHSE have requested practices to submit plans for access from those practices who have applied code 104 to over 80% of their population, TPP will be enabling access as of 1st February, practices have again received the option to pause if required. No change to risk score. February 2023 NHSE have requested practices to submit plans for access from those practices who have applied code 104 to over 50% of their population, TPP will be enabling access as of 1st February, practices have again received the option to pause if required. No change to risk score. April: GP feedback has been gained at Clinical Governance meeting. There were no risks highlighted from those present. Across the ICB, 21 practices have code 104 applied to over 50% of their patients. The ICB will follow up these practices and signpost support from NECS. The risk will remain until all practices are offering access to patient records for more than 50% of their patients. Risk probability decreased from 3 to 2. June/July: GP feedback has been gained at Clinical Governance meeting. There were no risks highlighted from those present. Across the ICB, 20 practices have code 104 applied to over 50% of their patients. The ICB will follow up these practices and signpost support from NECS. The risk will remain until all practices are offering access to patient records for more than 50% of their patients. August 2023 - As of October 31st all practices are required to allow patients access to their records. The Primary Care Quality Team have sent further updates to all practices in August with links for support through EMIS and NECS.	2	3	6	2	3	6	2	2	4	Sep-23	SR1 SR4 SR8 SR9	Aug-23	Sep-23	Zara Jones Executive Director of Strategy and Planning	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care
19	23/24	Failure to deliver a timely response to patients due to excessive handover delays and transfer of patients to the appropriate care setting from Acute Hospitals. Risk of leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential significant levels of harm.	System Quality Group	Clinical	5	5	25	1. Discharge Flow workstream 2. P1 Strategy events 3. POG actions re: Surge beds 4. Focussed work re: Stockport discharges 5. 100 day challenge 6. SEC and SORG interventions. 7. Overview of HHO delays and robust scrutiny of progress to delivery improvement trajectories. Performance management of workforce and abstraction rates to ensure necessary resources are in place to respond to demand 9. Implementation of EMAS Hospital Handover Harm Prevention Tool at Acute Trusts. 9. Ongoing work in commissioning Same Day Emergency Care and direct access to specialities such as surgery, gynaecology and urology and community providers implementing urgent two-hour community response to suitable patients, thereby increasing the number of patients who can be safely treated in their own homes. 10. Regular monitoring of Actions and risk by CQRG. 11. Local system governance structures to manage difficult decisions: Derbyshire System pressures quality review panel. Decisions and discussions held at SORG. 12. HALO - recruited to support both Acutes and crews with handover delays, directing appropriate patients to SDEC, supporting pinning off etc 13. Funding for derby city 'Disability Direct home from hospital' scheme to transport and support P0 discharges home : will reduce delays for patients awaiting discharge and reduce readmission rates as patients supported once discharged.	System actions to reduce hospital handover delays. System urgent care improvement action plans. County Council re-launch of pathway 1 offer to improve access, capacity and flow. Consultation ends 7th May 23, planned start date Oct 23. Start date now delayed until Jan / Feb 24. Options appraisal to provide P1 discharge support being developed as cost pressure for system Pathway 1 work commenced with High Peak Locality focusing on LOS & opportunities to integrate health and social care. Launch date for integrated model 1st July. Plan to roll out to Amber Valley. Pathway 1 strategy : engaged with system leads regarding strategy. Operational workshops to look at transformation starting May 23, Strategic leads meeting to agree priorities May 23 Data : OPTICA tool to support with acute discharge planning to be implemented. Project commenced 23, due to be rolled out May 23 delayed due to integration with LA needed. Currently working on solution Strength based Approach to be rolled out at UHDB Medicine ward from November. Training completed March 23. Development of Model ward 311 UHDB with clarity of roles and outcomes and PDSA of impact ASC discharge fund investment : projects invested in which will increase number of discharges to support people to return home. Approval for initial projects to support discharge of patients back home including VCSE enhancement Pathway 3 - D2A pathway for those requiring Nursing care commenced – 4 beds block purchased. Process of admission and PDSA reviews in place Brokerage function at CRH and UHDB being reviewed to move to one process to discharge to care home from acute. ECIST - will be visiting the RDH site and providing recommendations and supporting the trust to improve their Type 1 performance, handover delays and reduce their bed occupancy levels Work ongoing to develop a memorandum of understanding (MOU) which sets out the commitment between ICB, Acute Providers, NHSE and Ambulance Trusts to support ambulance crews ending their shift on time, when in attendance at busy emergency departments with ambulance handover delays. Recruited 1 x HALO, start date to be agreed.	April 23 : plans to be agreed to allocate ASC discharge fund to support increase in discharges April 23 : discharge reporting review. Move to weekly update reporting May 23 : OPTICA discharge support tool to improve data on delays and flow May 23 : ASC county consultation ends and transformation of P1 services can commence May 23 : recruitment to pathway 1 team (DCHS) to support discharge, funded through DCHS May 23 : workshops to transform Pathway 1 process and flow commence with PDSA improvement cycle June 23 : Derby City disability direct launch scheme to support 10 P0 discharges per week with transport and support at home. This is being well utilised July 23 : County LA transformation date delayed until Jan 24. Currently reviewing options appraisal to look at alternative provision of P1 to support discharge through IPE (Integrated Place Exec board) July 23 : initial round of schemes to be funded through the health element of the ASCDF (Adult Social Care discharge fund) in July, approved schemes to IPE board for ratification before final approval at ICB for funding. Schemes include roles at CRH and UHDB to enable 7 day discharges, County scheme to support P0 discharges home with transport and support at home on discharge, Mental health transformation to reduce Length of stay in beds. August - No update	5	4	20	5	4	20	2	5	10	September 23	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8 SR9	Aug-23	Sep-23	Dr Chris Weiner Chief Medical Officer	Jo Warburton Dan Webster
20	23/24	Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum Seekers and unaccompanied asylum seekers with undertaking health assessments.	System Quality Group	Clinical	4	5	20	Local Partners continue to work closely together and meet regularly with the Home Office, SERCO and the East Midlands Councils Strategic Migration Team to discuss any issues, concerns or points to escalate in regard to the Contingency Hotels. Health and Social Care are providing services to meet the needs of the service users placed within our area.	Regular meetings with the Home Office, Serco and East Midland Councils Strategic Migration team to discuss concerns/ issues identified and points to escalate further – meetings have been taking place weekly and now going to be fortnightly DDICB are working closely with Primary Care Networks/ GP practices to commission/ deliver Primary Care Services to asylum seekers placed with our geographical area - all hotels and IAA have GP practice cover Both Health and Social Care services to continue to meet the statutory needs of looked after children - although under significant pressure Looked after children services are being offered All partners working closely together to try and meet the needs of asylum seekers and raise any concerns to the Home Office, SERCO and East Midlands Councils Strategic Migration team – concerns/ issues identified are being raised via meetings. Formal letters of concern have also been written to the Home Office.	update 24/07/23 - ongoing concerns with the use of contingency hotels - 4 of the 7 settings - two in the city and two in the county will be increasing the capacity to help come with the demand of asylum seekers needing to be placed. Also there are meetings taking place with Serco and Home Office in regard to a setting in Derbyshire being used as dispersal accommodation - this will have a potential capacity of 247. in light of the recent developments there is no change in the risk - as concerns are ongoing. 21/08/22 Ongoing challenges with contingency hotels- Hotel use continues. Two of the city Hotels are due to increase their room capacity to help met the demand of asylum seekers needing to be accommodated.	4	4	16	4	4	16	3	3	9	December 23	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8	Aug-23	Sep-23	Prof Dean Howells, Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding: Children/ Lead Designated Nurse for Safeguarding Children
NEW RISK 21	23/24	There is a risk that contracts cannot fulfil or hand back due contracts due to the cost-of-living increases/inflation. The ICB would need to find an alternative provider and in some cases regarding health care this could be immediate, which would likely come at considerable additional cost.	Transformation and Investment Committee	Finance	4	4	16	Understand financial pressures facing our providers. Maintain Contract Database Proactive Procurement	Contractors will at short notice inform the ICB that they can no longer fulfil their contractual obligations. This risk should cover a wide range of contracts from the supply of health care (General Medical practitioners and Individual care packages) to the supply of goods and services. Maintain a close working relationship with key with providers. Use contract database to understand which contracts are due for renewal and plan well ahead. Work closely with colleagues in A&GEM Procurement team to ensure we are aware of latest information available in the various markets the ICB works in	Proposed new risk for August 2023.				3	4	12	2	3	6	Ongoing	SR1 SR2 SR3 SR4 SR5 SR6 SR7 SR8	Aug-23	Sep-23	Zara Jones Executive Director of Strategy and Planning	Lana Davidson Senior Contract Manager

Appendix 2 - ICB Risk Register - Movement - August 2023

Risk Reference	Risk Description	Previous Rating (July)			Residual/ Current Risk Rating (August)			Movement - August	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
01	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the ICB constitutional standards and quality statutory duties.	5	4	20	5	4	20	⟺	As a result of the SORG refresh work, the weekly SORG meetings have been stood down and will be stood up when required going forward (process for escalation has been agreed and shared).	Zara Jones Executive Director of Strategy and Planning	Catherine Bainbridge, Head of Urgent Care Dan Merrison Senior Performance & Assurance Manager	
02	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the ICB.	2	3	6	2	3	6	⟺	Further paper to be presented to SLT for a decision to be made on the options.	Prof Dean Howells Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding Michelle Grant, Designated Nurse Safeguarding Adults/MCA Lead	
03	There is a risk to the sustainability of the individual GP practices across Derby and Derbyshire resulting in failure of individual GP Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care.	4	4	16	4	4	16	⟺	Primary Care Resilience meeting took place end of July 23 and a meeting is planned for September 23, this is to develop a system plan with a focus on primary care intelligence, core offer and support for practices in crisis.	Zara Jones Executive Director of Strategy and Planning	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care	
05	If the ICB does not review and update existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known and unknown risks to the Derby and Derbyshire ICB, which may lead to an ineffective response to local and national pressures.	2	3	6	2	3	6	⟺	Policies and plans approved at August meeting of Audit & Governance Committee allowing them to be submitted as evidence for the 2023 National Core Standards self assessment due by the deadline of 31 August.	Helen Dillistone - Chief of Staff	Chris Leach, Head of EPRR	
06	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position.	4	4	16	4	4	16	⟺	At Month 4 YTD system performance was £12.9m deficit against £12.6m planned, driven by pressures not included in the plan such as industrial action, pay award shortfall, and excess inflation, and Microsoft licensing. There is a shortfall in efficiencies delivered YTD., which continues to be a concern.	Keith Griffiths, Chief Financial Officer	Darran Green, Acting Operational Director of Finance	
07	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to the former Derby and Derbyshire CCG this data is not held consistently across the sites.	2	3	6	2	3	6	⟺	Limited progress due in part to workload and holiday absences within the HR team.	Linda Garnett Interim Chief People Officer	James Lunn, Head of People and Organisational Development	
09	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	3	4	16	3	4	16	⟺	Each Provider is rated amber or green for one or more Key Performance Indicator (KPI). No indicator is rated red. The target to achieve all KPIs was Month 12 22/23. UHDB and DHcFT have previously both confirmed that the processes will be in place for each of the standards by the end of Q4, (M12 22/23). Current risk rating remains 16.	Prof Dean Howells Chief Nursing Officer	Letitia Harris Clinical Risk Manager	
11	If the ICB does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change	3	3	9	3	3	9	⟺	The risk score cannot be reduced until the ICS starts to achieve its targets through the action plan for 2023/24.	Helen Dillistone Chief of Staff	Suzanne Pickering Head of Governance	

Risk Reference	Risk Description	Previous Rating (July)			Residual/ Current Risk Rating (August)			Movement - August	Rationale	Executive Lead	Action Owner	Graph detailing movement
		Probability	Impact	Rating	Probability	Impact	Rating					
13	Existing human resource in the Communications and Engagement Team may be insufficient. This may impact on the team's ability to provide the necessary advice and oversight required to support the system's ambitions and duties on citizen engagement. This could result in non-delivery of the agreed ICS Engagement Strategy, lower levels of engagement in system transformation and non-compliance with statutory duties.	3	3	9	3	3	9	⟷	Ongoing anticipation of ICB structure outcomes to seek to stabilise team and confirm roles.	Helen Dillistone Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement	
15	The ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSEI	2	3	6	2	3	6	⟷	Specialised services are due to be delegated in April 2024 and work is currently underway to understand any impacts	Helen Dillistone Chief of Staff	Chrissy Tucker - Director of Corporate Delivery	
16	Risk of increased anxiety amongst staff due to the uncertainty and the impact on well-being.	4	3	12	4	3	12	⟷	Sickness absence levels increased in July to 2.86%.	Linda Garnett Interim Chief People Officer	James Lunn, Head of People and Organisational Development	
17	Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised.	4	3	12	4	3	12	⟷	Joint Forward Plan published; engagement approach in development with aim to commence foundation discussions on change with wider stakeholder groups in autumn.	Helen Dillistone Chief of Staff	Sean Thornton - Deputy Director Communications and Engagement	
18	There is a risk of patient harm through existing safeguarding concerns due to patients being able to pro-actively view their medical record from 1st November 2022. This is a result of national changes to the GMS contract required by NHSE/I.	2	3	6	2	3	6	⟷	As of October 31st all practices are required to allow patients access to their records. The Primary Care Quality Team have sent further updates to all practices in August with links for support through EMIS and NECS.	Zara Jones Executive Director of Strategy and Planning	Hannah Belcher, Assistant Director of GP Commissioning and Development: Primary Care Judy Derricott Assistant Director of Nursing and Quality: Primary Care	
19	Failure to deliver a timely response to patients due to excessive handover delays and transfer of patients to the appropriate care setting from Acute Hospitals. Risk of leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential significant levels of harm.	5	4	20	5	4	20	⟷	County LA transformation date delayed until Jan 24.	Dr Chris Weiner Chief Medical Officer	Jo Warburton Dan Webster	
20	Under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby City and Derbyshire. Due to the number of contingency Hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care Services and Looked After Children Services in supporting Asylum Seekers and unaccompanied asylum seekers with undertaking health assessments.	4	4	16	4	4	16	⟷	Ongoing challenges with contingency hotels- Hotel use continues.	Prof Dean Howells Chief Nursing Officer	Michelina Racioppi Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children	
NEW RISK 21	There is a risk that contracts cannot fulfil or hand back due contracts due to the cost-of-living increases/inflation. The ICB would need to find an alternative provider and in some cases regarding health care this could be immediate, which would likely come at considerable additional cost.				3	4	12	NEW RISK	NEW RISK	Zara Jones Executive Director of Strategy and Planning	Lana Davidson Senior Contract Manager	NEW RISK

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 074

Report Title	ICB Corporate Committees' Terms of Reference							
Author	Suzanne Pickering, Head of Governance							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Helen Dillistone, Chief of Staff							
Paper purpose	Decision	☒	Discussion	☐	Assurance	☐	Information	☐
Appendices	Appendix 1 - Audit and Governance Committee Terms of Reference Appendix 2 - Finance, Estates and Digital Committee Terms of Reference Appendix 3 - People and Culture Committee Terms of Reference Appendix 4 - Population Health and Strategic Commissioning Committee Terms of Reference Appendix 5 - Public Partnership Committee Terms of Reference Appendix 6 - Quality and Performance Committee Terms of Reference Appendix 7 - Remuneration Committee Terms of Reference							
Assurance Report Signed off by Chair	Not Applicable							
Which committee has the subject matter been through?	Audit and Governance Committee – 10.08.2023 Finance, Estates and Digital Committee – 22.08.2023 People and Culture Committee – 06.09.2023 Population Health and Strategic Commissioning Committee – 14.09.2023 Public Partnership Committee – 29.08.2023 Quality and Performance Committee – 31.08.2023 Remuneration Committee – 14.09.2023							

Recommendations
The ICB Board is recommended to **APPROVE** the ICB Committee Terms of References.
Purpose
The purpose of this report is to for the ICB Board to formally approve the Committees' agree the Terms of References following review and agreement at each individual Committee.
Background
The ICB Committee Terms of Reference was formally adopted by the ICB Board on the 1st July 2022.

The Terms of References have been reviewed as part of the annual review and following the formal delegated responsibility of the Primary Medical Services, Pharmaceutical Services and Local Pharmaceutical Services, Primary Ophthalmic Services and Primary Dental Services delegation from NHSE.

Report Summary

The ICB Committees are established by NHS Derby and Derbyshire Integrated Care Board as Committees of the ICB Board in accordance with its Constitution and the ICB Governance Handbook.

The Terms of Reference are published on the ICB website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the ICB Board.

The purpose of the ICB Committees is to ensure that the ICB complies with the principles of good governance whilst effectively delivering the statutory functions of the ICB.

The ICB's Internal Auditors, 360 Assurance have undertaken a Committee Effectiveness review of the ICB Committees, and the recommendations of the report require Committees to review their functions and responsibilities and use the Committee annual reporting process to reflect on the defined responsibilities of the Committee and make adjustments where required. Each committee will be required to hold a Committee Development Session to undertake this review and amend its terms of reference accordingly. The Terms of Reference will therefore require a further review in December 2023 and ICB Board approval in March 2024.

The Terms of Reference have been reviewed and updated to reflect some key governance changes required. Recommended changes have been agreed by each Committee, clean final copies have been included in the paper and the material changes are as follows:

1. To reflect the recommendation from an Internal Audit Governance Review Report, all terms of references include a statement within section 4 (Authority) which refers to: Board delegations to the Committee are in line with the Scheme of Reservation and Delegation and the delegations are set out in Appendix 1 of each of the Terms of Reference.

2. Updates to the titles of the:

    (a) Executive Director of Corporate Affairs to 'Chief of Staff';
    (b) Executive Director of Finance to 'Chief Finance Officer;
    (c) Executive Director of Strategy and Planning to 'Chief Strategy and Delivery Officer'
    (d) Executive Director of Nursing and Quality to 'Chief Nursing Officer'
    (e) Executive Medical Director to 'Chief Medical Officer'

3. The ICB Chair's recommendation to include System Non-Executive Directors as members of non-statutory corporate Committees. Legal advice has been sought and provisions are detailed as follows:

    a) Schedule 1B, paragraph 11 of the NHS Act 2006 as amended by the Health and Care Act 2022 the constitution of an ICB must specify arrangements for the exercise of the integrated care board's functions. These arrangements may include provision:

        (i) for the appointment of committees or sub-committees of the integrated care board, and

(ii) for any such committees to consist of or include persons other than members or employees of the integrated care board.

In accordance with these provisions the ICB's constitution provides at paragraph 4.3.1 that the ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to a committee or sub-committee of the ICB. Paragraph 4.6.5 of the constitution provides that any such committee or sub-committee may consist of, or include, persons who are not ICB Members or employees.

In the light of these provisions, the ICB is able to appoint Non-executive Directors from NHS provider organisations to form part of the membership, voting, and quoracy of ICB committees.

b) There is a requirement for the ICB to have arrangements in place that manage conflicts of interest, the ICB Constitution provides for these at paragraph 6. Relevant provisions are included in sections:

6.2.1 decision-making will be open and transparent, will be inclusive and incorporate diverse views across the system. Decisions will be made in the interests of the health of the population and consistent with the statutory responsibilities of the ICB and ICS. Any individual involved in decisions relating to the ICB functions must be acting in the interests of the people of Derby and Derbyshire rather than furthering direct or indirect financial, personal, professional, or organisational interests. Decision making will be devolved to Place where appropriate;

6.2.3 the personal and professional interests of all ICB board members, ICB committee members and ICB staff who are involved in decision taking must be declared, recorded and managed appropriately. Declarations must be made as soon as practicable after the person becomes aware of the conflict or potential conflict and, in any event, within 28 days of the person becoming aware. This includes being clear and specific about the nature of any interest, and about the nature of any conflict that may arise regarding a particular decision.

Non-Executive Directors (NEDs) from NHS provider organisations who sit on ICB committees must comply with these requirements. As a general point, ICBs and NHS providers are in any event subject to a duty to have regard to the wider effect of their decisions, and this is seen as a means of promoting system working. It is therefore unlikely that any organisational interests of provider NEDs will conflict with the interests of the ICB.

4. Clarification of the above is provided in section 6.1.2 and 13.1.1 of each of the terms of references.

5. In line with legal advice, in relation to point 3 above, Quoracy has been amended to ensure all terms of references include ICB Non-Executive Members and a system Non-Executive Director.

6. A specific breakdown of members is now included within the 'quoracy' section for the following committees: Finance, Estates and Digital, Quality and Performance and People and Culture – this addresses the Internal Audit recommendation within the Committee Effectiveness Report.

7. Following agreement from members, the frequency of the People and Culture Committee has changed from quarterly to bi-monthly, as per the recommendation from the Committee Effectiveness report.

8. The Non-Executive Member of Quality and Performance has been removed from the membership of the Audit and Governance Committee.

9. A new section 11.1.6 has been included within the Remuneration Committee Terms of Reference – this is to clarify the process of approving changes to Non-Executive Member pay when a review within the nationally agreed pay scales is required.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☐	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☒			

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒
Details/Findings Not applicable.		**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision making process?

None identified.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☐	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
The ICB Committee terms of references includes an Equality and Due Regard section (Sections 9.3 and 9.4). There are no risks that will affect the ICB's obligations.

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

Details/Findings
Not applicable for this report.

Audit and Governance Committee

Terms of Reference

1. SCOPE

1.1 The Audit and Governance Committee (the "Committee") is established by NHS Derby and Derbyshire Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

1.2 These Terms of Reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the ICB Board.

1.3 The Committee is a Non-Executive Member chaired committee of the ICB Board and its members, including those who are not members of the ICB Board, are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE

2.1 The purpose of the Committee is to ensure that the ICB complies with the principles of good governance whilst effectively delivering the statutory functions of the ICB.

2.2 To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the ICB Board on the adequacy of governance, risk management and internal control processes within the ICB.

2.3 The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

2.4 The Committee has no executive powers, other than those delegated in the Scheme of Reservation and Delegation (SoRD) and specified in the Standing Financial Instructions, which includes:

2.4.1 complying with regulations governing best practice in relation to procurement, protecting and promoting patient choice, and anti-competitive conduct;

2.4.2 complying with public law requirements in relation to entering into contracts concerning commissioning arrangements and the use of public monies;

2.4.3 taking appropriate steps to ensure that the ICB is properly prepared to deal with emergencies that might affect it;

2.4.4 providing information, where required, to the Information Centre, e.g. to support publication of national data on healthcare services;

2.4.5 maintaining one or more publicly accessible registers of interests of members of the ICB, its employees, members of the ICB Board and members of committees

or subcommittees of the ICB, and to make arrangements to ensure that relevant conflicts or potential conflicts of interest are declared and included in the registers;

2.4.6 making arrangements for managing conflicts and potential conflicts of interest in such a way as to ensure that they do not, and do not appear to, affect the integrity of the ICB's decision-making processes, and to have regard to guidance published by NHS England on management of conflicts of interest;

2.4.7 meeting requirements of the Employment Rights Act 1996, the Equality Act 2010, the Data Protection and Freedom of Information Acts, the European Convention on Human Rights and Health and Safety; and

2.4.8 promoting innovation and research in the provision of health services.

3. RESPONSIBILITIES OF THE COMMITTEE

The Committee's duties can be categorised as follows:

3.1 Integrated governance, risk management and internal control

3.1.1 To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the ICB Board.

3.1.2 To ensure that financial systems and governance are established which facilitate compliance with Department of Health & Social Care's Group Accounting Manual.

3.1.3 To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks.

3.1.4 To have oversight of system risks where they relate to the achievement of the ICB's objectives.

3.1.5 To ensure consistency that the ICB acts consistently with the principles and guidance established in HM Treasury's Managing Public Money.

3.1.6 To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.1.7 To identify opportunities to improve governance, risk management and internal control processes across the ICB.

3.2 Internal Audit

To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the ICB Board. This will be achieved by:

3.2.1 considering the provision of the internal audit service and the costs involved;

3.2.2 reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the board assurance framework;

3.2.3 considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources;

3.2.4 ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and

3.2.5 monitoring the effectiveness of internal audit and carrying out an annual review.

3.3 **External Audit**

To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

3.3.1 considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit;

3.3.2 discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;

3.3.3 discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and

3.3.4 reviewing all external audit reports, including to those charged with governance (before its submission to the ICB Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

3.4 **Corporate Governance**

3.4.1 The Committee will discharge the ICB's responsibilities in respect of the following functions:

- Business Continuity;
- ICB Complaints and PALS, including Pharmaceutical, Ophthalmic, Dental and General Practice Services;
- Digital Development and ICT Assurance, including Cyber Security;
- Emergency Preparedness Resilience and Response;
- ICB Estates;
- Freedom of Information;
- Health, Safety, Fire and Security;
- Information Governance;
- Organisational Development including ICB Staff Survey;
- Procurement; and
- Research Governance.

3.4.2 In order to discharges these duties, the Committee will:

- produce an annual work programme;
- ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements;
- review the adequacy and effectiveness of their responsible policies and procedures for ensuring compliance and related reporting;
- ensure that arrangements are in place to monitor compliance with statutory responsibilities;
- promote good risk management and ensure robust controls are in place in accordance with the ICB's Risk Management Framework;
- establish and approve the terms of reference of such reporting sub-groups or task and finish groups as the Committee believes are necessary to fulfil its terms of reference;
- review the risk register for its area of remit, considering the adequacy of the submissions and whether new risks need to be added or whether any risks require immediate escalation to the ICB Board;
- review the Committee forward planner to assist with the Committee in discharging its duties effectively;
- scrutinise the performance of the ICT service provider against national requirements, reported Key Performance Indicators, cyber security, GP IT delivery assurance, business as usual requirements and project delivery, (as identified in the ICB digital strategy) ensuring risks are identified and managed appropriately.

3.5 **Other assurance functions**

3.5.1 To review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.

3.5.2 To review the work of other committees in the ICB, whose work can provide relevant assurance to the Audit and Governance Committee's own areas of responsibility.

3.5.3 To review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.

3.5.4 To review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:

(a) reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, Care Quality Commission; and

(b) reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

3.6 **Counter fraud**

3.6.1 To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud

Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

3.6.2 To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

3.6.3 To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

3.6.4 To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners; Fraud, Bribery and Corruption.

3.6.5 To report concerns of suspected fraud, bribery and corruption to the NHSCFA.

3.7 **Freedom to Speak Up**

To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

3.8 **Information Governance (IG)**

3.8.1 To receive regular updates on IG compliance (including uptake and completion of data security training), data breaches and any related issues and risks.

3.8.2 To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

3.8.3 To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

3.8.4 To provide assurance to the ICB Board that there is an effective framework in place for the management of risks associated with information governance.

3.9 **Financial reporting**

3.9.1 To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.

3.9.2 To ensure that the systems for financial reporting to the ICB Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

3.9.3 To review and approve the annual report and financial statements (including accounting policies) as delegated to them by the ICB Board, focusing particularly on:

(a) the wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

(b) changes in accounting policies, practices and estimation techniques;

(c) unadjusted mis-statements in the Financial Statements;

(d) significant judgements and estimates made in preparing of the Financial Statements;

(e) significant adjustments resulting from the audit;

(f) letter of representation; and

(g) qualitative aspects of financial reporting.

3.9.4 To receive and have oversight of Single Tender Waivers that are approved by the Chief Finance Officer.

3.10 **Conflicts of Interest**

3.10.1 The chair of the Audit and Governance Committee will be the nominated Conflicts of Interest Guardian.

3.10.2 The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

3.11 **Management**

3.11.1 To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.11.2 The Committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.

3.11.3 To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's standing orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

3.12 **Communication**

3.12.1 To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.

3.12.2 To develop an approach with other committees, including the Integrated Care Partnership, to ensure the relationship between them is understood.

4. AUTHORITY

4.1 The Audit and Governance Committee is authorised by the ICB Board to:

4.1.1 investigate any activity within its terms of reference;

4.1.2 seek any information it requires within its remit, from any employee or member of the ICB Board (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these Terms of Reference;

4.1.3 commission any reports it deems necessary to help fulfil its obligations;

4.1.4 obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice; and

4.1.5 create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's Constitution and SoRD, but may not delegate any decisions to such groups.

4.2 For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD. Decisions and functions delegated to the Committee are detailed in Appendix 1.

5. ACCOUNTABILITY AND REPORTING

5.1.1 The Committee is accountable to the ICB Board and shall report to the ICB Board on how it discharges its responsibilities.

5.1.2 The minutes of the meetings shall be formally recorded by the secretary and submitted to the ICB Board in accordance with the Standing Orders.

5.1.3 The Chair will provide assurance reports to the ICB Board at each meeting and shall draw to the attention of the ICB Board any issues that require disclosure to the ICB Board or require action.

5.1.4 The Audit and Governance Committee will provide the ICB Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on the:

(a) fitness for purpose of the board assurance framework;

(b) completeness and 'embeddedness' of risk management in the organisation;

(c) integration of governance arrangements;

(d) appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements; and

(e) robustness of the processes behind the quality accounts.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

6.1.1 The Committee members shall be appointed by the ICB Board in accordance with the ICB Constitution.

6.1.2 The ICB Board will appoint no fewer than three members of the Committee including two who are Independent Non-Executive Members of the ICB Board. Other members of the Committee need not be members of the ICB Board, but they may be. The Non-Executive Members are:

(a) Non-Executive Member of Audit and Governance;

(b) Non-Executive Member of Finance and Estates;

(c) Non-Executive Member of People and Culture ('by invitation' in accordance with the Committee's workplan).

6.1.3 Neither the Chair of the ICB Board, nor employees of the ICB will be members of the Committee.

6.1.4 Members will possess between them knowledge, skills and experience in accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business. When determining the membership of the Committee, active consideration will be made to diversity and equality.

6.2 Chair and vice chair

6.2.1 In accordance with the constitution, the Committee will be chaired by the Non-Executive Member for Audit and Governance, appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

6.2.2 Committee members may appoint a Vice Chair who will be another Non-Executive Member.

6.2.3 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

6.3 Attendees

6.3.1 Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

(a) Chief Finance Officer or their nominated deputy;

(b) Chief of Staff or their nominated deputy;

(c) Chief Executive Officer, as required;

(d) representatives of both internal and external audit; and

(e) individuals who lead on risk management and counter fraud matters.

6.3.2 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

6.3.3 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers.

6.3.4 All Executive Directors should be invited to discuss ICB objectives and risks in their area of responsibility at least annually.

6.3.5 The Chief Executive should be invited to attend the meeting at least annually.

6.3.6 The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

6.4 **Attendance**

6.4.1 It is expected that members will prioritise these meeting and make themselves available; exceptionally where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Committee. For Local Authority representatives this will be in accordance with the due political process.

6.4.2 Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

6.4.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

6.5 **Access**

Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management providers will have full and unrestricted rights of access to the Audit and Governance Committee.

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The Committee will meet five times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

7.2 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

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

7.4 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

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

7.6 Ratified minutes of the meeting will be circulated to all sub-groups for dissemination to their members.

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

8. QUORACY

8.1 For a meeting to be quorate a minimum of two Independent Non-Executive Members of the ICB Board are required, including the Chair or Vice Chair of the Committee.

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by video conference, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS AND DECISION MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Decision-Making

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

9.2.2 <u>Voting</u>

(a) Decisions will be taken in accordance with the Standing Orders. The Committee will reach conclusions by consensus. When this is not possible the Chair may call a vote.

(b) Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be record in the minutes.

9.2.3 Urgent Decisions

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

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

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

9.3 **Equality and Diversity**

9.3.1 The ICB aims to meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. The ICB aims to ensure that no one receives less favourable treatment due to their protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration is also given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

9.3.2 In carrying out its function, the ICB must have due regard to the Public Sector Equality Duty (PSED). This applies to all activities for which the ICB is responsible, including policy development, review and implementation.

9.4 **Due Regard**

The ICB has due regard to the PSED of the Equality Act 2010 to eliminate discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations between the protected groups.

10. IDENTIFYING AND MANAGING RISKS

10.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

10.2 The Committee will receive and review those risks delegated to it consisting of the board assurance framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

11. INTERDEPENDENCIES WITH OTHER GROUPS

Consideration will be given at each meeting as to whether any items need to be escalated to the ICB Board or another ICB Committee.

12. MANAGING CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

12.1.1 ensure that they continue to comply with relevant organisational policies/governance framework for probity and decision-making in line with sections 6.2.1 and 6.2.3 of the ICB's Constitution;

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

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

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

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

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

13. SECRETARIAT AND ADMINISTRATION

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

13.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed within five working days of the meeting, in accordance with the Standing Orders, and having been agreed by the Chair with the support of the relevant executive lead;

13.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

13.3 records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;

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

13.5 the Chair is supported to prepare and deliver reports to the Board;

13.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

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

14. REVIEW

14.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

Reviewed by Audit and Governance Committee:	10th August 2023
Approved by the ICB Board:	21st September 2023
Review Date:	January 2024

NHS
Derby and Derbyshire
Integrated Care Board

Appendix 1

ICB Committee	Decisions and functions delegated to the committee	Reference
Audit and Governance Committee	Delegated responsibility for: • the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the ICB's activities; • overseeing policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification; • overseeing policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service; • ensuring that there is an effective internal audit function and external audit plan that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance; • monitoring the integrity of the financial statements of the ICB and any formal announcements relating to financial performance; • ensuring that the systems for financial reporting to the ICB, including those of budgetary control, are subject to review as to completeness and accuracy of the information; • complying with regulations governing best practice in relation to procurement, protecting and promoting patient choice, and anticompetitive conduct; • complying with public law requirements in relation to entering into contracts concerning commissioning arrangements and the use of public monies; • taking appropriate steps to ensure that the ICB is properly prepared to deal with emergencies that might affect it; • providing information, where required, to the Information Centre, e.g. to support publication of national data on healthcare services; • maintaining one or more publicly accessible registers of interests of members of the ICB, its employees, members of the ICB Board and members of committees or subcommittees of the ICB, and to make arrangements to ensure that relevant conflicts or potential conflicts of interest are declared and included in the registers; • making arrangements for managing conflicts and potential conflicts of interest in such a way as to ensure that they do not, and do not appear to, affect the integrity of the	Audit and Governance Committee Terms of Reference

ICB Committee	Decisions and functions delegated to the committee	Reference
	ICB's decision-making processes, and to have regard to guidance published by NHSEI on management of conflicts of interest; • meeting requirements of the Employment Rights Act 1996, the Equality Act 2010, the Data Protection and Freedom of Information Acts, the European Convention on Human Rights and Health and Safety; and • promoting innovation and research in the provision of health services.	
	The delegation arrangements and financial authority limits are as follows: • monitoring of the use of single tender/single quote action (on behalf of ICB Board); • income and debt write-off – authorisation of write-offs of debt or income (total debt per debtor) (following ICB Executive Team approval); and • losses and special payments – authorisation and monitoring of losses and special payments (following ICB Executive Team approval).	SORD 3.4 SORD 5.2 SORD 6.1, 6.2

3.	**Procurement**	*The detailed procedures supporting these delegations can be found in the ICB Procurement Policy*	
3.4	Monitoring of the use of single tender/single quote action.	Audit and Governance Committee on behalf of ICB Board	Single tender/single quote will be reported quarterly for information only, at Audit and Governance Committee. All such contracts must be included on the Register of Procurement Decisions, delegated to the Finance Lead responsible for Financial Control.
5.	**Income and debt write-off**		
5.2	Authorisation to write-off debt or income (total debt per debtor)	Members of the Audit and Governance Committee (following Executive Team meeting)	This includes non-recovery of any payroll overpayments. Debit or credit notes are only to be raised after approval by the Members of the Audit and Governance Committee. All write-offs should be reported to Audit and Governance Committee.

6.	Losses and special payments	*All losses and special payments must be reported at every meeting to the Audit and Governance Committee*	
6.1	Authorisation of losses and special payments, including ex-gratia payments	Audit and Governance Committee (following ICB Executive Team approval)	Reference to the national Losses and Special Payments policy should be considered in conjunction with Audit and Governance Committee approval to ensure the approval is within the delegations given to the ICB. The Chief Finance Officer will report any cases they consider to be “novel, contentious or repercussive” to the Chair of the Audit and Governance Committee as soon as they become aware of the case. These should also be reported to NHS England in line with current guidance.
6.2	Monitoring of losses and special payments	Audit and Governance Committee	Liaison with the ICB's Local Counter Fraud Specialist & Police as required and in line with the ICB's Fraud, Corruption and Bribery Policy.

Finance, Estates and Digital Committee

Terms of Reference

1. SCOPE

1.1 The Finance, Estates and Digital Committee (the "Committee") is established by NHS Derby and Derbyshire the Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the ICB Board.

1.3 The Committee is a Non-Executive Member committee of the ICB Board and its members, including those who are not members of the ICB Board, are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE

To provide oversight and assurance to the ICB Board in the development and delivery of a robust, viable and sustainable system financial, estates and digital plans; and processes which meet the health and care needs of the citizens of Derby and Derbyshire and aid the implementation of the JUCD vision and strategy.

3. ROLES AND RESPONSIBILITIES

The Committee will gain assurance from the JUCD executive functions and provide assurance to the ICB Board on:

3.1 **Delivery**

3.1.1 Delivery of the single system wide finance, digital and estates (including continuous improvement) plan built around a re-defined way of delivering care (as defined by the JUCD strategy, vision and objectives) regarding:

(a) deliverability and level of risk;

(b) whether the plan delivers the best return on the resources available and can be delivered within the resources available.

3.1.2 Providing oversight of the framework and strategy for finance, digital and estates planning to ensure that each of the system partners have plans which are compatible with and compliment the system approach.

3.1.3 Oversight of the management of the system financial target.

3.1.4 Overseeing development of a 5-year rolling system financial projection which demonstrates ongoing efficiency and value improvements/impacts of longer term investments.

3.1.5 Overseeing development of the JUCD future financial regime and recovery to address our known financial pressures and to provide assurance to the ICB Board.

3.1.6 Ensuring effective oversight of future prioritisation and capital funding bids.

3.1.7 Oversight and monitoring of financial, digital, estates and continuous improvement performance and delivery in order to give the ICB Board confidence that JUCD is implementing its strategic outcomes.

3.2 **Statutory Oversight**

3.2.1 Providing the ICB Board with an accurate understanding of the system's current and forecast financial position and the development and oversight of the system's medium term financial recovery plan to correct any underlying challenge.

3.2.2 Considering full business cases for material service change or efficiency schemes.

3.2.3 Managing associated risks by developing and monitoring a Finance, Digital and Estates Committee Risk Register.

3.2.4 Reviewing exception reports on any material breaches of the delivery of agreed efficiency improvement plans including the adequacy of proposed remedial action plans.

3.2.5 Reviewing exception reports on any material in-year overspends against delegated budgets, including the adequacy of proposed remedial action plans.

3.2.6 Having responsibility to the ICB Board for oversight and advice on the current risk exposures with regard to the short and long term financial plans and the associated recovery strategies.

3.2.7 Identifying and allocating resources where appropriate to improve performance of identified schemes or ad-hoc finance and performance related issues that may arise.

3.2.8 Considering significant investment or disinvestment decisions.

3.2.9 Reviewing the forward agenda for the Committee to ensure preparatory work to meet national planning timelines are appropriately scheduled.

3.2.10 Ensuring that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements.

3.2.11 Reviewing the adequacy and effectiveness of relevant policies and procedures for ensuring compliance and related reporting.

3.2.12 Having oversight of the system Recovery and Restoration work related to finance and efficiency and receive assurance regarding progress.

4. ACCOUNTABILITY

4.1 The Committee is directly accountable to the ICB Board.

4.2 The Committee is responsible for managing any risks associated with delivery of the Finance, Digital and Estates Strategy and more general strategic finance, digital and estates performance risks across the system; a register will be maintained to ensure effective tracking of mitigations and escalation as necessary.

4.3 The minutes of the meetings shall be formally recorded by the secretary and submitted to the ICB Board in accordance with the Standing Orders.

4.4 The Chair of the Committee will report to the ICB Board following each meeting, confirming all decisions made, highlighting any concerns, actions taken, next steps and ongoing monitoring. The report will also include recommendations that are outside the delegated limits of the Committee and matters which require escalation to, and approval from the ICB Board, if not already approved by them.

4.5 The Committee will provide an annual report to the ICB Board on the effectiveness of the Committee to discharge its duties.

4.6 The Committee may investigate, monitor and review any activity within its terms of reference. It is authorised to seek any information it requires from any Group.

5. DELEGATED AUTHORITY

5.1 The Committee is a formal committee of the ICB. The ICB Board has delegated authority to the Committee as set out in the Scheme of Reservations and Delegation and may be amended from time to time. Decisions and functions delegated to the Committee are detailed in Appendix 1.

5.2 The Committee holds those powers as delegated in these Terms of Reference as determined by the ICB Board.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

6.1.1 Members of the Committee shall be appointed by the ICB Board in accordance with the ICB Constitution.

6.1.2 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

6.1.3 Any committee or sub-committee established in accordance with clause 4.6 of the ICB Constitution may consist of or include persons who are not ICB members or employees.

6.1.4 The membership of the Committee will comprise:

<u>Core Members</u>

(a) ICB Non-Executive Member of Finance and Estates

(b) ICB Non-Executive Member of Audit and Governance

(c) ICB Chief Finance Officer

(d) ICB Operational Director of Finance

(e) ICB Chief Strategy and Delivery Officer

(f) ICB Chief People Officer

(g) Foundation Trust Non-Executive Director – Acute

(h) Foundation Trust Non-Executive Director – Community

(i) 5 x System Director of Finance

System Members

(a) 2 x Chief Operating Officers

(b) System Estates Officer

(c) System Digital Officer

(d) System Continuous Improvement Officer

Participant Members by invite only

(e) General Practice Representative

(f) Local Authority Representative Derby City

(g) Local Authority Representative Derby County

(h) Third Sector/Voluntary Sector Representative

6.2 **Chair and Vice Chair**

The Chair of the Committee shall be the Non-Executive Member for Finance and Estates. In the event that the Chair is unavailable to attend, a Non-Executive Member will act as the Vice Chair and Chair the meeting, unless there is a conflict of interest. If the Chair has a conflict of interest then the Vice Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

6.3 **Attendance**

6.3.1 It is expected that core members will prioritise these meeting and make themselves available; exceptionally where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Committee. For Local Authority representatives this will be in accordance with the due political process.

6.3.2 Core members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

6.3.3 System members, or their nominated deputies, will be required to attend meetings when estates, digital and improvement are on the agenda. System members may also attend other meetings if appropriate.

6.3.4 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The group will meet monthly to ensure all Finance, Digital and Estates information submitted to the ICB Board has been properly scrutinised and to develop an agreed view on any future issues arising.

7.2 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

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

7.4 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

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

7.6 Ratified minutes of the meeting will be circulated to all sub-groups for dissemination to their members.

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

8. QUORACY

8.1 The quorum shall be 5 members made up of 2 Non-Executives, of which one will be an ICB Non-Executive Member and one will be a provider Non-Executive Director; and 3 Executive Directors, of which one should be the ICB Chief Finance Officer or nominated deputy and one should be a System Director of Finance or their nominated deputy.

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by video conference, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS AND DECISION-MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Decision-Making

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

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

9.2.3 Voting

(a) Decisions will be taken in accordance with the Standing Orders. The Committee will reach conclusions by consensus. When this is not possible the Chair may call a vote.

(b) Only core members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be record in the minutes.

9.2.4 Urgent Decisions

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

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

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

9.3 Equality and Diversity

9.3.1 The ICB aims to meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. The ICB aims to ensure that no one receives less favourable treatment due to their protected

characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration is also given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

9.3.2 In carrying out its function, the ICB must have due regard to the Public Sector Equality Duty (PSED). This applies to all activities for which the ICB is responsible, including policy development, review and implementation.

9.4 **Due Regard**

The ICB has due regard to the PSED of the Equality Act 2010 to eliminate discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations between the protected groups.

10. SUB-COMMITTEES

10.1 The Committee may delegate responsibility for specific aspects of its duties to sub committees or working groups. The Terms of Reference of each such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.

10.2 Any sub-committees or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the Committee.

11. IDENTIFYING AND MANAGING RISKS

11.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

11.2 The Committee will receive and review those risks delegated to it consisting of the Board Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

12. MANAGING CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

12.1.1 ensure that they continue to comply with relevant organisational policies/governance framework for probity and decision making, in line with sections 6.2.1 and 6.2.3 of the ICB's Constitution;

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

12.1.3 in advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be

managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals;

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

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

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

13. SECRETARIAT AND ADMINISTRATION

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

13.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed in accordance with the Standing Orders, having been agreed by the Chair with the support of the relevant executive lead;

13.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

13.3 records of members' appointments and renewal dates and the ICB Board is prompted to renew membership and identify new members where necessary;

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

13.5 the Chair is supported to prepare and deliver reports to the ICB Board;

13.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

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

14. REVIEW

14.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

Reviewed by Finance, Estates and Digital Committee:	11th September 2023
Approved by the ICB Board:	21st September 2023
Review Date:	January 2024

Appendix 1

Decisions and functions delegated to the Finance and Estates Committee

ICB Committee	Decisions and functions delegated to the committee	Reference
Finance and Estates Committee	Delegated responsibility to: • provide oversight and assurance to the ICB Board in the development and delivery of a robust, viable and sustainable system financial, estates and digital plans; and processes which meet the health and care needs of the citizens of Derby and Derbyshire and aid the implementation of the ICS vision and strategy; • provide the ICB board with an accurate understanding of the system's current and forecast financial position and the development and oversight of the system's medium term financial recovery plan to correct any underlying challenge; • identify and allocate resources including consideration of significant investment or disinvestment decisions; • ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements and review adequacy; and • open bank accounts or make changes to banking arrangements.	Finance and Estates Committee Terms of Reference SORD 7.1

7.	**Bank accounts and payment methods**		
7.1	Opening of bank accounts or changes to banking arrangements	Finance and Estates Committee	The ICB will use Government Banking Services only.

People and Culture Committee

Terms of Reference

1. SCOPE

1.1 The People and Culture Committee (the "Committee") is established by NHS Derby and Derbyshire Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

1.2 These Terms of Reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the ICB Board.

1.3 The Committee is a Non-Executive Member committee of the ICB Board and its members, including those who are not members of the ICB Board, are bound by their respective organisation's Standing Orders and other policies.

2. PURPOSE

The purpose of the Committee is to:

2.1 oversee the development and delivery of an Integrated Care System ("ICS") People and Culture Strategy which supports the sovereign organisations in Joined Up Care Derbyshire, Provider Leadership Collaborative and Integrated Place Partnership, City and County to achieve their objective of improving the health and well-being of the people in Derby and Derbyshire;

2.2 provide assurance to the ICB Board, the sovereign organisations in Joined Up Care Derbyshire, Provider Collaborative and Integrated Care Partnerships on the implementation of the strategy and the identification and mitigation of people, culture and workforce risks.

3. ROLES AND RESPONSIBILITIES

The Committee will be responsible for:

3.1 ensuring that the Derby and Derbyshire ICS has an ambitious People and Culture strategy;

3.2 ensuring the People and Culture strategy supports the ICS and its partners to achieve the ambition to be an Anchor Institution;

3.3 improving equality, diversity, and inclusion for our current and future workforce; maximising our potential as employers to reduce health inequalities and to improve the health and wellbeing of our communities;

3.4 promoting a positive culture to enable the system to be an agile, inclusive, and modern employer to attract, recruit and retain the people we need to deliver our plans;

3.5 overseeing the development and delivery of the work programme to grow our system leadership capacity, capability, talent, and culture across our ICS;

3.6 ensuring there is a robust package of support and focus on the wellbeing of the workforce including health and safety, safeguarding and security management across our ICS;

3.7 ensuring plans are in place to develop, support and retain the health and care workforce, adopting a "one workforce" approach with all partners across the ICS, promoting collaborative recruitment, education and training of existing and future health and care staff where appropriate;

3.8 ensuring analysis and intelligence is used to coordinate our ICS workforce plan that integrates workforce, activity and finance planning where appropriate across health and care to meet current and future population, service and workforce needs, across programmes, pathways and Place;

3.9 overseeing the development and progress of a system wide approach to delivering People Services; ensuring the ten People Functions for the ICS are in place to make Derby and Derbyshire a better place to live and work for the ICS people;

3.10 promoting integrated system-working and to support collaborative working at scale; and

3.11 having oversight of the ICB people function, as set out in NHS England's Building strong integrated care systems everywhere: guidance on the ICS people function.

4. DELEGATED AUTHORITY

4.1 At this stage the group would not have any formally delegated authority from the Boards of sovereign organisations. However, there may be specific areas where the ICB Board, Provider Leadership Collaborative Board and Integrated Place Partnership has come to a collective agreement which may be delegated to the People and Culture Committee to enact. ICB delegated responsibilities can be found at Appendix 1.

4.2 The seniority of individual members means that they are committing their respective organisations and making decisions within the scope of their own authority in tandem with other members of the group.

5. ACCOUNTABILITY

5.1 The Committee is accountable to the ICB Board and sovereign organisations.

5.2 The minutes of the meetings shall be formally recorded by the secretary and submitted to the ICB Board and made available to the sovereign organisations in accordance with the Standing Orders.

5.3 The Chair of the Committee will report to the ICB Board following each meeting, confirming all decisions made. The report will include recommendations that are outside the delegated limits of the Committee and which require escalation to, and approval from the ICB Board, if not already approved by them.

5.4 The Committee will provide an annual report to the ICB Board, Provider Leadership Collaborative Board and Integrated Place Partnership including progress and a summary of key achievements in delivery of the People and Culture strategy.

5.5 The Committee shall maintain an annual work programme, ensuring that all matters for which it is responsible are addressed in a planned manner, with appropriate frequency across the year.

5.6 The Committee may investigate, monitor and review any activity within its terms of reference. It is authorised to seek any information it requires from any Group.

5.7 The Chair is responsible for proactively notifying the Chair of the ICB Board, of any matters pertinent to the business of the Strategic People and Culture Committee which need to be on the agenda of Board meetings.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

6.1.1 Members of the Committee shall be approved by the ICB Board in accordance with the ICB Constitution.

6.1.2 Any committee or sub-committee established in accordance with clause 4.6 of the ICB Constitution may consist of or include persons who are not ICB members or employees.

6.1.3 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

6.1.4 The membership of the Committee will comprise of:

(a) ICB Non-Executive Member for People and Culture;

(b) ICB Non-Executive Member for Finance and Estates;

(c) ICB Chief People Officer;

(d) System Non-Executive Directors/ Chairs of Trust People Committees;

(e) Chief People Officers/HRD's from Provider Trusts;

(f) Programme Director of the Provider Leadership Collaborative Board;

(g) Chair of the Integrated Place Executive;

(h) Local Authorities HRD (or nominated Representative) and Service Lead;

(i) Independent Primary Care Provider leader;

(j) East Midlands Ambulance Service NHS Trust representation;

(k) Derbyshire Health United 111 (East Midlands) Community Interest Company representation.

6.1.5 Subject experts will be attendees at each meeting.

6.1.6 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

6.1.7 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.

6.2 **Chair and Vice Chair**

6.2.1 The Chair of the Committee shall be the ICB Non-Executive Member for People and Culture. In the event that the Chair is unavailable to attend, the Vice Chair will deputise and Chair the meeting.

6.2.2 The Vice Chair shall be the ICB Non-Executive Member for Finance and Estates.

6.3 **Attendance**

6.3.1 It is expected that members will prioritise these meeting and make themselves available; exceptionally where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Committee.

6.3.2 Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

6.3.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The Committee will meet formally bi-monthly and align to the reporting to timetable for the ICB Board meeting to ensure all people, culture and workforce information submitted to the Board has been properly scrutinised and to develop an agreed view on any future issues arising.

7.2 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

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

7.4 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

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

7.6 Ratified minutes of the meeting will be circulated to all sub-groups for dissemination to their members.

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

8. QUORACY

8.1 The quorum necessary for the transaction of business shall be 6 members to include 2 Non-Executives (to include 1 ICB Non-Executive Member (to include the Chair or Vice Chair) and 1 System Non-Executive Director),1 ICB Executive Member and 3 other members .

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by video conference, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS AND DECISION-MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with their respective organisation's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Decision-Making

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

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

9.2.3 <u>Voting</u>

(a) Decisions will be taken in accordance with the ICB's Standing Orders. The Committee will reach conclusions by consensus. When this is not possible the Chair may call a vote.

(b) Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be record in the minutes.

9.2.4 Urgent Decisions

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

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

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

9.3 **Equality and Diversity**

9.3.1 The ICB aims to meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. The ICB aims to ensure that no one receives less favourable treatment due to their protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration is also given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

9.3.2 In carrying out its function, the ICB must have due regard to the Public Sector Equality Duty (PSED). This applies to all activities for which the ICB is responsible, including policy development, review and implementation.

9.4 **Due Regard**

The ICB has due regard to the PSED of the Equality Act 2010 to eliminate discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations between the protected groups.

10. SUB-COMMITTEES

10.1 The Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of each such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.

10.2 Any sub-committees or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the Committee.

11. INTERDEPENDENCIES WITH OTHER GROUPS

The Committee will ensure any financial concerns are escalated to the Finance and Estates Committee.

12. IDENTIFYING AND MANAGING RISKS

12.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

12.2 The Committee will receive and review those risks delegated to it consisting of the Board Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item at each meeting.

13. MANAGING CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

13.1.1 ensure that they continue to comply with relevant organisational policies/ governance framework for probity and decision-making, in line with sections 6.2.1 and 6.2.3 of the ICB's Constitution;

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

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

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

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

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

14. SECRETARIAT AND ADMINISTRATION

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

14.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed in accordance with the Standing Orders, having been agreed by the Chair with the support of the relevant executive lead;

14.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

14.3 records of members' appointments and renewal dates and the ICB Board is prompted to renew membership and identify new members where necessary;

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

14.5 the Chair is supported to prepare and deliver reports to the ICB Board;

14.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

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

15. REVIEW

15.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

Reviewed by People and Culture Committee:	6th September 2023
Approved by the ICB Board:	21st September 2023
Review Date:	December 2023

Appendix 1

ICB Committee	Decisions and functions delegated to the committee	Reference
People and Culture Committee	Delegated responsibility to: • promote education and training of existing and future health care staff; • deliver the commitments of the NHS People Plan across the system; • oversee plans to develop, support and retain the health and care workforce, adopting a "one workforce" approach with all partners across the ICS; • ensure the appropriate workforce capacity and capability to deliver the ICS objectives together with an organisational development plan; and • oversee the demonstration of equality, diversity and inclusion in its plans and their implementation.	People and Culture Committee Terms of Reference

Population Health and Strategic Commissioning Committee

Terms of Reference

1. SCOPE

1.1 The Population Health and Strategic Commissioning Committee (the "Committee") is established by NHS Derby and Derbyshire Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

1.2 These Terms of Reference, which must be published on the ICB website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the ICB Board.

1.3 The Committee is a non-executive chaired committee of the ICB Board and its members, including those who are not members of the ICB Board, are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE

2.1 The purpose of the Committee is to ensure that the ICB complies with the principles of good governance whilst effectively delivering the statutory functions of the ICB.

2.2 The Committee has delegated authority to make decisions as set out in the ICB's Prime Financial Policies and the Scheme of Reservation and Delegation.

2.3 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England has delegated the exercise of the following functions in the delegation agreement to the ICB relating to:

2.3.1 primary medical services;

2.3.2 primary dental services and prescribed dental services;

2.3.3 primary ophthalmic services;

2.3.4 pharmaceutical services and local pharmaceutical services.

Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB. The ICB has established the Population Health and Commissioning Committee to function as a corporate decision-making body for the management of these delegated functions and the exercise of the delegated powers. This Committee will receive recommendations from the Primary Care Sub Group for decision on behalf of the ICB in line with the national delegation agreement.

3. ROLES AND RESPONSIBILITIES

The Committee will have delegated responsibility for overseeing the provision of health services in line with the allocated resources across the ICS through a range of activities including:

3.1 ensuring strategic, long-term and outcome-based contracts and agreements are in place to secure the delivery of the ICB's commissioning strategy, Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28 and associated operating plans;

3.2 overseeing the preparation and publication of the ICB's commissioning strategy, Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28 and associated operating plans, aligned to the Health and Wellbeing Boards and Integrated Care Partnership strategies;

3.3 overseeing the implementation of ICB commissioning policies, within the financial envelope to help secure the continuous improvement of the quality of the services commissioning by the ICB;

3.4 overseeing the development of savings plans and services as detailed in the ICB's Operational Plan, approving the appropriate business cases and mobilisation plans, subject to appropriate evidence being provided (with particular reference to statutory equality and engagement duties) to support the decisions made;

3.5 prioritising service investments/disinvestments arising from strategic and operational plans, underpinned by value-based decisions and against available resources, and ensuring that appropriate evaluation is in place for new and existing investments;

3.6 ensuring commissioning decisions are underpinned and informed by communications and engagement with the membership and local population as appropriate;

3.7 supporting providers (working both within the Integrated Care System and Integrated Care Partnership) to lead major service transformation programmes to achieve agreed outcomes, including through joining-up health, care and wider support;

3.8 working alongside councils to invest in local community organisations and infrastructure and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in social and economic development and environmental sustainability;

3.9 driving a focus on reducing health inequalities, improved outcomes and quality, and ensuring that the delivery of the ICB's strategic and operational plans are achieved within financial allocations

4. DELEGATED AUTHORITY

4.1 The Committee is a formal committee of the ICB. The ICB Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time. Decisions and functions delegated to the Committee are detailed in Appendix 1.

4.2 The Committee holds those powers as delegated in these Terms of Reference as determined by the ICB Board.

4.3 The Committee may further establish sub-groups and delegate decisions in accordance with guidance, for example to provider collaboratives at scale and at place.

5. ACCOUNTABILITY

5.1 The Committee is directly accountable to the ICB Board.

5.2 The minutes of the meetings shall be formally recorded by the secretary and submitted to the ICB Board in accordance with the Standing Orders.

5.3 The Chair of the Committee will report to the ICB Board following each meeting, confirming all decisions made, highlighting any concerns, actions taken, next steps and ongoing monitoring. The report will also include recommendations that are outside the delegated limits of the Committee and matters which require escalation to, and approval from the ICB Board, if not already approved by them.

5.4 The Committee will advise the Audit and Governance Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

5.5 The Committee will provide an annual report to the ICB Board on the effectiveness of the Committee to discharge its duties.

5.6 The Committee shall maintain an annual work programme, ensuring that all matters for which it is responsible are addressed in a planned manner, with appropriate frequency across the year.

5.7 The Committee may investigate, monitor and review any activity within its terms of reference. It is authorised to seek any information it requires from any Group.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

6.1.1 Members of the Committee shall be appointed by the ICB Board in accordance with the ICB Constitution.

6.1.2 Any committee or sub-committee established in accordance with clause 4.6 of the ICB Constitution may consist of or include persons who are not ICB members or employees.

6.1.3 The membership of the Committee will comprise of:

(a) ICB Non-Executive Member for Population Health and Strategic Commissioning and Public Partnerships

(b) ICB Board Clinical (Other) Member

(c) Two System Non-Executive Directors

(d) Representative for Provider Collaborative at Scale

(e) Representative for Provider Collaborative at Place

(f) Representative for Clinical and Professional Leadership Group – Clinician(s)

(g) GP Clinical Lead

(h) Secondary Care Doctor

(i) Allied Health Professional Representative

(j) Director of Public Health

(k) Chief Strategy and Delivery Officer

(l) Chief Nursing Officer

(m) Chief Medical Officer

(n) Chief Finance Officer

(o) Director of Primary Care

(p) Director of Medicines Management and Clinical Policies

(q) Chief People Officer

6.1.4 Subject experts will be attendees at each meeting.

6.1.5 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

6.1.6 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.

6.2 **Chair and Vice Chair**

The Chair of the Committee shall be the Non-Executive Member for Population Health and Strategic Commissioning and Public Partnerships. In the event that the Chair is unavailable to attend, the ICB Board Clinical (Other) Member will act as the Vice Chair and Chair the meeting, unless there is a conflict of interest. If the Chair has a conflict of interest then the Vice Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

6.3 **Attendance**

6.3.1 It is expected that members will prioritise these meeting and make themselves available; exceptionally where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Committee. For Local Authority representatives this will be in accordance with the due political process.

6.3.2 Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

6.3.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The Committee will meet monthly before every ICB Board meeting to ensure all information submitted to the ICB Board has been properly scrutinised and to develop an agreed view on any future issues arising.

7.2 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

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

7.4 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

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

7.6 Ratified minutes of the meeting will be circulated to all sub-groups for dissemination to their members.

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

8. QUORACY

8.1 The quorum necessary for the transaction of business shall be 7 members, to include 2 Non-Executive Members (to include 1 ICB Non-Executive Members and 1 System Non-Executive Director), 1 ICB Executive Director and 4 other members including two clinical.

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by telephone conference call, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS, VALUES AND DECISION-MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Values

In delivering their roles and responsibilities, the Committee shall undertake to contribute towards delivery of the following key purposes of an Integrated Care System:

9.2.1 strive to improve the outcomes in population health and healthcare;

9.2.2 tackle inequalities in outcomes, experience and access;

9.2.3 enhance productivity and value for money; and

9.2.4 assist the NHS in supporting broader social and economic development.

9.3 Decision-Making

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

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

9.3.3 <u>Voting</u>

(a) Decisions will be taken in accordance with the Standing Orders. The Committee will reach conclusions by consensus. When this is not possible the Chair may call a vote.

(b) Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be record in the minutes.

9.3.4 <u>Urgent Decisions</u>

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

(b) Where an urgent decision is required a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via telephone conference or communicate by

email to take an urgent decision. The quorum, as described above, must be adhered to for urgent decisions.

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

9.4 **Equality and Diversity**

9.4.1 The ICB aims to meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. The ICB aims to ensure that no one receives less favourable treatment due to their protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration is also given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

9.4.2 In carrying out its function, the ICB must have due regard to the Public Sector Equality Duty (PSED). This applies to all activities for which the ICB is responsible, including policy development, review and implementation.

9.5 **Due Regard**

The ICB has due regard to the PSED of the Equality Act 2010 to eliminate discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations between the protected groups.

10. IDENTIFYING AND MANAGING RISKS

10.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

10.2 The Committee will receive and review those risks delegated to it consisting of the Board Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

11. SUB-COMMITTEES

11.1 The Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of each such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.

11.2 Any sub-committees or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the Committee.

12. INTERDEPENDENCIES WITH OTHER GROUPS

The Committee will ensure any quality concerns are escalated to the System Quality and Performance Committee. The Finance and Estates Committee and Integrated Care Partnership will also be dependent on this Committee.

13. CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

13.1.1 ensure that they continue to comply with relevant organisational policies/ governance framework for probity and decision-making in line with sections 6.2.1 and 6.2.3 of the ICB's Constitution;

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

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

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

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

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

13.1.6 Conflicts of interest will apply to all providers of Primary Medical Care Services including GP partners, Primary Care Networks, Derbyshire Community Health Services NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust and DHU Healthcare for decisions relating to Primary Medical Care Services.

14. SECRETARIAT AND ADMINISTRATION

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

14.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed in accordance with the Standing Orders, having been agreed by the Chair with the support of the relevant executive lead;

14.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

14.3 records of members' appointments and renewal dates and the ICB Board is prompted to renew membership and identify new members where necessary;

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

14.5 the Chair is supported to prepare and deliver reports to the ICB Board;

14.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

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

15. REVIEW

15.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

Reviewed by Population Health & Strategic Commissioning Committee: 14th September 2023

Approved by the ICB Board: 21st September 2023

Review Date: January 2024

Appendix 1

Decisions and functions delegated to the Population Health & Strategic Commissioning Committee

ICB Committee	Decisions and functions delegated to the committee	Reference
Population Health and Strategic Commissioning Committee	Delegated responsibility for: • overseeing the preparation and publication of the commissioning plan with the involvement of the Health and Wellbeing Boards and aligned to the strategy developed by the ICP; • developing and implementing the commissioning strategy and policy of the ICB and to help secure the continuous improvement of the quality of services, including the specified duties under the Mental Health Act; • retaining a focus on health inequalities, improved outcomes and quality and ensure that the delivery of the ICB's strategic and operational plans are achieved within financial allocations; • commissioning consistently with the duties of the Secretary of State and NHSEI objectives, having regard to the Constitution; • making decisions within the limits as set out in the ICB's Scheme of Reservations and Delegation; and • further delegating to sub-committees relating specifically to primary care medical services but will retain oversight and accountability.	Population Health and Strategic Commissioning Committee Terms of Reference
Population Health and Strategic Commissioning Committee	The delegation arrangements and financial authority limits are as follows: • the approval of decisions within budget delegated to the Committee where the annual revenue consequence is less than £1,500,000.	SORD 1.1(d)

1.	**Commissioning and Investment Decisions**	***This includes capital and revenue expenditures and income (both healthcare and non-healthcare), and activities relating to such i.e. business cases, procurements, terminations and disinvestments***	
1.1	Approval of decisions <u>within budget</u>, where the annual revenue consequence is: (a) Up to £50,000 (b) Up to £100,000 (c) Up to £1,000,000 (d) Up to £1,500,000 (e) Above £1,000,000	 (a) Functional Directors (Budget Managers) (b) Executive Directors (Budget Holders) (c) ICB Executive Team (d) Population Health & Strategic Commissioning Committee (e) ICB Board	These delegations apply where decisions are within budgets delegated to the individual or Committee. The delegated individual must ensure recurrent budget / funding is available for future years before approval. Committees, Delivery Boards, Provider Collaborative and other such forums are not delegated to make decisions. Those delegated may wish to seek assurance from any such forum before the approval of a decision. Where a Primary Care contract or arrangement which has, or is capable of having, a term that exceeds five years, approval from NHS England's Local Team Director or Director of Finance must be sought.

Public Partnership Committee

Terms of Reference

1. SCOPE

1.1 The Public Partnership Committee (the "Committee") is established by NHS Derby and Derbyshire Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

1.2 These Terms of Reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the ICB Board.

1.3 The committee is a non-executive chaired committee of the ICB board and its members, including those who are not members of the ICB board, are bound by the standing orders and other policies of the ICB.

2. PURPOSE

The purpose of the Committee is to:

2.1 monitor the continued development and delivery of the Joined Up Care Derbyshire (JUCD) Engagement Strategy to ensure alignment with the ten principles for working with people and communities outlined in national guidance;

2.2 ensure any service changes and plans are developed and delivered through effective engagement with those affected by change and that patients, carers and the public are at the centre of shaping the future of health and care in Derbyshire;

2.3 provide a lay forum within which discussions can take place to assess levels of assurance and risk in relation to the delivery of statutory duties in public and patient involvement and consultation, as defined within the Health & Care Act 2022;

2.4 retain a focus on the need for engagement in strategic priorities and programmes, to ensure the local health and care system is developing robust processes in the discharging of duties relating to involvement and consultation;

2.5 promote innovation and improvement in public and patient engagement;

2.6 provide update reports to the ICB Board on assurance and risk; and on the delivery of duties and activities relating to patient and public engagement and involvement;

2.7 champion Patient and Public Involvement in all processes relating to ICB and JUCD decisions;

2.8 seek assurance that the ICB is following defined processes to take due regard when considering and implementing service changes as defined by the Equality Act 2010 and delivered through targeted engagement.

3. ROLES AND RESPONSIBILITIES

The Committee is asked to:

3.1 make recommendations on the 'phase 2' responsibilities of the Committee, likely from autumn 2022, concurrent with the confirmation of the scope of the Integrated Care Partnership, specifically relating to the scope, reporting arrangements and membership of this committee;

3.2 champion patient and public engagement across the Derbyshire health and care system, providing a watchful eye in scrutinising service developments;

3.3 ensure that the development and delivery of the Derby and Derbyshire Integrated Care Strategy is driven by the insight and opinions gathered from local people;

3.4 champion the routine principles of continuous engagement and co-production when assessing all public engagement activity, challenging and escalating findings where standards and principles have not been met;

3.5 seek assurance of work to reach underserved groups and that this is being coordinated across partners and agencies, ensuring that all voices are being heard;

3.6 seek assurance, through reports, reviews and presentations that the public are an integral part of designing, commissioning, transforming and monitoring services;

3.7 seek assurance that the ICB and wider system are meeting statutory duties relating to Patient and Public Engagement, as laid out in the Health & Care Act 2022, including those relating to Local Authority Scrutiny;

3.8 seek assurance that the system has robust mechanisms for training relevant staff on statutory duties relating to Patient and Public Engagement, as laid out in the Health & Care Act 2022;

3.9 oversee the development and delivery of a robust infrastructure of engagement mechanisms including, but not limited to, place-level engagement, reference groups to provide insight on emerging issues, a citizen's panel from which can be drawn individuals across a matrix of geography/conditions/protected characteristics, project-specific lay representation and other mechanisms as required;

3.10 ensure due process and appropriate methodologies have been followed in terms of involving the public in system projects, including providing constructive advice and challenge on proposed methods;

3.11 sign off the approach to all formal consultation programmes, either with delegated authority from the ICB Board or prior to their final sign off at those meetings;

3.12 seek assurance that the system has processes to ensure that adherence to the Equality Act duties of due regard is informing engagement programmes accordingly;

3.13 report to the ICB Board with regard to key risk areas and monitoring actions;

3.14 make recommendations for improvements and innovations in the way the system works with patients and the public;

3.15 oversee the development, completion and action planning of any internal or external audits relating to public engagement;

3.16 respond to external reviews and National Lessons Learnt reviews and bulletins especially with regards to the way patients and the public are engaged;

3.17 ensure that all voices are heard at committee and programme meetings and that all groups are given appropriate opportunity to shape local services;

3.18 act as an advocate for the engagement work being carried out for the future of health and social care in Derbyshire through appropriate networks.

4. DELEGATED AUTHORITY

4.1 The Committee is a formal committee of the ICB. The ICB Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time. Decisions and functions delegated to the Committee are detailed in Appendix 1.

4.2 The Committee holds those powers as delegated in these Terms of Reference as determined by the ICB Board.

5. ACCOUNTABILITY

5.1 The Committee is directly accountable to the ICB Board.

5.2 The Committee is authorised by the ICB Board to provide the ICB Board with appropriate assurances in respect of ensuring the voice of the public is heard throughout the ICB processes in the planning, commissioning, transformation and monitoring of services and to provide advice and support in the delivery of appropriate and effective methodologies.

5.3 The minutes of the meetings shall be formally recorded by the secretary and submitted to the ICB in accordance with the Standing Orders.

5.4 The Chair of the Committee will report to the ICB Board following each meeting, confirming all decisions made. The report will include recommendations that are outside the delegated limits of the Committee and which require escalation to, and approval from the ICB Board, if not already approved by them.

5.5 The Committee will provide an annual report to the ICB Board on the effectiveness of the Committee to discharge its duties.

5.6 The Committee shall maintain an annual work programme, ensuring that all matters for which it is responsible are addressed in a planned manner, with appropriate frequency across the year.

5.7 The Committee may investigate, monitor and review any activity within its terms of reference. It is authorised to seek any information it requires from any Group.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

6.1.1 Members of the Committee may be appointed from the ICB Board, Officers of the ICB or other external bodies as required to enable the Committee to fulfil its purpose.

6.1.2 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

6.1.3 Any committee or sub-committee established in accordance with clause 4.6 of the ICB Constitution may consist of or include persons who are not ICB members or employees.

6.1.4 The membership of the Committee in Phase 1 will comprise of the following voting and non-voting members:

Voting Members

- Chair, ICB Non-Executive Member for Public Partnership
- Vice-Chair, ICB Non-Executive Member for Audit and Governance
- Patient Lay Members
- NHS Foundation Trust Governor Members
  - Chesterfield Royal Hospital NHS FT
  - Derbyshire Community Health Services NHS FT
  - Derbyshire Healthcare NHS FT
  - University Hospitals of Derby and Burton NHS FT
- Voluntary Sector Representative
- ICB Diversity & Inclusion Network representative

Non-voting Members

- Chief Executive, Healthwatch Derby
- Chief Executive, Healthwatch Derbyshire
- ICB Chief of Staff
- ICB Deputy Director of Communications and Engagement
- Community engagement representative, Derbyshire County Council
- Community engagement representative, Derby City Council
- ICB Head of Engagement

6.1.5 Phase 2 membership will be confirmed in due course. Subject experts will be attendees at each meeting.

6.1.6 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

6.1.7 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.

6.2 **Chair and Vice Chair**

The Chair of the Committee shall be a Non-Executive Member of the ICB Board. In the event that the Chair is unavailable to attend, a Non-Executive Member will act as the Vice Chair and Chair the meeting, unless there is a conflict of interest. If the Chair has a conflict of interest then the Vice Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

6.3 **Attendance**

6.3.1 It is expected that members will prioritise these meeting and make themselves available; exceptionally where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Committee. For Local Authority representatives this will be in accordance with the due political process.

6.3.2 Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

6.3.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The Committee will meet monthly before every ICB Board meeting to ensure all Quality and Performance information submitted to the ICB Board has been properly scrutinised and to develop an agreed view on any future issues arising.

7.2 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

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

7.4 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

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

7.6 Ratified minutes of the meeting will be circulated to all sub-groups for dissemination to their members.

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

8. QUORACY

8.1 The quorum shall be 1 ICB Non-Executive Member, to include the Chair or Vice Chair, plus at least 2 representatives drawn from the lay members and FT Governors, and 1 Executive Director or Deputy.

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by video conference, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS AND DECISION-MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Decision-Making

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

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

9.2.3 <u>Voting</u>

(a) Decisions will be taken in accordance with the Standing Orders. The Committee will reach conclusions by consensus. When this is not possible the Chair may call a vote.

(b) Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be record in the minutes.

9.2.4 <u>Urgent Decisions</u>

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

(b) Where an urgent decision is required a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via video conference or communicate by email

to take an urgent decision. The quorum, as described above, must be adhered to for urgent decisions.

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

9.3 **Equality and Diversity**

9.3.1 The ICB aims to meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. The ICB aims to ensure that no one receives less favourable treatment due to their protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration is also given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

9.3.2 In carrying out its function, the ICB must have due regard to the Public Sector Equality Duty (PSED). This applies to all activities for which the ICB is responsible, including policy development, review and implementation.

9.4 **Due Regard**

The ICB has due regard to the PSED of the Equality Act 2010 to eliminate discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations between the protected groups.

10. SUB-COMMITTEES

10.1 The Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of each such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.

10.2 Any sub-committees or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the Committee.

11. IDENTIFYING AND MANAGING RISKS

11.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

11.2 The Committee will receive and review those risks delegated to it consisting of the Board Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

12. CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

12.1.1 ensure that they continue to comply with relevant organisational policies/governance framework for probity and decision-making, in line with sections 6.2.1 and 6.2.3 of the ICB's Constitution;

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

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

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

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

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

13. SECRETARIAT AND ADMINISTRATION

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

13.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed in accordance with the Standing Orders, having been agreed by the Chair with the support of the relevant executive lead;

13.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

13.3 records of members' appointments and renewal dates and the ICB Board is prompted to renew membership and identify new members where necessary;

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

13.5 the Chair is supported to prepare and deliver reports to the ICB Board;

13.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

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

14. REVIEW

14.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

Reviewed by Public Partnership Committee:	18th August 2023
Approved by the ICB Board:	21st September 2023
Review Date:	January 2024

Appendix 1

ICB Committee	Decisions and functions delegated to the committee	Reference
Public Partnership Committee	Delegated responsibility to: • ensure appropriate engagement and consultation with patients and the public for new or changing services; • assess levels of assurance and risk in relation to the delivery of statutory duties in public and patient involvement and consultation, as defined within the Health & Social Care Act 2012; • retain a focus on the need for engagement in strategic priorities and programmes, to ensure the local health system is developing robust processes in the discharging of duties relating to involvement and consultation; and • seek assurance that the Derbyshire system is following defined processes to take due regard when considering and implementing service changes as defined by the Equality Act 2010 and delivered through targeted engagement.	Public Partnership Committee Terms of Reference

Quality and Performance Committee

Terms of Reference

1. SCOPE

1.1 The Quality and Performance Committee (the "Committee") is established by NHS Derby and Derbyshire Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

1.2 These Terms of Reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the ICB Board.

1.3 The Committee is a non-executive member chaired committee of the ICB Board and its members, including those who are not members of the ICB Board, are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE

2.1 The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of service and performance, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care.

2.2 The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and performance. It needs to ensure internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care.

2.3 The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

2.4 The purpose of the Committee is to:

2.4.1 maintain system oversight in relation to quality and performance across the ICB;

2.4.2 be assured that the system is focused on:

(a) developing and reviewing shared quality and performance priorities for the system;

(b) sharing knowledge, insights and learning to inform improvement;

(c) understanding variation and risks to quality across the system, including early warning flags; and

(d) discussing collective action needed to address risks and issues, which the system is responsible for delivering with support from wider partners;

2.4.3 be assured that focus is on quality and performance across pathways, care journeys, services and sectors (e.g. planned care, urgent and emergency care, mental health, learning disabilities and autism, children and young people, Primary Care and Social Care);

2.4.4 be sighted on quality, performance and outcome information against key performance trajectories and be assured that quality issues are appropriately acted upon;

2.4.5 be sighted on exceptions from the ICS Quality Report and gain assurance that the system and each statutory board deliver against all Key Quality Indicators, aligned to the Quality Framework;

2.4.6 receive matters of escalation in relation to exceptions from the ICS Quality Report, and other concerns raised by the System Quality Group and the System Oversight and Delivery Group;

2.4.7 maintain oversight that the system organisations discharge their statutory duties in relation to the achievement of continuous quality improvement;

2.4.8 be assured in terms of delivery against of the Constitution, NHS Long Term Plan, Public Health Outcomes Framework and associated NHS performance regimes, and the Local Authority Quality Assurance Strategy agreeing any action plans or recommendations as appropriate;

2.4.9 manage any risks associated with the delivery of the System Quality Strategy and more general strategic quality risks across the system; a register will be maintained to ensure effective tracking of mitigations and escalation as necessary; and

2.4.10 oversee and monitor patient outcomes, experience and access to services.

3. ROLES AND RESPONSIBILITIES

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

3.1 be assured that there are robust processes in place for the effective management of quality and performance;

3.2 scrutinise structures in place to support quality, performance, planning, control and improvement, to be assured that the structures operate effectively and timely action is taken to address areas of concern;

3.3 agree and put forward the key quality priorities that are included within the ICB strategy/annual plan, including priorities to address variation/inequalities in care;

3.4 oversee and monitor the delivery of the ICB key statutory requirements;

3.5 review and monitor those risks on the Board Assurance Framework and the System Quality Group Risk Register which relate to quality and performance, and high-risk operational risks which could impact on care. the System Quality Group will need to escalate relevant risks to the Corporate Risk Register;

3.6 ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner;

3.7 oversee and scrutinise the ICB's response to all relevant Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the Department of Health and Social Care, NHSEI and other regulatory bodies/external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained;

3.8 maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites;

3.9 oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes;

3.10 ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place;

3.11 receive assurance that the ICB identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded;

3.12 receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD report);

3.13 to be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities;

3.14 scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children;

3.15 scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control;

3.16 scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services;

3.17 scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety;

3.18 have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Committee (e.g. System Quality Groups, Infection Prevention and Control, Safeguarding Boards /Hubs etc.); and

3.19 ensure the delivery of the quality and performance aspects within the ICB Strategy and Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28. .

3.20 **Collaboration**

The Committee will maintain oversight and receive assurance in relation to ensuring:

3.20.1 there is a collaborative approach to promote multi-professional leadership and a shared vision for quality and performance within the System;

3.20.2 a culture of learning and improvement to ensure provision of high-quality sustainable services;

3.20.3 quality oversight is maintained in relation to public health outcomes and the wider determinants of health; and take appropriate action as required to support the reduction in health inequalities; and

3.20.4 quality and performance oversight is maintained in relation to the performance of Health and Social Care organisations within the ICS in terms of the Care Quality Commission (CQC) and any other relevant regulatory bodies.

3.21 **Systems**

The Committee will maintain oversight and receive assurance in relation to ensuring:

3.21.1 there are clear roles and accountabilities in relation to quality and performance oversight;

3.21.2 effective improvement mechanisms are in place, including peer review and external support;

3.21.3 ensuring there are processes to effectively identify early warning signs that there is a quality or performance issue;

3.21.4 processes are established to identify, resolve and escalate risk emerging from poor quality as a result of poor performance against performance indicators;

3.21.5 implementation of the Patient Safety Strategy, including process and compliance in relation to PSIRF; being informed of all Never Events and informing the key partners of any escalation or sensitive issues;

3.21.6 processes are in place to interpret and implement local, regional and national policy (e.g. quality accounts, safeguarding etc.) and provide assurance that policy requirements are embedded in services;

3.21.7 receiving assurance from the System Quality Group on the approval of nursing and quality policies. The Committee shall provide assurance on this to the ICB Board via the Committee's assurance report;

3.21.8 considerations relating to safeguarding children and adults are integral to services and robust processes are in place to deliver statutory functions of all Health and Social Care Organisations within the ICS; and

3.21.9 Equality Impact Assessments (EQIAs) are undertaken and reviewed by System Quality Group for proposed service changes using the established mechanisms with any matters of concern escalated.

The definition of the System and the scope is any quality and performance issues within the boundary of Derbyshire/Derby City. It covers health and social care providers, private providers of care, voluntary and charitable services.

3.22 **Learning and Insight**

The Committee will maintain oversight and receive assurance in relation to:

3.22.1 establishing systems to draw from intelligence in order to inform quality and performance improvement, and to act on early warning signs;

3.22.2 maintaining oversight in terms of variation and risk across clinical pathways and to provide a view on the quality aspects of clinical pathways, care journeys and Transformation Programmes;

3.22.3 ensuring that quality and performance assurance data is used to inform commissioning decisions and drive improvements;

3.22.4 ensuring that processes are in place to provide assurance and oversight that services are high quality; meaning that they are safe, effective, caring, responsive and well-led and provide patients, service users and carers with positive experiences of care, and

3.22.5 will liaise with appropriate external bodies such as the CQC or professional regulatory bodies.

3.23 **Improvement**

The Committee will maintain oversight and receive assurance in relation to ensuring:

3.23.1 that at every service level there is a consistent set of meaningful “measures that matter” which can be used to inform improvement;

3.23.2 data and intelligence are effectively utilised in order to identify and prioritise the most important quality and performance issues, enabling corrective action to be taken; and

3.23.3 action is taken where required to investigate any quality, safety or patient experience concerns, noting action is taken to ensure that improvements in quality are implemented where necessary.

4. DELEGATED AUTHORITY

4.1 The Committee is a formal committee of the ICB. The ICB Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time. Decisions and functions delegated to the Committee are detailed in Appendix 1.

4.2 The Committee holds those powers as delegated in these Terms of Reference as determined by the ICB Board.

5. ACCOUNTABILITY

5.1 The Committee is directly accountable to the ICB Board.

5.2 The minutes of the meetings shall be formally recorded by the secretary and submitted to the ICB Board in accordance with the Standing Orders.

5.3 The Chair of the Committee will report to the ICB Board following each meeting, confirming all decisions made, highlighting any concerns, actions taken, next steps and ongoing monitoring. The report will also include recommendations that are outside the delegated limits of the Committee and matters which require escalation to, and approval from the ICB Board, if not already approved by them.

5.4 The Committee will provide an annual report to the ICB Board on the effectiveness of the Committee to discharge its duties.

5.5 The Committee shall maintain an annual work programme, ensuring that all matters for which it is responsible are addressed in a planned manner, with appropriate frequency across the year.

5.6 The Committee may investigate, monitor and review any activity within its terms of reference. It is authorised to seek any information it requires from any Group.

5.7 The Committee will receive schedules assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

6.1.1 Members of the Committee shall be appointed by the ICB Board in accordance with the ICB Constitution.

6.1.2 Any committee or sub-committee established in accordance with clause 4.6 of the ICB Constitution may consist of or include persons who are not ICB members or employees.

6.1.3 The ICB Board will appoint no fewer than four members of the Committee including two who are Non-Executive Members of the ICB Board. Other attendees of the Committee need not be members of the ICB Board, but they may be.

6.1.4 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

6.1.5 The membership of the Committee will comprise of:

(a) ICB Board Clinical (Other) Member;

(b) ICB Non-Executive Member for Finance and Estates;

(c) ICB Chief Nursing Officer;

(d) ICB Chief Medical Officer;

(e) ICB Chief Strategy and Delivery Officer;

(f) Provider Non-Executive Directors, with responsibility for Quality;

(g) Primary Care Representative.

6.1.6 Local Authority representatives will be invited to attend the meeting as participants.

6.1.7 Subject experts and supporting officers will be attendees at each meeting.

6.1.8 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

6.1.9 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.

6.2 **Chair and Vice Chair**

The Chair of the Committee shall be the ICB Board Clinical (Other) Member of the ICB Board. In the event that the Chair is unavailable to attend, the ICB Non-Executive Member for Finance and Estates will act as the Vice Chair and Chair the meeting, unless there is a conflict of interest. If the Chair has a conflict of interest then the Vice Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

6.3 **Attendance**

6.3.1 It is expected that members will prioritise these meeting and make themselves available; exceptionally where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Committee. For Local Authority representatives this will be in accordance with the due political process.

6.3.2 Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

6.3.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The Committee will meet monthly before every ICB Board meeting to ensure all quality and performance information submitted to the ICB Board has been properly scrutinised and to develop an agreed view on any future issues arising.

7.2 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

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

7.4 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

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

7.6 Ratified minutes of the meeting will be circulated to all sub-groups for dissemination to their members.

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

8. QUORACY

8.1 The quorum shall be one ICB Non-Executive Member, to include the Chair or Vice Chair, plus at least the Chief Nursing Officer, or Chief Medical Officer from the ICB (or deputy), and two provider representatives (to include one provider Non-Executive Director, with responsibility for Quality). Nominated deputies are invited to attend in place of the regular member as required.

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by video conference, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS AND DECISION-MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Decision-Making

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

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

9.2.3 Voting

(a) Decisions will be taken in accordance with the Standing Orders. The Committee will reach conclusions by consensus. When this is not possible the Chair may call a vote.

(b) Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be record in the minutes.

9.2.4 Urgent Decisions

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

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

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

9.3 Equality and Diversity

9.3.1 The ICB aims to meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. The ICB aims to ensure that no one receives less favourable treatment due to their protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration is also given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

9.3.2 In carrying out its function, the ICB must have due regard to the Public Sector Equality Duty (PSED). This applies to all activities for which the ICB is responsible, including policy development, review and implementation.

9.4 Due Regard

The ICB has due regard to the PSED of the Equality Act 2010 to eliminate discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations between the protected groups.

10. SUB-COMMITTEES

10.1 The Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups (see Appendix 2). The Terms of Reference of each such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.

10.2 Any sub-committees or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the Committee.

11. IDENTIFYING AND MANAGING RISKS

11.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

11.2 The Committee will receive and review those risks delegated to it consisting of the Board Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

12. MANAGING CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

12.1.1 ensure that they continue to comply with relevant organisational policies/governance framework for probity and decision-making, in line with sections 6.2.1 and 6.2.3 of the ICB's Constitution;

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

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

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

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

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

13. SECRETARIAT AND ADMINISTRATION

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

13.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed within five working days of the meeting, in accordance with the Standing Orders, and having been agreed by the Chair with the support of the relevant executive lead;

13.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

13.3 records of members' appointments and renewal dates and the ICB Board is prompted to renew membership and identify new members where necessary;

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

13.5 the Chair is supported to prepare and deliver reports to the ICB Board;

13.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

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

14. REVIEW

14.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

14.3 The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Reviewed by Quality and Performance Committee: 31st August 2023

Approved by the ICB Board: 21st September 2023

Review Date: January 2024

Appendix 1

Decisions and functions delegated to the Quality and Performance Committee

ICB Committee	Decisions and functions delegated to the committee	Reference
Quality and Performance Committee	Delegated responsibility to ensure: • the system organisations discharge their statutory duties in relation to the achievement of continuous quality improvement; • quality and outcome information against key performance trajectories is received and quality issues identified, ensuring they are acted upon; • delivery against of the Constitution, NHS Long Term Plan, Public Health Outcomes Framework, and associated NHS performance regimes, agreeing any action plans or recommendations as appropriate; • continuous improvements in quality and outcomes of clinical effectiveness, safety and patient experience are secured; • processes are in place to interpret and implement local, regional and national policy (e.g. Quality Accounts, Safeguarding etc.) and provide assurance that policy requirements are embedded in services; and • considerations relating to safeguarding children and adults are integral to services and robust processes are in place to deliver statutory functions of all Health and Social Care Organisations within the ICS.	Quality and Performance Committee Terms of Reference

Appendix 2

Quality and Performance Committee Delegation Structure

Remuneration Committee

Terms of Reference

1. SCOPE

1.1 The Remuneration Committee (the "Committee") is established by NHS Derby and Derbyshire Integrated Care Board (the "ICB") as a Committee of the ICB Board in accordance with its Constitution.

1.2 These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the ICB Board.

1.3 The Committee is a Non-Executive Member committee of the ICB Board and its members, including those who are not members of the ICB Board, are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE

2.1 The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary it will confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) and non-executive members.

2.2 The ICB Board has also delegated the following functions to the Committee:

2.2.1 elements of the nominations and appointments process for ICB Board members;

2.2.2 oversight of executive board member performance.

3. RESPONSIBILITIES OF THE COMMITTEE

The Committee's duties are as follows:

3.1 for the Chief Executive, Directors and other Very Senior Managers:

3.1.1 determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars;

3.1.2 determine arrangements for termination of employment and other contractual terms and non-contractual terms;

3.2 for all staff:

3.2.1 determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change);

3.2.2 oversee contractual arrangements;

3.2.3 determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate; and

3.3 possible additional functions that ICBs might choose to include in the scope of the committee include:

3.3.1 functions in relation to nomination and appointment of (some or all) ICB Board members;

3.3.2 functions in relation to performance review/ oversight for directors/senior managers;

3.3.3 succession planning for the ICB Board;

3.3.4 assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and Proper Person Regulation (FPPR).

4. AUTHORITY

4.1 The Remuneration Committee is authorised by the ICB Board to:

4.1.1 investigate any activity within its terms of reference;

4.1.2 seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference;

4.1.3 obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;

4.1.4 create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and SoRD but may /not delegate any decisions to such groups.

4.2 For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservations and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private. Decisions and functions of the Committee are detailed in Appendix 1.

5. ACCOUNTABILITY AND REPORTING

5.1 The Committee is accountable to the ICB Board and shall report to the ICB Board on how it discharges its responsibilities.

5.2 The minutes of the meetings shall be formally recorded by the secretary and a verbal update provided to the ICB Confidential Board following each of its meetings. Where

an individual's remuneration is discussed, the conflicts of interest and any personal or individual's sensitivities must be managed appropriately.

5.3 The Committee will provide the ICB Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

6. MEMBERSHIP AND ATTENDANCE

6.1 Membership

6.1.1 The Committee members shall be appointed by the ICB Board in accordance with the ICB Constitution.

6.1.2 The ICB Board will appoint no fewer than three members of the Committee including two Independent Non-Executive Members of the ICB Board. Other members of the Committee need not be members of the ICB Board, but they may be. The Non-Executive Members are:

(a) Non-Executive Member of Remuneration;

(b) Non-Executive Member of Population Health and Strategic Commissioning; and

(c) ICB Board Clinical (Other) Member.

6.1.3 The Chair of the Audit and Governance Committee may not be a member of the Remuneration Committee.

6.1.4 The Chair of the ICB Board may be a member of the Committee but may not be appointed as the Chair.

6.1.5 When determining the membership of the Committee, active consideration will be made to diversity and equality.

6.2 Chair and Vice Chair

6.2.1 In accordance with the constitution, the Committee will be chaired by the Non-Executive Member responsible for Remuneration, appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

6.2.2 Committee members may appoint a Vice Chair from amongst the members.

6.2.3 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.

6.2.4 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

6.3 Attendees

6.3.1 Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

6.3.2 Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

(a) the ICB's most senior HR Advisor or their nominated deputy;

(b) Chief Finance Officer or their nominated deputy; and

(c) Chief Executive or their nominated deputy.

6.3.3 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

6.3.4 No individual should be present during any discussion relating to:

(a) any aspect of their own pay; and

(b) any aspect of the pay of others when it has an impact on them.

7. MEETING ARRANGEMENTS AND FREQUENCY

7.1 The Committee will meet in private.

7.2 The Committee will meet at least twice each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

7.3 The ICB Board, Chair or Chief Executive may ask the Remuneration Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

7.4 The Chair of the Committee may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

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

7.6 The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference.

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

8. QUORACY

8.1 For a meeting to be quorate a minimum of two of the Members is required, including the Chair or Vice Chair.

8.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by video conference, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken.

8.4 If any member of the Committee has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

9. BEHAVIOURS AND DECISION-MAKING

9.1 Behaviours

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

9.2 Decision-Making

9.2.1 Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

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

9.2.3 Voting

(a) Decisions will be taken in accordance with the Standing Orders. The Committee will reach conclusions by consensus. When this is not possible the Chair may call a vote.

(b) Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

(c) Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

9.2.4 Urgent Decisions

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

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

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

9.3 **Equality and Diversity**

9.3.1 The ICB aims to meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. The ICB aims to ensure that no one receives less favourable treatment due to their protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration is also given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

9.3.2 In carrying out its function, the ICB must have due regard to the Public Sector Equality Duty (PSED). This applies to all activities for which the ICB is responsible, including policy development, review and implementation.

9.4 **Due Regard**

The ICB has due regard to the PSED of the Equality Act 2010 to eliminate discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations between the protected groups.

9.5 **Benchmarking and guidance**

The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

10. IDENTIFYING AND MANAGING RISKS

10.1 The Committee will help to identify concerns and risks, diagnose and develop actions/improvement plans to mitigate and respond to risks, and oversee implementation.

10.2 The Committee will receive and review those risks delegated to it consisting of the Assurance Framework, corporate risks and any other significant risks. These risks will be a standing agenda item of the sub-committee meetings at least quarterly and at every meeting if risks are escalating or of concern.

11. MANAGING CONFLICTS OF INTEREST

Members of the Committee shall adopt the following approach:

11.1.1 ensure that they continue to comply with relevant organisational policies/governance framework for probity and decision-making;

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

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

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

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

(a) requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions;

(b) allowing the individual to participate in the discussion, but not the decision-making process;

(c) allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.

11.1.6 In respect of the Non-Executive members who constitute the majority of the membership of the Remuneration Committee, their own remuneration and terms of service is set out as part of the national framework. However, where a review within the nationally agreed pay scales is required, an Advisory Group will be established to make a formal recommendation for any changes to pay within the national pay scales. This will then be ratified by the Board. The membership of the Advisory Group will include the ICB Chair, the ICB CEO, the ICB Board Clinical (Other) Member, one other ICB Executive Director, plus an ICB HR Advisor.

12. SECRETARIAT AND ADMINISTRATION

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

12.1 the agenda and papers are prepared in accordance with the ICB's Corporate Governance Framework and distributed within five working days of the meeting, in accordance with the Standing Orders, and having been agreed by the Chair with the support of the relevant executive lead;

12.2 attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;

12.3 records of members' appointments and renewal dates and the ICB Board is prompted to renew membership and identify new members where necessary;

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

12.5 the Chair is supported to prepare and deliver reports to the ICB Board;

12.6 the Committee is updated on pertinent issues/ areas of interest/ policy developments;

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

13. REVIEW

13.1 The Committee will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

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

Reviewed by Remuneration Committee:	14th September 2023
Approved by the ICB Board:	21st September 2023
Review Date:	January 2024

Appendix 1

Decisions and functions of the Remuneration Committee

ICB Committee	Decisions and functions delegated to the committee	Reference
Remuneration Committee	The function of making recommendations to the ICB Board about the exercise of its functions in relation to: • determining the remuneration, fees and allowances payable to employees of the ICB and to other persons providing services to it; • determining allowances payable under pension schemes established by the ICB; and • the appropriate remuneration and terms of service for the Chief Executive Officer, Executive Directors, other Very Senior Managers, Clinicians and Independent Non-Executive Members.	Remuneration Committee Terms of Reference

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 075

Report Title	Integrated Assurance and Performance Report
Author	Jo Hunter, Director of Quality Sukhi Mahil, Assistant Director Workforce Strategy, Planning and Transformation Sam Kabiswa, Assistant Director, Planning and Performance Georgina Mills, Head of Financial Reporting
Sponsor (Executive Director)	Dr Chris Clayton, Chief Executive Officer
Presenter	• Quality – Prof Dean Howells • Performance – Zara Jones, Executive Director of Strategy and Planning • Workforce - Linda Garnett, Interim ICB Chief People Officer • Finance – Keith Griffiths, Chief Finance Officer

Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐

Appendices	Appendix 1 – Integrated Assurance & Performance Report Appendix 2 – JUCD System Finance Report to 31st July 2023 (Month 4) Appendix 3 – Delivering Operational Resilience across the NHS this winter (Letter from NHS England)
Assurance Report Signed off by Chair	Not Applicable
Which committee has the subject matter been through?	Finance and Estates Committee: 22nd August 2023 Quality and Performance Committee: 31st August 2023 People and Culture Committee: 6th September 2023

Recommendations

The ICB Board are recommended to **NOTE** the Month 4 performance Operational Plan update against the plan commitments and targets.

Purpose

- Update the ICB Board on the Month 4 performance against the 2023/24 operational plan objectives/commitments, quality standards workforce and finance.
- Update on the work being done to plan for the winter in line with NHSE requirements.

Background

The 2023/24 Operational Plan set clear, measurable objectives which are fundamental to the NHS' contribution to improving health outcomes. The plan was submitted to NHSE on the 4th May.

The improvements in the plan are planned to be achieved by using our assets more productively with minimal or no growth in workforce. The financial plan assumed a break-even position.

Work to develop a more cohesive and integrated framework for future reporting against delivery of the plan is continuing with the aim of:

- creating a single version of the truth with greater alignment/triangulation between the various components (performance, workforce and finance); and
- for performance, agree a consistent set of data sets and sources to enable us to better forecast performance. This will also include adopting a more collaborative and common approach to the use of data and reporting of performance against targets and commitments as system.

The work and commitments required to achieve the integrated approach is complex and there is a significant amount of development work still required to create a truly integrated and triangulated monitoring and reporting framework. This development is being phased in collaboration with system partners to ensure ownership. In the meantime, the respective leads are continuing to work together to ensure the position is more joined up.

Report Summary

The summary below highlights the key areas to note, and additional information can be found in the supporting appendices.

QUALITY

- National collective commitment from the Home Office, Department of Health & Social Care, the National Police Chiefs' Council, Association of Police and Crime Commissioners, and NHS England has been published to end the inappropriate and avoidable involvement of police in responding to incidents involving people with mental health needs - **Right Care, Right Person (RCRP).** Tactical Working group including Derbyshire Police and Health & Social Care partners are developing a draft local agreement for Derbyshire (with identified gaps) for the Senior Director Working Party at the end of September.
- Volume Two of the Manchester Arena Inquiry (Emergency Response) has been published. This is the second report of three and examines the emergency response following the attack at the Manchester Arena. There are 149 Recommendations in total with 14 monitored recommendations for NWAS and a further 63 recommendations that effect EMAS (JESIP/Wider Health/LRF). EMAS have completed an initial SWOT analysis of all 149 recommendations and developed an action plan to track implementation.
- DDICB 360 safeguarding audit was completed with an outcome of significant assurance.

PERFORMANCE

Work has now started to review how we are performing against the forecasts we set out within the plan. The review will help us identify and manage key issues and areas of risk/focus to ensure we achieve the challenging objectives which we have set ourselves.

The review coincides with NHSE's winter planning ask (please see Appendix 3) on which guidance was recently issued. NHSE has set out four areas where focussed work is required to ensure that we are prepared for winter:

- continue to deliver on the UEC Recovery Plan by ensuring high-impact interventions are in place;
- completing operational and surge planning to prepare for different winter scenarios;
- ICBs should ensure effective system working across all parts of the system; and
- supporting our workforce to deliver over winter.

The 'Performance' slides within Appendix 1 set out how we propose to take forward this work.

In terms of performance to date:

Planned Care and Cancer

- The number of people waiting 65 weeks or longer on an incomplete RTT pathway: Behind plan at the end of June 2023, with 406 more patients waiting 65 weeks or longer than planned at an ICB level (UHDB: 1,985 actuals vs. 1,511 plans; CRH: 314 actual vs. 382 plan).
- The number of people on a community service waiting list: There are marginally more people on a community service waiting list at the end June 2023 (24,186) compared to when we started this financial year (24,026) as at end of March 2023. However, we have a higher proportion of people waiting longer than 18 weeks now (26%) compared to the level in March 23 (22%).
- Cancer waits longer than 63 days: both Trusts are ahead of target at the end of July 2024.
- 75% of cancers diagnosed within 28 days of referral: The CRH continue to deliver the standard and UHDB are making marginal improvement gains.
- Achieving the diagnostics target continues to be a challenge, with both Trusts behind trajectory.

Urgent and Emergency Care

- 4 hr A&E: Both Trusts continue to achieve against their 4-hr target, with July performance standing at 70.9% and 71.8% at the CRH and UHDB respectively. Stepping up performance in September and October is needed to give us some headroom for the winter months.
- Urgent Community Response: The Urgent Community Response Service continues to exceed the response time standard.
- General and Acute Bed Occupancy: Overall G&A bed occupancy is better than planned in July.
- Category 2 999 response times: Performance continues to operate above target both for the Derbyshire operation and the East Midlands as a whole.

Mental Health, Learning Disabilities and Autism

- IAPT, perinatal, adult SMI contacts: good performance against plan with all 3 metrics likely to have over-achieved at the end of Q1.
- Demand diagnosis rate: ahead of plan at the end of July.
- SMI Health checks – just fell short at the end of Q1.
- Out of area placements – off plan.

WORKFORCE

Whilst the system needs to monitor the position against the workforce plan submitted to NHSE earlier this year, a more rounded understanding of the position, through alignment of the Whole Time Equivalent (WTE) numbers and the finance pay bill is necessary. The 'Workforce' slides attached at Appendix 1, are therefore summarised in two parts; Month 4 position against plan (tables 1a-c) and the actual position compared to establishment (table 2); the latter aiming to provide the most reasonable overview based on the current mechanisms that are in place.

2023/24 Workforce Plan Position Month 4 (NHS Foundations Trusts, including EMAS)

At Month 4, the total workforce across all areas (substantive, bank and agency) was 183.13 WTE below plan. Compared to Month 3, there was an improvement in recruitment to substantive positions (increase of 277.55 WTE).

All organisations, except for CRH are below plan against the total workforce position. This is due to an adjustment in the workforce plan necessary to enable delivery of a balanced financial plan. This is now evident in the monthly over-performance against the workforce plan. As noted in the appendices, reporting issues with the UHDB data have been identified, which will be rectified for month 5 reporting. It is anticipated that this will result in UHDB also being over plan in the same way as CRH.

Whilst overall agency usage has declined compared to the previous month, the position remains above plan. A significant proportion of this will be due to the changes in EMAS and the increase in the agency position against plan (184 WTE actual against a plan of 20 WTE). EMAS do not use agency staff to cover vacancies but the changes to the PWR have meant that the only place to record the over-time / additional PAS equivalents is in the agency category. This has the potential to skew the overall system agency position (including when looking at the agency spending cap) and therefore this proportion will need to be recognised as a separate component when looking at the overall agency position.

All Trusts are making a concerted effort to reduce agency usage and spend. It has been agreed that there will be no agency usage to cover industrial action from Month 5 and therefore there should be a corresponding reduction on that basis. It is important to note that this approach, however, will create increased risks in relation to elective recovery and potentially patient safety.

The current high level primary care workforce plan position is included in this month's report. This identifies the current position against plan as 210 WTE below plan. The was observed mainly from Direct Patient Care (ARRS funded) roles at 144 WTE below plan.

It is recognised that the level of detail available to provide a comprehensive view of primary care is not evident. Discussions are now underway to consider how to develop this, so that the approach and reporting is more akin to the workforce and finance alignment work, in the same way as for the NHS FTs.

<u>2023/24 Month 4 - Workforce actual position (WTE) comparison to establishment (WTE)</u>

All organisations, except for CRH and DHcFT remain below their respective establishment, with the overall system position being 177wte below the establishment figures provided by finance (this is with the caveat that the UHDB revised figures will change this position). Despite this position the pay bill for staff remains overspent in Month 4 by £4.6m (YTD £18.9m overspent, of which £5.8m is agency spend). Whilst the WTE figures are within finance establishment the pay-cost overspend is assumed to be as a result of ongoing industrial action and the AfC pay award uplift not being reflected in the plan. Furthermore there are potentially further explanations for the pay bill not matching the WTE actuals, which are being worked through in the work being taking forward jointly with workforce and finance colleagues as described below.

Table 2 in the 'Workforce' slides is a significant step forward to begin looking at staffing levels and the pay bill as one. However, it is recognised that there are several caveats and further considerations needed before it is possible to draw firm conclusions. This approach is therefore intended to provide a best view of the position whilst the alignment work continues to evolve.

<u>Workforce and Finance Alignment Developments</u>

Whilst progress is being made, it is acknowledged that at this stage, the developments to align workforce and finance are not sophisticated enough to fully explain the position. Therefore, we have now brought together finance and workforce colleagues from across the system to work together to resolve some of the issues and to get us to a point where we have one version of the truth across workforce and finance.

This was the first-time colleagues had come together in this way and it was evident that there was a strong desire to work together to address the issues being identified. Given the strong support to continue working in this way, it was agreed to meet again in September (monthly thereafter). A number of working groups have now been established to progress the actions identified in the session, ahead of the September meeting.

Some of the areas that have been agreed to progress/explore further include:

- agreed that the difference between the establishment and staff in post actuals is the right proxy measure for vacancies (noting this can only be recognised as the funded vacancy position once efficiencies have been applied);
- better understanding that the funded establishment is what we can afford and the staff in post is the number contracted;
- exercise to be undertaken to develop a better understanding of the impact of additional hours worked and other enhancements and how that could be affecting the pay bill position. PWR would only pull out the contracted WTE's, so there is a need to apportion all the additional payments attributed to a WTE to determine the overall the impact on the pay bill;
- subject to finance discussions there was support for all organisations to rebase establishment plans to include the required efficiency levels. This would be at the highest level by apportioning the required efficiencies to the establishment, recognising that it would be for the delivery boards/ services to develop the detailed plans to ensure safe staffing levels are not compromised;
- funded establishment data would be routinely provided via the DDoFs (no formal data return required for this) this should be with the efficiencies applied so that it is actual funded establishment being reported;
- develop a clearer explanation of what workforce and finance plans are saying, what we are monitoring/reporting against on and why; how do the two plans stack up and what are the differences that we cannot resolve and need to acknowledge that there may be elements which will never align;
- whilst work is underway to improve alignment between ESR and the Finance ledger system, there will still be a degree of difference. A review is to be undertaken to understand how significant these differences are, to then agree the tolerances that would be acceptable;
- sharing assumptions/ definitions being applied – we know there are differences but don't know exactly what they are at present.

We have commenced this journey to attempt to build the aligned view of workforce and finance that is so desperately needed; this has not been done before; it will be complex and developmental. That said, the sense of urgency is recognized with the need to progress the immediate actions with other areas needing to be more medium to longer term.

FINANCE

As of 31st July 2023, the JUCD year to date position is £25.5m deficit against a £12.6m planned deficit, a £12.9m overspend against the plan. Factors contributing to this are the industrial action, excess inflation, Microsoft licencing costs and efficiency slippage. Consequently, the likely case year end forecast for 2023/24 is a deficit of £37.3m, which reflects these pressures that were not known at the time of planning. It also includes a £4m underspend, which relates to dental but there is a risk of clawback by NHSE as these are ring-fenced funds.

The worst-case scenario of a £108.1m deficit includes additional risks related to carrying out the financial plan, such as pressures on capacity and activity, drugs costs and income reduction.

The system efficiency delivery is £2.9m under plan year to date, this is split £8.1m behind plan on recurrent efficiencies and £5.2m over plan on non-recurrent efficiencies. Unless this is recovered, this will impact future years. The efficiencies have been phased based on an increasing rate of delivery as the year progresses, therefore, it is important that the development of schemes gathers pace to support the delivery of the current forecast position of breakeven. At month four, there is still £40m of schemes that are still in the opportunity phase or unidentified. As a result, the assurance on delivery of efficiencies is limited.

The system is still committed to delivering a breakeven position at year end and is reflected in the best-case year-end forecast.

The Provider Collaborative and Place will be required to make a significant contribution to delivering the in-year and recurrent underlying position.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☒	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☒
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☒	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☒
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☒			

No further risks identified.

Has this report considered the financial impact on the ICB or wider Integrated Care System?

Yes ☒	No☐	N/A☐

Details/Findings	**Has this been signed off by a finance team member?**
The papers are provided for information only and therefore have no financial impact.	Darran Green, Acting Operational Director of Finance

Have any conflicts of interest been identified throughout the decision-making process?

None identified.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒
Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?			
There are no risks that would affect the ICB's obligations.			
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?			
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings The ICB is committed to the achievement of Net Zero Targets and the delivery of the Derbyshire ICS Green Plan.			

Derby and Derbyshire
Integrated Care Board

Integrated Assurance and Performance Report

September 2023

Dr Chris Clayton ICB Chief Executive Officer
Prof Dean Howells, Chief Nurse Officer
Zara Jones, Executive Director of Strategy and Planning
Linda Garnett, Interim ICB Chief People Officer
Keith Griffiths, Chief Finance Officer

Quality

Prof Dean Howells, Chief Nurse Officer
Dr Deji Okubadejo, Non-Executive Member

Quality of Care, Access and Outcomes – position against plans, key risks and mitigations: Quality and Safety – Key Issues

Derby and Derbyshire Integrated Care Board

Key Messages1					
#	Concern or Issue	Programme/Specialty i.e. Maternity, cancer	Organisation/Place/ System Wide	Concern/Issue identified, Description/Impact	Proposed mitigation/Action being taken/Key Learning Points
1	IPC	HCAI	System	Trajectories for 23/24 released by NHSE. The targets will be challenging to meet based on last year's performance and data for year so far.	- On 28 July 2023 NHSE led a regional HCAI reduction event. Actions from the event will be sent out in the next month and reviewed for local implementation. - CRH and UHDB remain on enhanced monitoring and support on the NHSE Midlands IPC escalation matrix. Work continues at both Acute trusts to effectively implement recovery action plans. Assurance gained at Trust internal IPC committees. - Post infection Reviews have not identified any new learning to add into the existing recovery plans which early data suggests is starting to have a positive impact, particularly for CRH
2	Safety	Maternity	UHDB/CRH	Increasing stillbirth rate	- UHDB improvement plan has been developed with associated workstreams to implement as part of the Maternity Safety Support Programme. They have Tier 3 oversight arrangements. NHSE advisors are working closely with the Trust to develop quality improvement initiatives. Stillbirth rate in June 2023 remained at 5.08/1000 births with 3 stillbirths reported in the month. The reported neonatal death rate for June 2023 was 2.25/1000 live births following 1 neonatal death. This is above the national rate of 1.53/1000 for a level 3 neonatal unit. The extended perinatal thematic review is in progress with an interim report shared with the LMNS Board. A date for the final report has not yet been shared. - CRH stillbirth rate was 1.06/1000 total births which is showing a consistent decrease from July 2022 when the rate was 2.75/1000. The neonatal death rate remained at 0.36/1000 live births, however 1 neonatal death was reported. Both are below the ONS & MBRRACE national averages. - A review into the third- and fourth-degree tear rates has been completed. There were no consistent themes however the practice education team will continue to work closely with staff and monitor clinical practice. The rate of 48.1/1000 over a 3-month rolling period shows improvement but it is still above the national average of 46.8/1000 births. - The results of the CQC inspection in May reported a rating of Good across the two domains: safe and well led. - National reports - Saving Babies Lives Care Bundle Version 3 and Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 5 were both released on June 1st, 2023. Both Trusts have reviewed the requirements to meet the standards required. The LMNS will assess both Trusts for compliance against the 6 elements of SBLCBv3 from August, on a quarterly basis using the NHSE assurance template and guidance. - Ockenden assessments and reviews will be undertaken by the LMNS in October 2023, to determine compliance against the 7 Immediate and Essential Actions from the first report in 2020.

Quality of Care, Access and Outcomes – position against plans, key risks and mitigations: Quality and Safety – Key Issues

Derby and Derbyshire Integrated Care Board

Key Messages					
#	Concern or Issue	Programme/Specialty i.e. Maternity, cancer	Organisation/Place/System Wide	Concern/Issue identified, Description/Impact	Proposed mitigation/Action being taken/Key Learning Points
3	Safety	LeDeR	System	The national LeDeR team met the Confidential Advisory Group (CAG) team at DHSC as part of the annual review to discuss data flows and data processing. The CAG team advised there is currently no legal basis for any private organisation to process any data on behalf of LeDeR and that having a contract with an ICB does not waive this concern. With immediate effect all ICBs have been informed that any LeDeR reviews with external organisations were to be put 'on hold' whilst CAG amendments are put in place by the Regional Team. This could take up to 12 weeks.	- DDICB currently have eight LeDeR Reviews with Positive Behaviour Support Consultancy (PBSC) - PBSC confirmed that they already have a CAG agreement in place and have sent the certificate to the NHSE. This has been sent to the advisory group who have advised it could take up to 35 days for confirmation. - Nationally mandated 6-month timescales for completion of LeDeR reviews. Honorary contract implemented between Derby and Derbyshire ICB and PBSC. Reviews to re-commence 14th August.. - national team plan to develop a framework for an approved list of suppliers who are named on a CAG amendment which ICBs can use to carry out LeDeR reviews in future.
4	Safety	Primary Care	Elmwood Medical Centre	Care Quality Commission conducted an unannounced inspection on 23rd January 2023. The outcome of the CQC inspection was Elmwood Medical Centre been given a rating of Inadequate, issued with 2 warning notices and placed in Special Measures.	- The practice was given until 31st March 2023 to provide assurance to the CQC in regard to the warning notices with the plan that a follow up focused CQC inspection would take place in the near future. - CQC carried out a focussed reinspection of the practice on the 26th June 2023 to look at the actions carried out by GTD/Elmwood Practice in response to the warning notices issued in January 2023. - The practice were able to evidence the good progress made and whilst there was still work to complete, CQC took the decision that the warning notices would be closed down and requirement notices put in place for the remaining breaches.
5	Right Care, Right Person (RCRP)	Mental Health	System	Publication of the Collective national commitment from the Home Office, Department of Health & Social Care, the National Police Chiefs' Council, Association of Police and Crime Commissioners, and NHS England to work to end the inappropriate and avoidable involvement of police in responding to incidents involving people with mental health needs.	- Strong commitment from all system partners including Derbyshire Police and Health & Social Care partners - Derbyshire Police and partners already working towards local agreement – Most Appropriate Agency (MAA) - MAA / RCRP Partnership Working Meeting held 18th July with senior director representation from Police/Health & Social Care partners. - Tactical Working group 8th August to: a) work through scenarios and impact on each service b) contemplate other scenarios not included, risks, challenges, mitigations and gaps c) Operational process, triage and communication route for informed joint decision making d) to compile a SOP/MOU for Exec/Director Group for review

Quality of Care, Access and Outcomes – position against plans, key risks and mitigations: Quality and Safety – Key Issues

Derby and Derbyshire Integrated Care Board

Key Messages					
#	Concern or Issue	Programme/Specialty i.e. Maternity, cancer	Organisation/Place/System Wide	Concern/Issue identified, Description/Impact	Proposed mitigation/Action being taken/Key Learning Points
6	Manchester Arena Inquiry – Emergency Response	Urgent Care/EMAS	System	The purpose of the Manchester Arena Inquiry was to investigate the deaths of the victims of the 2017 Manchester Arena attack. Volume Two (Emergency Response), is the second of three and examines the emergency response following the attack at the Manchester Arena. There are 149 Recommendations in total. Fourteen Monitored Recommendation (NWAS – R14 - R27) and a further 63 recommendations that effect EMAS (JESIP/Wider Health/LRF).	Known Outcomes from National Groups: - Stronger annual EPRR Assurance Process (Lead ICB scrutiny on initial self-assurance) - National review of current Major Incident clinical roles and functions (use of senior clinicians, more proactive advance on-scene treatments) - Introduction of new national triage processes (Ten Second Triage (TST) & Major Incident Triage Tool (MITT)) Voluntary Sector EPRR capability framework (ACCE) EMAS completed an initial SWOT analysis of all 149 recommendations and developed an action tracker. Progressed key actions: - Major Incident Pre-Determined Attendance (PDA) reintroduced - Review of Mass Casualty Plan completed - Agreed with NHSE Mass Casualty Dispersal Grid - NARU action cards added to Trust (frontline staff/managers) iPad's - Changed name of Tactical Commander to Duty Commander to remove confusion on deployment - Agreed education programme for 2023/24 - a week refresher course for all frontline commander - Established an EMAS MAI Strategic Delivery Board - Part of the national MAI Recommendations Oversight Group led by AACE and other national groups Next Steps - Continued engagement with Lead commissioners, local, regional and national groups - Develop stronger local engagement with fellow responders - Review of EPRR Education program in light of changes across the MAI recommendations - Develop Specialist Commander capacity, training and exercising - Review and develop Incident Command capacity, training and exercising in the Emergency Operations Centres - Risk based approach to the prioritisations of recommendation delivery - Develop a communication strategy internally and externally.

LEARNING AND SHARING - best practices, outcomes
DDICB 360 safeguarding audit completed – outcome: significant assurance. The team are progressing on the 4 actions – 3 lows and 1 medium. Interim ICB AHP Project Lead extended until March 24. Focus around providing assurance on how AHPs are embedded into the ICS risk management strategy, including how AHP related risks are identified, reported, and addressed across the system.

Performance

Zara Jones, Executive Director of Strategy & Planning
Dr Deji Okubadejo, Non-Executive Member

Operational Plan Summary

NHS
Derby and Derbyshire
Integrated Care Board

Planned Care and Cancer

- **The number of people waiting 65 weeks or longer on an incomplete RTT pathway:** Behind plan at the end of June 2023, with 406 more patients waiting 65 weeks or longer than planned at an ICB level (UHDB: 1,985 actuals vs. 1,511 plan; CRH: 314 actual vs. 382 plan).
- **The number of people on a community service waiting list:** There are marginally more people on a community service waiting list at the end June 2023 (24,186) compared to when we started this financial year (24,026) as at end of March 2023. However, we have a higher proportion of people waiting longer than 18 weeks now (26%) compared to the level in March 23 (22%).
- **Cancer waits longer than 63 days:** both Trusts are ahead of target at the end of July 2024.
- **75% of cancers diagnosed within 28 days of referral:** The CRH continue to deliver the standard and UHDB are making marginal improvement gains.
- **Achieving the diagnostics target continues to be a challenge,** with both Trusts behind trajectory.

Urgent and Emergency Care

- **4 hr A&E:** Both Trusts continue to achieve against their 4-hr target, with July performance standing at 70.9% and 71.8% at the CRH and UHDB respectively. Stepping up performance in September and October is needed to give us some headroom for the winter months.
- **Urgent Community Response:** The Urgent Community Response Service continues to exceed the response time standard.
- **General and Acute Bed Occupancy:** Overall G&A bed occupancy is better than planned in July.
- **Category 2 999 response times:** Performance continues to operate above target both for the Derbyshire operation and the East Midlands as a whole.

Mental Health, Learning Disabilities and Autism

- **IAPT, perinatal, adult SMI contacts**: Good performance against plan with all 3 metrics likely to have over-achieved at the end of Q1.
- **Demand diagnosis rate:** ahead of plan at the end of July.
- **SMI Health checks** – just fell short at the end of Q1.
- **Out of area placements** – off plan.

Operational Plan – Performance

Derby and Derbyshire Integrated Care Board

*Figures in italics are **provisional** - Unavailable data is marked as n/a*
** Provisional data is unpublished by NHSE*

Area	Objective	Level	Operational Plan / Local Target	Full Year OP Target Profile	M03/Q1 OP Target Profile	M1 Position	M2 Position	M3 Position	M4 Position	M5 Position	Comment
Primary Care	Increase General Practice appointment activity		Operational Plan	6,707,340	549,335	471,753	538,841	568,802	536,175		
	Increase referrals into Community Pharmacy Consultation Services (Quarterly Target)		Operational Plan	39,197	8,615	*2,529*	*2456*	*2214*			
	Recover dental activity to pre-pandemic levels (Quarterly Target)		Operational Plan	1,531,764	382,941			*510,869*			This is YTD dental activity at 30/08/23. this represents 33.3% of the total planned activity. Activity can be submitted up to two months after treatment date.
Mental Health, Autism & Learning Disabilities	Increase the dementia diagnosis rate (Quarterly Target)	ICB	Operational Plan		64.0%	66.3%	66.4%	67.1%	67.7%		
	Provide access for 28,294 people to receive IAPT in 23/24 (Quarterly Target)	ICB	Operational Plan	28,294	6877	2265	4700	*n/a*			On track for Qtr 1 target - rolling total
	Increase the number of women accessing specialist perinatal services in 2023/24 (Quarterly Target).	ICB	Operational Plan	2,757	270	260	365	*n/a*			
	Increase the number of children and young people accessing a mental health service (Quarterly Target).	ICB	Operational Plan	52,481	12,000	10,630	10,720	*n/a*			Monthly activity number is a rolling 12 month total
	Increase the number of adults with a severe mental health illness receiving 2+ contacts with a community health service (Quarterly Target).	ICB	Operational Plan	44,815	10,508	11,730	11,685	*n/a*			Monthly activity number is a rolling 12 month total
	Ensure that 75% of individuals listed on GP registers as having a learning disability will receive annual health check (Quarterly Target).	ICB	Operational Plan	75%	11.9%	2.7%	6.7%	11.5%			Qtr 1 target missed by 0.46% - rolling total
	Reduce the number of adults who are autistic, have a learning disability or both who are in beds commissioned by the ICB and NHSE.	ICB	Operational Plan	36	52	45	48	48			
	Reduce the number of children who are autistic, have a learning disability or both who are in inpatient beds	ICB	Operational Plan	3	6	6	6	*4*			
	Reduce out of area placements - Bed Days	DHCFT	Operational Plan	736	1,196	1,790	1,855	*n/a*			

Key to RAG Ratings
On Plan
Close to Plan
Off Plan

Operational Plan – Performance

Derby and Derbyshire
Integrated Care Board

Area	Objective	Level	Operational Plan / Local Target	Full Year OP Target Profile	M03/Q1 OP Target Profile	M1 Position	M2 Position	M3 Position	M4 Position	M5 Position	Comment
Cancer	Ensure that at least 75% of people receive communication of a diagnosis for cancer or ruling out of cancer, or a decision to treat if made before a communication of diagnosis, within 28-days following an urgent referral for suspected cancer.	CRH	Operational Plan		78%	77.0%	77.8%	78.2%			
		UHDB	Operational Plan		68%	66.9%	70.0%	71.6%			
	Reduce the number of people waiting longer than 62 days for their first definitive treatment for cancer.	CRH	Operational Plan	43	49	47	48	44	47		
		UHDB	Operational Plan	268	376	473	473	369	366		
Planned Acute Care	No person waiting longer than 65 weeks on an RTT pathway at the end March 2024.	CRH	Operational Plan	0	417	314	313	314			
		UHDB	Operational Plan	0	1,729	1,704	1,924	1,985			
		DDICB	Operational Plan		1,598	1,813	1,988	2,059	*2,143*		
	No person waiting longer than 78 weeks on an RTT pathway.	CRH	Not OP targets	0	0	16	14	6			
		UHDB	Not OP targets	0	0	144	130	99			
		DDICB	Not OP targets	0	0	195	193	129	*148*		
	No person waiting longer than 104 weeks on an RTT pathway.	CRH	Not OP targets	0	0	0	0	0			
		UHDB	Not OP targets	0	0	0	0	1			
		DDICB	Not OP targets	0	0	3	6	0	*2*		
	At least 85% of people receive a diagnostic test within 6 weeks by March 2024.	CRH	Operational Plan	85%	85%	78.3%	76.4%	78.3%			Percentage compliance is based on all diagnostic tests. The 85% target is expected achievement at Apr 24 (hit 85% by Apr 24 and 95% by Apr 25). Current performance is on track
		UHDB	Operational Plan	85%	85%	66.0%	67.9%	70.3%			
Urgent and Emergency Care	No less than 76% attending ED waiting longer than 4 hours either to be treated, admitted or discharged, by March 2024.	CRH	Operational Plan	76%	58%	67.9%	64.8%	68.8%	70.9%		Both Trusts are currently meeting and exceeding the 4 hour operational plan target.
		UHDB	Operational Plan	76%	57%	66.7%	68.4%	67.7%	71.8%		
	30 minutes or less for EMAS to respond to a category 2 incident, on average.	ICB	Operational Plan		0	00:31:00	00:35:00	00:40:00	00:38:48		
		EMAS	Operational Plan	30 Mins	30 mins	00:33:32	00:34:23	00:39:34	00:36:16		
	Both Acute Trusts to operate at an average general and acute occupancy rate of 92%.	CRH	Operational Plan	88.97%	99.6%	94.2%	94.5%	94.0%	92.4%		The operational plan targets for July are 99.8% CRH and 94% UHDB. In July both Trusts had occupancy levels lower than the planned target. However the plan submission is not compliant with the national target of 92%
		UHDB	Operational Plan	92.89%	94.9%	89.8%	93.3%	94.0%	92.2%		
	At least 70% of referrals into the Urgent Community Response Service to be responded to within 2 hours.	ICB	Operational Plan		70%	67.0%	90.0%	*88.0%*			An issue has been identified with the submission fields in CSDS not corresponding to the UCR services. The locally reported position is 82% at may / 80% at June). This is being investigated with NHSE.
	Increase virtual ward capacity.	ICB	Operational Plan	255	156	123	138	138	146		
	Increase virtual ward utilisation.	ICB	Local Target	80%	50%	33.0%	18.0%	45.0%	21.0%		Month End Snapshot
	Reduce emergency admissions resulting from a frailty induced fall.		Local Target			*n/a*	*n/a*	*n/a*			

Operational Plan – Activity Community

NHS
Derby and Derbyshire
Integrated Care Board

Area	Activity Metric	Level	Operational Plan / Local Target	Full Year OP Target Profile	M03/Q1 OP Target Profile	M1 Position	M2 Position	M3 Position	M4 Position	M5 Position	Comment
Community Data	D2A - The number of people discharged by location and discharge pathway per month	ICB	OP Activity Measure		7,926	7,585	8,360	8,378	8654		
	D2A - Pathway 0 - Non-complex discharge		OP Activity Measure		7,220	6,989	7,676	7,652	7943		
	D2A - Pathway 1 - Home with Support		OP Activity Measure		433	300	381	384	380		
	D2A - Pathway 2 - Intermediate Care		OP Activity Measure		214	236	256	276	259		
	D2A - Pathway 3 - 24-hour care placement		OP Activity Measure		59	60	47	66	72		
	Community Waiting List - Quarterly Target	ICB	OP Activity Measure	24,026		24,352	23,483	24,186			24,026 target is the Mar 23 waiting list position
	Community Waiting List by weeks - 0-1 weeks	ICB			4,257	4,260	3,343	3,217			
	Community Waiting List by weeks - 1-2 weeks				2,372	2,360	2,124	2,304			
	Community Waiting List by weeks - 2-4 weeks				3,126	2,688	3,184	3,231			
	Community Waiting List by weeks - 4-12 weeks				6,813	6,956	6,590	6,368			
	Community Waiting List by weeks - 12-18 weeks				1,581	2,198	2,458	2,594			
	Community Waiting List by weeks - 18-52 weeks				4,500	4,413	4,493	4,994			
	Community Waiting List by weeks - over 52 weeks				978	1,124	1,291	1,478			
	Community Waiting List by weeks - Unknown				399	353					

Operational Plan – Activity CRHFT

NHS
Derby and Derbyshire
Integrated Care Board

Data Extracted from NHS Futures - Operational Planning Tool - Activity and Performance

Provider	Subject	Measure Name		Apr-23	May-23	Jun-23	Jul-23	Qtr 1
CRH	Elective	Elective day case spells - E.M.10a	2023/24 Actuals	2,154	2,492	2,413		7,059
			2023/24 Plans	2,289	2,421	2,326	2,690	7,036
		Elective ordinary spells - E.M.10b	2023/24 Actuals	257	329	343		929
			2023/24 Plans	321	385	373	393	1,079
	Outpatients	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance - E.M.32g	2023/24 Actuals	6,160	7,110	7,026		20,296
			2023/24 Plans	6,841	6,922	6,440	7,401	20,203
		Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance - E.M.32h	2023/24 Actuals	17,896	19,565	19,593		57,054
			2023/24 Plans	18,325	19,551	18,238	20,038	56,114
	A&E	A&E - Type 1 - E.M.13a	2023/24 Actuals	5,365	5,697	6,487	7,573	17,549
			2023/24 Plans	5,673	5,762	5,700	5,925	17,135
		A&E - Other - E.M.13b	2023/24 Actuals	2,552	3,067	2,192	1,185	7,811
			2023/24 Plans	2,668	2,841	2,765	2,685	8,274
		A&E - Total - E.M.13	2023/24 Actuals	7,917	8,764	8,679	8,758	25,360
			2023/24 Plans	8,341	8,603	8,465	8,610	25,409
	Non Elective and Emergency Care	Non-elective spells with a length of stay of 1 or more days - E.M.11b	2023/24 Actuals	2,336	2,178	2,285		6,799
			2023/24 Plans	2,131	2,187	2,143	2,111	6,461
		Non-elective spells with a length of stay of zero days - E.M.11a	2023/24 Actuals	1,371	1,604	1,619		4,594
			2023/24 Plans	540	555	567	590	1,662

Operational Plan – Activity UHDBFT

NHS
Derby and Derbyshire
Integrated Care Board

Data Extracted from NHS Futures - Operational Planning Tool - Activity and Performance

Provider	Subject	Measure Name	Type	Apr-23	May-23	Jun-23	Jul-23	Qtr 1
UHDB	Elective	Elective day case spells - E.M.10a	2023/24 Actuals	8,443	9,212	9,330		26,985
			2023/24 Plans	9,414	10,404	9,909	10,404	29,727
		Elective ordinary spells - E.M.10b	2023/24 Actuals	969	1,151	1,221		3,341
			2023/24 Plans	1,089	1,204	1,146	1,204	3,439
	Outpatient	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance - E.M.32g	2023/24 Actuals	25,758	30,670	27,049		83,477
			2023/24 Plans	30,681	33,910	32,296	33,910	96,887
		Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance - E.M.32h	2023/24 Actuals	62,350	72,288	60,972		195,610
			2023/24 Plans	64,583	71,382	67,983	71,382	203,948
	A&E	A&E - Type 1 - E.M.13a	2023/24 Actuals	14,480	15,992	15,999	15,491	46,471
			2023/24 Plans	15,398	16,029	15,799	15,443	47,226
		A&E - Other - E.M.13b	2023/24 Actuals	12,831	14,370	14,170	14,435	41,371
			2023/24 Plans	8,612	9,377	9,181	9,341	27,170
		A&E - Total - E.M.13	2023/24 Actuals	27,311	30,362	30,169	29,926	87,842
			2023/24 Plans	24,010	25,406	24,980	24,784	74,396
	Non Elective and Emergency Care	Non-elective spells with a length of stay of 1 or more days - E.M.11b	2023/24 Actuals	5,774	5,292	5,414		16,480
			2023/24 Plans	4,733	4,891	4,733	4,891	14,357
		Non-elective spells with a length of stay of zero days - E.M.11a	2023/24 Actuals	2,520	2,678	2,722		7,920
			2023/24 Plans	2,805	2,898	2,805	2,898	8,508

Constitutional Standards – Urgent Care

NHS
Derby and Derbyshire
Integrated Care Board

ICB Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire ICB Current Month	NHS Derby & Derbyshire ICB YTD	NHS Derby & Derbyshire ICB consecutive months non-compliance	Chesterfield Royal Hospital FT Current Month	Chesterfield Royal Hospital FT YTD	Chesterfield Royal Hospital FT consecutive months non-compliance	University Hospitals of Derby & Burton FT Current Month	University Hospitals of Derby & Burton FT YTD	University Hospitals of Derby & Burton FT consecutive months non-compliance	NHS England Current Month	NHS England YTD	NHS England consecutive months non-compliance
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Jul-23	↓	77.3%	75.0%	51	80.9%	79.3%	94	76.0%	73.4%	23	73.5%	74.8%	94
		A&E 12 Hour Trolley Waits	0	Jul-23					34	357	36	168	1,050	16	23934	108,858	36

EMAS Dashboard for Ambulance Performance Indicators

	Area	Indicator Name	Standard	Latest Period	Direction of Travel	East Midlands Ambulance Service Performance (NHSD&DICB only - National Performance Measure) Current Month	East Midlands Ambulance Service Performance (NHSD&DICB only - National Performance Measure) YTD	East Midlands Ambulance Service Performance (NHSD&DICB only - National Performance Measure) consecutive months non-compliance	EMAS Performance (Whole Organisation) Current Month	EMAS Performance (Whole Organisation) YTD	EMAS Performance (Whole Organisation) consecutive months non-compliance	EMAS Completed Quarterly Performance 2023/24 Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24	NHS England Current Month	NHS England YTD	NHS England consecutive months non-compliance
Urgent Care	Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Jul-23	→	00:08:34	00:08:33	37	00:08:40	00:08:36	36	00:08:36				00:08:21	00:08:21	27
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Jul-23	↓	00:15:39	00:15:03	2	00:15:49	00:15:34	25	00:15:30				00:14:59	00:14:55	0
		Ambulance - Category 2 - Average Response Time	00:18:00	Jul-23	→	00:38:48	00:36:38	36	00:36:23	00:36:01	37	00:35:56				00:31:50	00:32:24	36
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Jul-23	→	01:22:40	01:18:32	36	01:18:08	01:17:42	36	01:17:42				01:07:53	01:09:16	28
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Jul-23	↓	06:21:50	05:32:33	36	05:18:58	05:17:48	36	05:15:07				04:21:53	04:17:40	28
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Jul-23	↓	04:38:13	04:11:18	28	04:17:18	04:25:51	28	04:28:26				05:32:05	05:33:02	28

111 Indicators

Area	Indicator Name	Standard	Latest Period	Direction of Travel	DHU Performance Current Month
111 Key Indicators	Abandonment Rate	5%	Jun-23	↑	2.3%
	Average Speed of Answer	00:00:27	Jun-23	↑	00:00:37

Key:			
	Performance Meeting Target	Performance Improved From Previous Period	↑
	Performance Not Meeting Target	Performance Maintained From Previous Period	→
	Indicator not applicable to organisation	Performance Deteriorated From Previous Period	↓

Constitutional Standards – Planned Care & Cancer

NHS
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Key:			
	Performance Meeting Target	Performance Improved From Previous Period	↑
	Performance Not Meeting Target	Performance Maintained From Previous Period	→
	Indicator not applicable to organisation	Performance Deteriorated From Previous Period	↓

ICB Dashboard for NHS Constitution Indicators				Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Jun-23	↓	56.2%	56.8%	65	60.0%	60.8%	50	53.4%	53.9%	66	59.2%	59.0%	88
	Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Jun-23	↓	7765	22286	41	1183	3636	39	7049	19921	40	383083	1139216	194
	Number of 78 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Jun-23	↓	129	517	27	6	36	27	99	373	27	7177	30100	27
	Number of 104 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Jun-23	↓	0	9	0	0	0	0	0	0	0	314	1319	27
Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Jun-23	↓	28.22%	29.42%	61	21.73%	22.35%	39	29.74%	31.88%	40	25.16%	26.19%	118
2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Jun-23	↑	86.0%	81.7%	34	90.6%	85.6%	7	77.8%	73.9%	34	80.5%	79.8%	37
	Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Jun-23	↑	90.3%	81.6%	13	82.1%	69.2%	10	92.6%	88.9%	3	74.7%	74.1%	37
28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Jun-23	↑	73.7%	71.8%	4	78.2%	77.7%	0	71.6%	69.6%	23	73.5%	72.1%	4
31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Jun-23	↑	88.7%	87.9%	30	90.4%	92.1%	22	89.5%	87.2%	35	91.3%	90.7%	30
	Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Jun-23	↑	65.5%	62.8%	43	89.5%	92.1%	2	62.1%	62.5%	25	79.0%	77.5%	59
	Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Jun-23	↑	96.6%	95.1%	7	100.0%	100.0%	0	95.8%	95.4%	7	98.0%	97.6%	0
	Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Jun-23	↑	77.8%	74.5%	15				71.8%	67.2%	15	96.5%	89.5%	0
62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Jun-23	↓	53.4%	54.9%	52	71.7%	69.4%	47	50.0%	51.3%	62	59.2%	59.6%	90
	First Treatment Administered - 104+ Day Waits	0	Jun-23	↑	52	138	87	7	22	62	52	134	87	2128	5640	90
	First Treatment Administered Within 62 Days Of Screening Referral	90%	Jun-23	↑	63.0%	62.9%	50	81.3%	77.7%	50	50.0%	47.6%	31	62.2%	63.7%	63
	First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Jun-23	↑	76.9%	73.5%		73.3%	77.8%		90.9%	81.2%		72.9%	73.4%	

Data Source

NHS
Derby and Derbyshire
Integrated Care Board

Area	Data source	Link
Increase General Practice appointment activity	NHS Digital - Appointments in General Practice	Appointments in General Practice - NHS Digital
Increase referrals into Community Pharmacy Consultation Services (Quarterly Target)	NHS Futures - NHS England Pharmacy Integration Programme Workspace - Primary Care Pharmacy - Monthly Report by phODS - Pharmacy Regional Reports - Midlands Regional Report - Latest month -	https://future.nhs.uk/connect.ti/PharmacyIntegration/view?objectId=38360112
Recover dental activity to pre-pandemic levels (Quarterly Target)	eDEN Dental data via BSA	
Increase the dementia diagnosis rate (Quarterly Target)	NHS Futures - Mental Health Core Data Pack	2324_DASHBOARD_CDP_VW - Mental Health, Learning Disability and Autism Resource Hub - FutureNHS Collaboration Platform
Provide access for 28,294 people to receive IAPT in 23/24 (Quarterly Target)		
Increase the number of women accessing specialist perinatal services in 2023/24 (Quarterly Target).		
Increase the number of children and young people accessing a mental health service (Quarterly Target).		
Increase the number of adults with a severe mental health illness receiving 2+ contacts with a community health service (Quarterly Target).		
Ensure that 75% of individuals listed on GP registers as having a learning disability will receive annual health check (Quarterly Target).	Foundry - NHS Performance Overview - Learning Disabilites & Autism - Annual Health Check	
Ensure that at least 75% of people receive communication of a diagnosis for cancer or ruling out of cancer, or a decision to treat if	Statistics » Cancer Waiting Times (england.nhs.uk)	https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
Reduce the number of people waiting longer than 62 days for their first definitive treatment for cancer.	Statistics » Cancer Waiting Times (england.nhs.uk)	https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
No person waiting longer than 65 weeks on an RTT pathway at the end March 2024.	Statistics » RTT (england.nhs.uk)	Statistics » Referral to Treatment (RTT) Waiting Times (england.nhs.uk)
At least 85% of people receive a diagnostic test within 6 weeks by March 2024.	Statistics » Monthly Diagnostic Waiting Times and Activity (england.nhs.uk)	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/
No less than 76% attending ED waiting longer than 4 hours either to be treated, admitted or discharged, by March 2024.	Data taken from: A&E 4 hour performance - NHS England,	https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
30 minutes or less for EMAS to respond to a category 2 incident, on average.	https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators).	
Both Acute Trusts to operate at an average general and acute occupancy rate of 92%.	Statistics - NHS England - Critical care and General & Acute Beds – Urgent and Emergency Care Daily Situation Reports 2023-24	https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/critical-care-and-general-acute-beds-urgent-and-emergency-care-daily-situation-reports/critical-care-and-general-acute-beds-urgent-and-emergency-care-daily-situation-reports-2023-24/
At least 70% of referrals into the Urgent Community Response Service to be responded to within 2 hours.	https://www.england.nhs.uk/statistics/statistical-work-areas/2-hour-urgent-community-response/	
Increase virtual ward capacity.	Foundry (Virtual Ward Dashboard)	
Increase virtual ward utilisation.		
D2A - The number of people discharged by location and discharge pathway per month	NECS	\\ntpcts60.nntha.loc\shared_info\Collaborative Working\NECS Derbyshire Contract Reporting\Sitrep_metrics\Intial_Sample_data.xlsx
D2A - Pathway 0 - Non-complex discharge		
D2A - Pathway 1 - Home with Support		
D2A - Pathway 2 - Intermediate Care		
D2A - Pathway 3 - 24-hour care placement		
Community Waiting List - Quarterly Target	Statistics - NHS England - Community Waiting list	Statistics » Community Health Services Waiting Lists (england.nhs.uk)
Activity	NHS Futures	NHS Futures – NHS Planning Workspace – Tools – Activity and Performance Plan VS Actual Tool

Workforce

Linda Garnett, Interim ICB Chief People Officer
Margaret Gildea, Non-Executive Member

Workforce Summary: Month 4 (including EMAS)

NHS
Derby and Derbyshire
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Tables 1a and 1b: 2023/24 Workforce Plan Position Month 4

- To note, data quality issues with the UHDB PWR have been identified and work is underway to correct the position. For the purpose of this report it has been agreed to use the information from the PWR as submitted, with the recognition that full reconciliation will be required at M5.
- The total workforce across all areas (substantive, bank and agency) was 183.13 WTE below plan at M4.
- Compared to M3, there was an improvement in recruitment to substantive positions (increase of 277.55 WTE) and whilst agency usage has declined overall, there has been an increase in bank usage.
- National changes in PWR resulted in mis-alignment to the workforce plan which initially resulted in some anomalies with certain staff groupings. Local work-arounds have been put in place to manage this.

Table 1c: 2023/24 Primary Care Workforce

- The total workforce across was 210WTE below plan at M4. The gap was observed mainly from Direct Patient Care roles (ARRS funded) (144 WTE).
- The current high level primary care workforce plan position is included this month. Discussions are underway to consider how to develop this and present a more rounded position.

Table 2: 2023/24 Month 4: Workforce actual position (WTE) comparison to establishment (WTE)

- As a system work continues to better align workforce and finance.
- Table 2 aims to demonstrate the pay costs associated with the staff in post actuals (note this is with the recognition that there is some misalignment between ESR and finance ledger systems and actions are being taken to resolve this and/or agree acceptable tolerance levels).
- From this analysis, the M4 position demonstrates:
  - The M4 pay bill for staff cost is overspent by £4.6m (YTD £18.9m overspent, of which £5.8m is agency spend).
  - However, the overall system position against the total workforce (as set out above) remains below plan and when compared to the establishment the position is actually 177WTE below plan (this is with the caveat that the UHDB revised figures will change this position). So whilst the WTE figures are within establishment the pay-cost overspend is assumed to be as a result of ongoing industrial action.
  - In addition, the position does not fully reflect the agreed AfC pay uplift as being included in the plan for all organisations; DCHS have made this adjustment, whereas the other providers are still reporting the plan before the pay award funding whereas the actuals include the associated pay award costs. This will be amended for M5 reporting now discussions on the pay award allocation are concluding.
  - Furthermore, efficiency plans/ phasing as the associated impact on workforce are not fully factored in consistently across for all organisations, which will also impact on the overall workforce position, particularly in relation to the establishment position.

Table 1a: 2023/24 Workforce Plan Position Month 4 (NHS Foundations Trusts, including EMAS)

NHS
Derby and Derbyshire
Integrated Care Board

ICB Total	Reporting Period: Jul 2023					
	Month 4			Trend		
	Plan	Actual	Variance from plan	Previous month	Changes in actual vs previous month	Trend (Actual) previous 12 months
Workforce						
Total Workforce (WTE)	28,849.49	28,666.36	183.13	28,494.29	↑	
Substantive (WTE)	27,380.89	27,145.90	234.99	26,868.35	↑	
Bank (WTE)	1,194.13	1,096.64	97.49	1,090.80	↑	
Agency (WTE)	274.47	423.82	-149.35	535.14	↓	
Cost						
Pay Cost (£'000) *	123,844	128,431	4,587	125,978	↑	

* Planned pay cost do not fully reflect the agreed AfC pay uplift and impact on workforce as a result of efficiency plans which are in development.

Table 1b: 2023/24 Workforce Plan Position Month 4 - Provider Breakdown

NHS
Derby and Derbyshire
Integrated Care Board

		Plan	Actual	Variance from plan	Supporting Narrative
CRH	Workforce (WTE)				• CRH is achieving c50% of its YTD efficiency plan, which already includes an element of staff costs – Current schemes will continue and new schemes will be added throughout the year • The impact of regular strikes continues to be felt putting pressure on current resources, and is not an environment well-suited to reducing those resources • It has been confirmed that agency staff cannot backfill for striking staff, which may give a temporary reprieve re WTE. However, this stores up a backlog of activity which will need to be addressed alongside the existing obligation to process activity at >103% of 19/20 levels. The Trust will do so as efficiently as possible, but >103% + backlog will make material WTE reductions extremely difficult.
	Total Workforce	4,703.79	4,897.41	-193.62	
	Substantive	4,296.33	4,446.49	-150.15	
	Bank	295.20	323.81	-28.61	
	Agency	112.26	127.11	-14.85	
	Cost (£)				
	Pay Cost (£'000)	£19,711	£21,204	-£1,493	
DCHS	Workforce (WTE)				• Delivery is roughly to plan at M4 • Agency is below plan which is also reflected in the M4 agency pay bill • Changes have been made to M4 PFR to reflect the agreed pay uplift. Note retrospective changes can not be made to PFR and therefore this is all reflected in the M4 position, which has distorted the pay-bill position. • The actual pay costs reflect gross staff costs, which do not take the capitalised workforce adjustments into account.
	Total Workforce	3,793.71	3,762.59	31.12	
	Substantive	3,697.25	3,662.39	34.86	
	Bank	71.85	86.33	-14.48	
	Agency	24.61	13.87	10.74	
	Cost (£)				
	Pay Cost (£'000)	£15,659	£14,053	£1,606	
DHcFT	Workforce (WTE)				• Overall WTE usage within plan. • Challenge remains with recruiting into substantive posts to reduce bank and agency usage and therefore reducing the overall pay cost average.
	Total Workforce	3,066.43	3,043.43	23.00	
	Substantive	2,851.57	2,810.90	40.67	
	Bank	164.05	174.68	-10.63	
	Agency	50.81	57.85	-7.04	
	Cost (£)				
	Pay Cost (£'000)	£12,372	£13,280	-£908	
EMAS	Workforce (WTE)				• The data for EMAS includes the total Trust workforce i.e. core service, Cat2 additional investment and additional contracted PAS. • Whilst EMAS do not use agency staff to cover vacancies , the changes to the PWR have meant that the only place to currently record the over-time WTE/ additional PAS equivalents is in the agency category, hence the significant difference in plan V actual on agency.
	Total Workforce	4,221.64	4,221.04	0.60	
	Substantive	4,148.98	3,983.47	165.51	
	Bank	52.66	53.94	-1.28	
	Agency	20.00	183.63	-163.63	
	Cost (£)				
	Pay Cost (£'000)	£17,431	£16,981	£450	
UHDB	Workforce (WTE)				• Note – Some anomalies with PWR reporting have been identified due to 'scripting issues' for calculating workforce data. The position will be corrected in M5 reporting. • Foundation Trainees (F1) Rotation in Jul which caused the increase of WTE in Medical Dental Staff Group temporarily.
	Total Workforce	13,063.91	12,741.89	322.02	
	Substantive	12,386.75	12,242.65	144.10	
	Bank	610.37	457.88	152.49	
	Agency	66.79	41.36	25.43	
	Cost (£)				
	Pay Cost (£'000)	£58,671	£62,913	-£4,242	

Table 1c: 2023/24 Primary Care Workforce

NHS
Derby and Derbyshire
Integrated Care Board

	Baseline	Plan	Actual	Plan	Plan	Plan
Primary Care	**Staff in post outturn**	**Q1**		**Q2**	**Q3**	**Q4**
Joined Up Care Derbyshire STP	**Year End**	**As at the end of**	**As at the end of**	**As at the end of**	**As at the end of**	**As at the end of**
	(31-Mar-23)	**Jun-23**	**Jun 23**	**Sep-23**	**Dec-23**	**Mar-24**
Workforce (WTE)	**Total WTE**	**Total WTE**	**Total WTE**	**Total WTE**	**Total WTE**	**Total WTE**
Total Workforce	**3,378**	**3,439**	**3,229**	**3,548**	**3,614**	**3,647**
GPs excluding registrars	766	767	740	795	789	778
Nurses	364	365	354	363	363	361
Direct Patient Care roles (ARRS funded) *	465	510	366	580	636	669
Direct Patient Care roles (not ARRS funded)	282	286	268	290	293	298
Other – admin and non-clinical	1502	1512	1,501	1519	1532	1542

Summary

- The total workforce across was 210WTE below plan at M4. The gap was observed mainly from Direct Patient Care roles (ARRS funded) (144 WTE).

* Direct Patient Care roles (ARRS funded) was extracted from NHS Digital Primary Care Network Workforce publication, while other workforce data was from HEE. Note – it is recognised that there is a discrepancy in the direct patient care roles (ARRS funded) as the workforce plan categories do not align with the NHS Digital reporting categories. This is in the process of being rectified to identify how best to align the data to the plan.

Table 2: 2023/24 Month 4 - Workforce actual position (WTE) comparison to establishment (WTE)

Derby and Derbyshire Integrated Care Board

Data Sources:

- Provider Finance Returns (PFR)
- Finance - Deputy DoFs (Finance Ledgers)
- Provider Workforce Returns (PWR)

	Data Source: Provider Finance Return (PFR)						Data Source: Finance (DDOFs)							
	M4 Pay Budget *	M4 Pay Actual **	M4 Pay Variance	YTD Pay Budget *	YTD Pay Actual	YTD Pay Variance	M4 Establishment (as per Finance) **	Staff in Post (Substantive) M4 Actual	Vacancies ***	Vacancy Rate ***	Bank M4 Actual	Agency M4 Actual	Net Staffing (Substantive, Bank & Agency Total) M4 Actual	Establishment V Actual Variance
	£'000	£'000	£'000	£'000	£'000	£'000	WTE	WTE	WTE	%	WTE	WTE	WTE	WTE
ICB Total	123,844	128,431	-4,587	489,535	508,428	-18,894	28,843	27,146	1,697	5.88%	1097	424	28,666	177
CRH	19,711	21,204	-1,493	79,269	84,101	-4,832	4,704	4,446	258	5.47%	324	127	4,897	-193
DCHS	15,659	14,053	1,606	54,678	55,770	-1,092	3,819	3,662	157	4.10%	86	14	3,763	56
DHcFT	12,372	13,280	-908	49,244	52,113	-2,869	3,015	2,811	204	6.77%	175	58	3,043	-28
EMAS	17,431	16,981	450	68,140	66,693	1,447	4,241	3,983	258	6.07%	54	184	4,221	20
UHDB	58,671	62,913	-4,242	238,204	249,751	-11,547	13,064	12,243	821	6.29%	458	41	12,742	322

Notes:

*** The planned pay costs do not include the full impact of the agreed AfC pay uplift**

**** The establishment figures do not include the full impact of all the required efficiencies and subsequent impact on workforce**

***** For the purpose of this comparison exercise the vacancy numbers are based on the difference between establishment and staff in post as a proxy measure. It is recognised that there is a variance in the figures compared to those submitted in PWR; this is because of the establishment figures being extracted from the finance ledger whereas the vacancy actuals submitted on PWR are derived from ESR.**

Finance

Keith Griffiths, Chief Finance Officer
Jill Dentith, Non-Executive Member

The following slides summarise the information supplied in the SFEC report

M04 System Finance Summary – Financial Position

- As of 31st July 2023, the JUCD year to date position is a £12.9m overspend against the plan
- The forecast continues to be breakeven with growing material risks
  - The costs of industrial action
  - Excess inflation impacting on CHC, prescribing and mental health
  - Efficiency delivery
  - Operational pressures
  - ERF income due to lower elective activity affected by industrial action
- Consequence of this is the acute providers could run out of cash before the year end
- The financial position does not include the costs of meeting the unfunded pay award deficit of £13m

M04 System Finance Summary – Financial Position

Derby and Derbyshire Integrated Care Board

The YTD overspend is driven by unfunded pressures:-

The effect of industrial action £5m

Cost of living increases (£6.8m YTD, could increase to £20.0m worst case 2023/24 FOT)

The system also has a pressure as a result of the pay award (£0.5m YTD, likely case increasing to £2.8m)

Other pressures are from efficiency slippage, high-cost patients and drugs, Better Care Fund and Section 117 costs. Work continues to identify mitigations and accelerate delivery of the transformation programme

Due to bank staff, agency, and the premium costs of non-contractual pay, which are currently impossible to measure, workforce continues to cost more than anticipated

Dealing with operational problems relating to strikes detract focus from the important work on transformation, efficiencies and productivity

JUCD is committed to deliver a 2023/24 breakeven position on the assumptions made as part of the final submitted plan

I&E position by Provider Month 04 Position	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's	Full Year Plan £m's	Full Year Forecast £m's	Forecast Variance £m's
NHS Derby and Derbyshire ICB	0.0	(0.5)	**(0.5)**	0.0	0.0	**0.0**
Chesterfield Royal Hospital	(2.8)	(5.4)	**(2.6)**	0.0	0.0	**0.0**
Derbyshire Community Health Services	0.3	(1.4)	**(1.7)**	0.0	0.0	**0.0**
Derbyshire Healthcare	0.9	1.0	**0.1**	0.0	0.0	**0.0**
EMAS	0.0	0.6	**0.6**	0.0	0.0	**0.0**
University Hospital of Derby and Burton	(11.0)	(19.8)	**(8.8)**	0.0	0.0	**0.0**
JUCD Total	**(12.6)**	**(25.5)**	**(12.9)**	**0.0**	**0.0**	**0.0**

M04 System Finance Summary – Risk

NHS
Derby and Derbyshire
Integrated Care Board

Likely Case Risks

The unmitigated most likely outturn position of £37.3m over plan as described in the table reflects the risks that could not have been envisaged when the Operational Plan was submitted and are driven by influences outside of the control of the JUCD. The two acute providers are the biggest contributors to the overspend and have no mitigations to cover the problem

- Excess inflation is expected to cost the system £20m because costs are higher than the 2.9% growth included in 2023/24 allocations
- Industrial action is estimated to cost the system £12.7m over the year with 30% of activity including additional cover, outpatient appointments and elective/day case procedures lost. This does not take account of the significant amount of management time taken to manage this situation and the impact this distraction has had on the ability to deliver recurrent efficiency savings
- Pay award pressures relating to UHDB PFI, CRH subsidiary and DHU
- The system is also seeing unusual increased cost pressures in mental health and community services
- The likely case assumes full delivery of efficiencies, but this is looking increasing unlikely based upon current delivery

Month 04 Position	2023/24 Organisations Forecast Range		
Organisation	Best Case £m's	Likely Case £m's	Worst Case £m's
NHS Derby and Derbyshire ICB	0.0	(7.6)	(25.5)
Chesterfield Royal Hospital	0.0	(10.9)	(21.4)
Derbyshire Community Health Services	0.0	(1.8)	(6.5)
Derbyshire Healthcare	0.0	(1.6)	(3.8)
East Midlands Ambulance Service	0.0	0.0	0.0
University Hospitals of Derby And Burton	0.0	(15.5)	(51.0)
JUCD Total Surplus/(Deficit)	0.0	(37.3)	(108.1)

M04 System Finance Summary – Worst Case / Emerging Risk

Derby and Derbyshire Integrated Care Board

Worst Case Risks

- Additional risks to the financial plan include efficiency delivery, capacity pressures and reduction of patient related income e.g. ERF which is a consequence of industrial action
- The assumption that dental services are underspending by £4m has been stripped out of the worst case. The ICB is aware that at a National level NHSE are looking at ways to reinvest this money in the service. All ICBs across the Midlands have identified underspends and have them within their forecast outturn and this has been made very clear to NHSE. If the allocation is reinvested then all ICB's forecast positions will deteriorate.

Revenue Emerging Risks

- ERF is being reported as cost neutral as per NHSE guidance at month 4. The activity information produced nationally and received recently suggests UHDB are considerably below their target, however this has been challenged and it has been accepted that the data is inaccurate. The extent of the financial impact is still to be determined
- There is a current request to underwrite a £0.3m support against a Primary Care GP practice where the ICB has a legal duty to provide primary care medical services to those patients registered. This is not an isolated incident and there are several practices that are having financial difficulties that could require the ICB to step in at short notice and at considerable cost, to maintain patient care
- The National team have changed their view to support the revenue cost of capital and will now only cover depreciation this year reducing allocations by £3-3.8m, this has not been included in the position due to the timing of the information. This has been raised with Region for additional funding
- The NHS111 service is out for procurement at a higher specification to the current service; it is estimated this will cost significantly more

Capital Emerging Risks

- HMRC have rejected DHcFT'S first stage appeal for claims for zero rated VAT abatement on construction costs of three mental health units amounting to £12.4m, a formal request for an Alternative Dispute Resolution (ADR) hearing has been submitted and a HMRC Mediator is to set up a meeting between HMRC and the Trust's VAT advisors to assess the viability of the ADR. If this fails the mixed dormitory eradication programme will not be delivered

M04 System Finance Summary – Efficiencies

Derby and Derbyshire Integrated Care Board

The annual efficiency plan is to deliver £136m, year to date the achievement is £2.9m under a plan of £34.1m. The delivery has been planned at an increasing level and at a third of the way through the year this is less than a quarter of the required savings

- There are growing concerns on the viability of the efficiency programme, putting pressure on the ability to deliver the financial plan and the cash position of organisations within the system
- There are still £40m of plans yet to be developed further than identifying the area they should be delivered
- Where there has been additional £3.1m of schemes developed since month 3 there is a need for this to gather pace to meet the system plan
- The System Sustainability Board is meeting monthly to review progress and support removal of any blockers
- The use of ePMO is improving, using the package as the single point of record for efficiency schemes will allow robust reviews of savings plans and provide transformation a platform to initiate and follow through ideas to delivery
- Only 47% of efficiencies have been delivered recurrently to date, further work is therefore required to identify and deliver transformational change across the system. The provider collaborative is working on standardising processes to deliver corporate efficiencies such as reducing premium workforce costs
- The Programme Delivery Boards have so far been the System's main vehicle for delivering financial transformation across organisations, but the evidence provided indicates these are not delivering
- Overall there are no mitigations to cover the emerging shortfalls, which would suggest we need to consider immediate difficult actions to ensure sufficient cash is available to meet our contractual liabilities

Efficiencies by Provider Month 04 Position	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's	Full Year Plan £m's	Full Year Forecast £m's	Forecast Variance £m's
NHS Derby and Derbyshire ICB	12.1	11.6	(0.4)	44.2	44.2	0.0
Chesterfield Royal Hospital	4.3	2.1	**(2.2)**	15.7	15.7	**0.0**
Derbyshire Community Health Services	3.1	2.5	**(0.5)**	9.2	9.2	**0.0**
Derbyshire Healthcare	2.9	2.9	**(0.0)**	8.8	8.8	**0.0**
EMAS	3.7	4.3	**0.5**	11.2	11.2	**0.0**
University Hospital of Derby and Burton	8.0	7.8	**(0.2)**	47.0	47.0	**0.0**
JUCD Total	**34.1**	**31.2**	(2.9)	**136.0**	**136.0**	**0.0**

M04 System Finance Summary – Capital

Derby and Derbyshire Integrated Care Board

- The capital plan is £159.7m, consisting of £101.6m from the National team, £58.1m from the Regional team
- UHDB are ahead on a number of their critical estates schemes and EMAS have incurred expenditure earlier than planned on vehicles, offset by DCHS's Bakewell development
- The year to date underspend currently on EMAS PTS transport vehicles, the Kings Treatment Centre and the Community Diagnostic Centre developments in UHDB, are projected to achieve the plan by year end
- The forecast overspend is mainly due to EMAS, who did not identify operating leases in accordance with IFRS 16 requirements at planning stage. This was raised with the National team again this month but a response has not yet been received
- The System requires £200m plus just to maintain its patient facing estates and equipment, which is a considerable shortfall from the amount received. This is on top of any investment required to improve the estate and equipment
- Included in the plan is the dormitory eradication programme, which is at risk due to inflation and VAT abatement issue currently under review

	YTD plan £'m	YTD Actual £'m	Variance £'m	Full year plan £'m	Full year forecast £'m	Variance £'m
Chesterfield Royal Hospital	2.5	2.4	0.2	9.8	9.8	0.0
Derbyshire Community Health Services	1.8	1.4	0.4	10.3	10.4	(0.1)
Derbyshire Healthcare	22.8	22.7	0.0	68.3	68.3	0.0
EMAS	6.0	4.2	1.8	14.9	21.5	(6.7)
University Hospital of Derby and Burton	7.0	4.1	2.9	54.8	54.8	0.0
Additional Capital to distribute				1.6	1.6	0.0
JUCD Total	40.0	34.8	5.3	159.7	166.4	(6.7)

M04 System Finance Summary – Cash

Derby and Derbyshire Integrated Care Board

The table below describes the cash plan and balance, year to date and forecast outturn, DCHS and DHcFT have the largest cash balances disproportionately to their size

To cover the cash needed to keep the acute providers in a positive balance, it is essential to transact cash releasing efficiencies

Taking into consideration the risks in the position, CRH and UHDB are predicting to run out of cash in October and December respectively

The possibility is being explored to arrange temporary provider to provider cash support

Inevitably Trusts will need to apply to the Department of Health for interest-bearing loans. Where CRH is currently re-applying after being turned down in their initial request

Provider Cash Month 04 Position	Opening Balance 01/04/23 £m's	Cash Plan Month 04 £m's	Cash Balance Month 04 £m's	Cash Variance Month 04 £m's	Plan year ending 31/03/2024 £m's	Forecast year ending 31/03/2024 £m's	Year End Variance 31/03/2024 £m's
Chesterfield Royal Hospital	20.2	12.0	15.0	3.0	19.9	19.9	0.0
Derbyshire Community Health Services	37.3	27.8	31.3	3.5	34.1	34.1	0.0
Derbyshire Healthcare	53.9	31.9	40.2	8.3	23.7	23.7	0.0
EMAS	18.2	19.6	26.8	7.2	13.7	13.7	0.0
University Hospital of Derby and Burton	48.4	55.1	55.3	0.2	35.6	33.3	(2.3)
JUCD Total	178.0	146.4	168.5	22.1	127.0	124.7	(2.3)

JUCD System Finance Report to 31st July 2023 (M04)

1. Introduction

This report details the JUCD System Financial Position as at 31st July 2023, focusing on the I&E position, delivery of efficiencies, capital, and cash. This is followed by details of the developing efficiency programme and the emerging risks across the submitted plan.

2. Executive Summary

Income and Expenditure Performance

As at 31st July 2023, the JUCD year to date position is a £25.5m deficit against a £12.6m planned deficit, a £12.9m overspend against plan. Contributing to this are continued pressures outside of the plan from industrial action, excess inflation and Microsoft licences amounting to £12.4m of the system overspend. Other pressures are from efficiency slippage, high-cost patients and drugs, Better Care Fund and Section 117 costs.

Table 2.1 below outlines the systems year to date and forecast position at month four. UHDB show the largest overspend, of which £6.1m is being driven by industrial action and excess inflation. DCHS have a £1.7m overspend however £0.5m of this is related to efficiencies where they have phased their plan in, equally per month and schemes have not been up and running to cover these from the beginning of the year. CRH have pressures of £5.4m year to date against a planned deficit of £2.8m, driven by industrial action and excess inflation, work continues on mitigations and to accelerate delivery of the transformation programme. The ICB have a slight overspend of £0.5m which includes continued overspends in Section 117 in Mental Health and prescribing offset by underspends in CHC, Dental and operational costs. DHcFT and EMAS are reporting small underspends to date.

The forecast outturn for all organisations continues to be breakeven with the commitment to mitigate the overspends and risks encountered.

Appendix 2

Table 2.1 *JUCD I&E Position Summary as at 31st July 2023*

I&E Position by Provider Type	Month 4 Planned Variance	Month 4 Actual Variance	Month Variance to Plan		Annual Planned Variance	Annual FOT Variance	FOT Variance to Plan
Month 04 Position	£m's	£m's	£m's		£m's	£m's	£m's
Chesterfield Royal Hospital	(2.8)	(5.4)	(2.6)		0.0	0.0	0.0
Derbyshire Community Health Services	0.3	(1.4)	(1.7)		(0.0)	0.0	0.0
Derbyshire Healthcare	0.9	1.0	0.1		0.0	0.0	0.0
EMAS	0.0	0.6	0.6		0.0	0.0	0.0
University Hospital of Derby and Burton	(11.0)	(19.8)	(8.8)		0.0	0.0	0.0
Other NHS Acute	0.0	(0.0)	(0.0)		0.0	0.0	0.0
Other NHS Mental Health	0.0	(0.4)	(0.4)		0.0	0.1	0.1
Other NHS Community Services	0.0	0.0	0.0		0.0	(0.1)	(0.1)
Acute Independent Sector	0.0	(0.3)	(0.3)		0.0	0.0	0.0
Mental Health Independent Sector	0.0	(1.4)	(1.4)		0.0	(1.5)	(1.5)
Community Services Non NHS	0.0	(0.3)	(0.3)		0.0	(0.0)	(0.0)
Continuing Health Care	0.0	1.3	1.3		0.0	0.0	0.0
Primary Care Prescribing	0.0	(3.3)	(3.3)		0.0	(4.4)	(4.4)
GP Co-Commissioning	0.0	(0.2)	(0.2)		0.0	(1.0)	(1.0)
Other GP Primary Care	0.0	0.1	0.1		0.0	(0.1)	(0.1)
Pharmacy	0.0	0.5	0.5		0.0	0.0	0.0
Optometry	0.0	0.0	0.0		0.0	0.0	0.0
Dental	0.0	2.5	2.5		0.0	0.0	0.0
Other Programmed Services	0.0	0.5	0.5		0.0	1.9	1.9
ICB Running Costs	0.0	2.2	2.2		0.0	10.0	10.0
ICB Operational Costs Other Programme	0.0	(1.6)	(1.6)		0.0	(4.8)	(4.8)
Grand Total	**(12.6)**	**(25.5)**	**(12.9)**		**(0.0)**	**0.0**	**0.0**

ERF continues to be reported as cost-neutral in month four as per guidance. NHSE have withheld 16% of the allocation which will be released if the relevant amount of elective activity has been undertaken. Further details are in the risk section.

Capital

The total capital envelope is £159.7m made up of £52.5m from the Regional team, £101.6m from the National team and an indicative £5.6m in relation to achieving a breakeven capital position at year end 2022/23.

The forecast position overall on capital is overspent £0.1m on the Regional team and £6.6m on the National team funding. This relates to EMAS, DCA vehicle schemes and Operating leases not identified at the planning stage.

Further details on the capital plan are set out below.

Cash

The reported annual cash flows for the System take into account the anticipated delivery of cash-releasing efficiencies. If these do not happen, it will have significant effect on the in-year cashflow. CRH has reapplied for cash support after being rejected earlier in the year and UHDB are expecting to request support for December.

3. Income and Expenditure Performance

As at 31st July 2023, the year to date system position is a £25.5m deficit against a £12.6m planned deficit, driven by the cost of excess inflation, industrial action, Microsoft licencing, and efficiency slippage.

The table 3.1 below shows the range of forecasts for the system outturn positions, highlighting the emerging risks. If these risks materialise, each organisation will need to provide mitigations.

The likely scenario considers cost pressures that were not anticipated in the planning phase, such as excess inflation, national Microsoft licencing charges and costs associated with industrial action. The worst-case scenario incorporates risks related to carrying out the financial plan, including limitations on capacity, income reduction, drugs costs and efficiency delivery.

Table 3.1 *JUCD I&E position best, most likely and worst case forecast position.*

Month 04 Position	2023/24 Organisations Forecast Range		
Organisation	Best Case £m's	Likely Case £m's	Worst Case £m's
NHS Derby and Derbyshire ICB	0.0	(7.6)	(25.5)
Chesterfield Royal Hospital	0.0	(10.9)	(21.4)
Derbyshire Community Health Services	0.0	(1.8)	(6.5)
Derbyshire Healthcare	0.0	(1.6)	(3.8)
East Midlands Ambulance Service	0.0	0.0	0.0
University Hospitals of Derby And Burton	0.0	(15.5)	(51.0)
JUCD Total Surplus/(Deficit)	0.0	(37.3)	(108.1)

Risks

Risks to achieving the year end position continue to develop as the year progresses. These risks can be grouped into two categories: those that are outside the system's control (excess inflation, industrial action and pay award costs) and those that might prevent the execution of the submitted plan. Delivering breakeven necessitates the mitigation of these risks.

Table 3.2 below represents the risks that cumulate to the worst case scenario for JUCD detailing the costs outside of the plan at a risk of £35.4m and the risks in delivering the plan at £72.7m, including £30.7m of efficiency risk. There has been an increase of £11.4m from month three mainly attributable to industrial action, delivery of efficiencies and the recognition of the ringfenced dental benefit which could be subject to NHSE/I clawback.

Appendix 2

Table 3.2 *System Identified Risks*

Risk Month 04 Position	ICB £m's	CRH £m's	DCHS £m's	DHcFT £m's	EMAS £m's	UHDB £m's	Total £m's
Outside Plan							
Excess inflation above national guidance	(7.6)	(3.0)	(2.1)			(7.3)	**(20.0)**
Industrial Action	0.0	(5.5)	(0.1)	(0.1)		(7.0)	**(12.7)**
Pay Award	0.0	(1.4)		(0.3)	0.1	(1.2)	**(2.8)**
Outside Plan Total	(7.6)	(9.9)	(2.2)	(0.3)	0.1	(15.5)	(35.4)
Efficiencies	(6.2)	(7.9)	(2.7)	(0.7)		(13.3)	**(30.7)**
Operational Pressures							
Baseline and non-recurrent Income			(0.9)			(11.4)	**(12.3)**
Capacity & Activity Pressures	(3.4)	(2.0)					**(5.4)**
Contract Payments							**0.0**
Drugs Costs	(3.1)	(1.0)					**(4.1)**
Increasing pathway to 103/107%						(2.3)	**(2.3)**
Cost of Cash Support						(1.8)	**(1.8)**
Other	(1.3)	(0.6)	(0.6)	(2.8)	(0.1)	(6.7)	**(12.1)**
Benefits	(4.0)						**(4.0)**
Operational Pressures Total	(11.8)	(3.6)	(1.5)	(2.8)	(0.1)	(22.2)	(42.0)
Total	**(25.5)**	**(21.4)**	**(6.5)**	**(3.8)**	**0.0**	**(51.0)**	**(108.1)**

In the previous month's report, specific details of the risks connected to the pay award and Microsoft licence agreements were given, and those circumstances still pose a threat to the financial position.

Dental Benefit

Dental is part of the newly delegated Pharmacy, Optometry and Dental services from NHSE/I, it is widely known that there is a disparity of services within the region with pressures on NHS dentists resulting in NHS dental contracts being handed back and therefore reduced dental provision across the region. Year to date there is an underspend of £2.5m showing against this service due to unspent reserves and contract payments based on expected performance levels. The forecast underspend of £4m also relates to dental, which is shown elsewhere in the position and is at risk of clawback by NHSE/I. The forecast being shown this way is in line with the other East Midlands ICB's financial reporting.

ERF

A detailed narrative on ERF was provided in the month three report. ERF continues to be reported as cost-neutral in month four as per guidance. NHSE have withheld 16%, £7.4m of the allocation which is being held and will be released if the relevant amount of elective activity has been undertaken. JUCD are performing well below the elective target of 101%, with current performance estimated at 97%. Considerable work is required to improve this position to the forecast achievement by year end. As a result, Associate ICB income may decline, which would add to the system's pressure.

Revenue Cost of Capital

During 2022/23 there was a National review of Capital with Revenue consequences, the aim of the funding is to help mitigate any short-term revenue affordability barriers to provider capital investment. A return was requested covering three years from 2022/23, detailing the costs on specific investments. Support was given to JUCD in 2022/23 to cover the 3.5% dividend paid on (PDC) and depreciation.

During planning it was assumed that the £7.3m relating to this year would be received to cover the costs of capital, new national guidance has recently been received that is indicating that only the depreciation costs will be covered reducing the support to between £3m and £3.8m depending on if new capital schemes will be included. The biggest risk is on DHcFT's ward replacement scheme which will reduce expected funding by £2.5m.

As per further guidance the pressure resulted from this of £3.5m to £4.3m has been reported to the Regional NHSE/I team with the expectation funding will be available to support this. JUCD is awaiting confirmation of how much this will equate to.

Due to the timing of this information this has not been considered in the month 4 position or worst case scenario.

VAT Abatement

The two new Adult Acute Units (AAUs) and Psychiatric Intensive Care Unit (PICU) have a significant risk to the programme due to the assumed VAT abatement. HMRC has formally rejected DHcFT's initial, and first stage appeal for claims for zero rated VAT abatement on construction costs for the two AAUs and PICU. This has led to a potential cost pressure of £12.4m split: £10.7m for the two AAUs and £1.7m for PICU.

A formal request for an Alternative Dispute Resolution (ADR) hearing was submitted by the Trust's VAT advisers on 26 June 2023, with a request to 'stay' the Tribunal process to allow HMRC to agree or reject this request. The stay period will be for a maximum of 150 days. On 6 July 2023 contact was made by a HMRC Mediator to set up a meeting between HMRC and the Trust's VAT Advisers to assess the viability of ADR as a route forward for this case.

The regional and national leads linked into the Mental Health Programmes are aware of the on-going situation.

Efficiencies

As mentioned in the month three report, there continues to be a lack of assurance on the deliverability of the efficiency plans based on the information at month four. This not only puts pressure on the system's ability to meet its statutory duty of breakeven but also impacts on the cash position and will impact on financial sustainability moving forwards.

The below table tracks the development of the schemes from month three to month four.

Table 3.3 *System Efficiency Plan Development*

System Efficiencies Month 04 Position	Fully Developed £m's	Plans in Progress £m's	Opportunity £m's	Unidentified £m's	Total £m's
Annual Total - at Month 3	68.8	24.9	34.9	8.2	136.8
Annual Total - at Month 4	69.1	27.8	32.5	7.5	136.8
Total - Movement	0.3	2.8	(2.4)	(0.7)	(0.0)

The above shows that there has been minimal progress on the development of schemes during the month with only an additional £3.1m of schemes progressing past an opportunity. There is a clear need for the development of schemes to gather pace, not only to meet the efficiency

plan but to help mitigate the risks as shown in the section above. To support this, the System Sustainability Board is meeting monthly to review progress and support removal of any blockers.

The table below sets out the month four efficiencies by organisation and the actual delivery against those plans. The year to date has fallen further behind compared to month three, particularly at CRH, and is now £2.9m below plan.

Table 3.4 *System Efficiency Delivery*

Efficiencies by Provider Month 04 Position	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's	Full Year Plan £m's	Full Year Forecast £m's	Forecast Variance £m's
NHS Derby and Derbyshire ICB	12.1	11.6	(0.4)	44.2	44.2	0.0
Chesterfield Royal Hospital	4.3	2.1	(2.2)	15.7	15.7	0.0
Derbyshire Community Health Services	3.1	2.5	(0.5)	9.2	9.2	0.0
Derbyshire Healthcare	2.9	2.9	(0.0)	8.8	8.8	0.0
EMAS	3.7	4.3	0.5	11.2	11.2	0.0
University Hospital of Derby and Burton	8.0	7.8	(0.2)	47.0	47.0	0.0
JUCD Total	34.1	31.2	(2.9)	136.0	136.0	0.0

As part of the 2023/24 plan, there was an expectation that 70% of the efficiency plans would be delivered recurrently to support the system moving to a financially sustainable position moving forwards. The below table shows the split of the YTD efficiency delivery between recurrent and non-recurrent.

Table 3.5 *YTD Efficiencies split recurrent and non-recurrent*

Efficiencies by Provider - YTD Month 04 Position	YTD Plan £m's		YTD Actual £m's		YTD Variance £m's	
	Recurrent	Non-Recurrent	Recurrent	Non-Recurrent	Recurrent	Non-Recurrent
NHS Derby and Derbyshire ICB	6.2	5.9	5.9	5.8	(0.3)	(0.1)
Chesterfield Royal Hospital	3.2	1.0	1.3	0.8	(1.9)	(0.3)
Derbyshire Community Health Services	2.3	0.7	0.5	2.0	(1.8)	1.3
Derbyshire Healthcare	2.2	0.7	0.4	2.5	(1.8)	1.8
EMAS	3.1	0.7	3.0	1.3	(0.1)	0.6
University Hospital of Derby and Burton	5.7	2.4	3.5	4.3	(2.2)	1.9
JUCD Total	22.6	11.4	14.5	16.6	(8.1)	5.2

From the table, only 47% of efficiencies have been delivered recurrently to date and is £8.1m behind plan. Further work is therefore required to identify and deliver transformational change across the system. To help this, the provider collaborative is working on standardising processes to deliver corporate efficiencies such as reducing premium workforce costs.

4. Activity, Workforce and Finance Triangulation

The development of the local productivity tool is dependent on being able to robustly triangulate finance, activity and workforce and use information that is routinely produced and validated by partner organisations. Work is progressing with CRH on the activity component as the third part of the triangulation process to ensure that the inputs into the model are validated. The

intention is that the finance and workforce data will be extracted from the monthly returns submitted to regulators. Although progress has been slow since the initial update to the committee, investing time now in getting the tool and supporting methodology right and supported will ensure a better quality output.

No activity data has been received for the report.

Workforce

JUCD continues to be under plan for whole time equivalents (WTE) as detailed in table 4.1, with the expenditure is still overspending as detailed in table 4.2, there will be a significant element of overall non-contractual pay behind the £18.9m overspend due to industrial action.

Table 4.1 *Workforce Plan for 2023/24 & WTE from Provider Workforce Return*

Workforce WTE M04	Jul Planned WTE	Jul Actual WTE	Jul WTE Variance
Chesterfield Royal Hospital	4,703.8	4,897.4	(193.6)
Derbyshire Community Health Services	3,793.7	3,762.6	31.1
Derbyshire Healthcare	3,066.4	3,043.4	23.0
EMAS	4,221.6	4,221.0	0.6
University Hospital of Derby and Burton	13,059.2	12,741.9	317.3
JUCD Total	**28,844.8**	**28,666.4**	**178.4**

Chesterfield Royal Hospital has more whole time equivalents than planned increasing by 55.2 WTE from June with the other organisations reporting under their plan.

Table 4.2 *Workforce Costs from Provider Finance Return*

Staff Costs by Provider Month 04 Position	2022/23 M12	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's	Full Year Plan £m's	Full Year Forecast £m's	Forecast Variance £m's
Chesterfield Royal Hospital	253.4	79.3	84.1	**(4.8)**	232.5	232.5	**0.0**
Derbyshire Community Health Services	170.8	54.7	55.8	**(1.1)**	163.9	164.3	**(0.4)**
Derbyshire Healthcare	155.6	49.2	52.1	**(2.9)**	149.9	157.9	**(8.0)**
EMAS	198.0	68.1	66.7	**1.4**	207.6	207.6	**0.0**
University Hospital of Derby and Burton	750.5	238.2	249.8	**(11.5)**	696.7	694.5	**2.3**
JUCD Total	**1,528.3**	**489.5**	**508.4**	**(18.9)**	**1,450.5**	**1,456.6**	**(6.1)**

EMAS is the only organisation underspending year to date with the remainder overspending, resulting in a pressure to the system of £18.9m, this is expected to be improve at CRH and underspend at UHDB by year end. DCHS position has improved by £6m due to the income of £6.6m for the pay award now being included in the plan, whereas the other providers are still reporting the plan at before the pay award funding and the actuals with the pay award costs. This will be amended for M5 reporting now discussions on the pay award allocation are concluding. Additional expenses to cover the industrial action and under-delivery of pay efficiencies are also contributing to the overspend.

The table below outlines the Agency Staff costs year to date and forecast outturn.

Table 4.3 *2023/24 Agency Staff Plan*

Agency by Provider Month 04 Position	2022/23 M12	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's	Full Year Plan £m's	Full Year Forecast £m's	Forecast Variance £m's
Chesterfield Royal Hospital	15.5	3.2	5.0	(1.8)	9.1	9.1	0.0
Derbyshire Community Health Services	1.4	0.4	0.3	0.1	1.3	1.1	0.2
Derbyshire Healthcare	7.6	1.8	3.4	(1.6)	5.3	7.9	(2.6)
EMAS	0.7	0.3	0.3	(0.0)	0.8	0.8	0.0
University Hospital of Derby and Burton	14.5	3.6	6.0	(2.4)	10.7	10.7	(0.1)
JUCD Total	39.7	9.3	15.0	(5.8)	27.2	29.6	(2.5)

The year to date overspend has increased by £1.4m spread over CRH, DHcFT and UHDB as a result of the further industrial action throughout July. All providers except for Derbyshire Healthcare are expecting to improve this position to breakeven or under by year end.

While a specialised in-patient bed for eating disorders is being sought, a complicated eating disorder patient continues to be supported on one of Derbyshire Healthcare's wards, which is contributing to the overspend on the organisation's agency cost.

5. Prescribing

According to an analysis of the cost and volume plan, the actual costs for April and May both exceed the budget due to the increased price of drugs. Drug tariff costs were exceptionally high during the previous financial year, and while it was anticipated that they would decline this year this has not been the case to the levels expected.

A price concession occurs when the Department of Health and Social Care (DHSC) agrees to pay back extra expenses, when prices rise above the levels set by the drug tariff usually where some medications have grown more difficult to obtain due to supply and demand difficulties. Price concessions in July are pushing up costs by about £0.8m as opposed to £0.4m in April. Drugs are also coming off a price concession and going back into the national drugs tariff at price higher than previously seen.

This is a national trend, consequently it is not specific to Derbyshire.

To cut down on these overspends, the focus is on efficiency measures that maximise savings in each area and over deliver on current schemes to offset some of the increase in drugs prices, as well as developing new schemes. According to a PCN level study, Glossop PCN has the greatest spending to date. The team is prepared to start working in Glossop on extending efficiency projects.

6. Capital

The capital budget is £159.7m, consisting of £101.6m from the National team, £52.5m plus an indicative £5.6m from the Regional team.

The capital allocation from the Regional team is shown in table 6.1, the full year plan includes a 5% tolerance for each organisation with the additional £1.6m being listed as unallocated. A draft framework for additional allocations is to be presented to the Directors of Finance.

The year to date position is marginally overspent where UHDB are ahead of schedule on a number of their critical estates schemes and EMAS have incurred expenditure earlier than planned on the DCA vehicles, offset by DCHS Bakewell development. EMAS's overspend continue at a lessor rate into forecast outturn.

Table 6.1 *Regional funded Capital plan for the system*

Regional Funded Capital by Provider	YTD plan £'m	YTD Actual £'m	Variance £'m	Full year plan £'m	Full year forecast £'m	Variance £'m
Chesterfield Royal Hospital	2.3	2.2	0.0	8.1	8.1	0.0
Derbyshire Community Health Services	1.5	1.3	0.2	5.3	5.3	0.0
Derbyshire Healthcare	6.5	6.5	0.0	19.5	19.5	0.0
EMAS	0.0	0.7	(0.7)	8.9	9.0	(0.1)
University Hospital of Derby and Burton	2.8	3.4	(0.6)	14.7	14.7	0.0
Additional Capital less planning tolerance				1.6	1.6	0.0
JUCD Total	**13.1**	**14.2**	**(1.1)**	**58.1**	**58.2**	**(0.1)**

The National team provides additional funding, primarily for leases and funding bids. The distribution of funds and their associated expenditure by provider is shown in the table below.

Table 6.2 *National funded Capital plan and actuals for the system*

National Funded Capital by Provider	YTD plan £'m	YTD Actual £'m	Variance £'m	Full year plan £'m	Full year forecast £'m	Variance £'m
Chesterfield Royal Hospital	0.3	0.1	0.1	1.7	1.7	0.0
Derbyshire Community Health Services	0.3	0.1	0.2	5.0	5.1	(0.1)
Derbyshire Healthcare	16.3	16.3	0.0	48.8	48.8	0.0
EMAS	6.0	3.5	2.5	6.0	12.5	(6.5)
University Hospital of Derby and Burton	4.2	0.7	3.5	40.1	40.1	0.0
JUCD Total	**27.0**	**20.6**	**6.4**	**101.6**	**108.3**	**(6.6)**

The National capital plan is underspent year to date, this relates to EMAS PTS transport vehicles, the Kings Treatment Centre and the Community Diagnostic Centre developments in UHDB, these are projected to achieve the plan by year end. The forecast position is mainly due to EMAS, who's operating leases were not identified at planning stage. This was raised with the National team again this month but a response has not yet been received.

Risks to the Capital due to the revenue cost of capital and VAT abatement are mentioned in the risk section 3 above.

7. Cash

The table below reports the cash balance at the end of July at £22.1m above plan, the forecast at £2.3m below plan is assuming that the cash releasing efficiencies are met. Within these parameters UHDB are still forecasting to be below plan by £2.3m.

Table 7.1 *Cash Balances*

Provider Cash	Opening Balance 01/04/23	Cash Plan Month 04	Cash Balance Month 04	Cash Variance Month 04	Plan year ending 31/03/2024	Forecast year ending 31/03/2024	Year End Variance 31/03/2024
Month 04 Position	£m's	£m's	£m's	£m's	£m's	£m's	£m's
Chesterfield Royal Hospital	20.2	12.0	15.0	3.0	19.9	19.9	0.0
Derbyshire Community Health Services	37.3	27.8	31.3	3.5	34.1	34.1	0.0
Derbyshire Healthcare	53.9	31.9	40.2	8.3	23.7	23.7	0.0
EMAS	18.2	19.6	26.8	7.2	13.7	13.7	0.0
University Hospital of Derby and Burton	48.4	55.1	55.3	0.2	35.6	33.3	(2.3)
JUCD Total	178.0	146.4	168.5	22.1	127.0	124.7	(2.3)

Taking into consideration the risks in the position and the possibility these will not be mitigated as the system moves through the year, the probable cash balances are forecast below. This is predicting that CRH will run out of cash by October and UHDB by December. CRH have applied to NHSE/I for cash support to cover this deficit.

Table 7.2 *Month by Month Cash Forecast*

Month 04 Position										
Organisation	June £m's	July £m's	August £m's	September £m's	October £m's	November £m's	December £m's	January £m's	February £m's	March £m's
Chesterfield Royal Hospital	5.6	4.0	3.1	1.4	(2.7)	(6.8)	(10.9)	(15.0)	(19.1)	(23.2)
Derbyshire Community Health Services	36.6	31.3	29.5	27.4	28.4	24.7	25.5	23.6	22.7	26.7
Derbyshire Healthcare	40.2	40.2	37.9	33.5	31.3	29.1	26.9	25.0	23.0	23.6
East Midlands Ambulance Service	27.6	26.8	29.8	28.7	29.4	28.2	26.3	26.2	20.5	13.7
University Hospitals of Derby And Burton	66.2	55.1	49.5	28.5	23.0	6.6	(8.5)	(13.9)	(25.6)	(36.8)
JUCD Total Surplus/(Deficit)	176.3	157.3	149.9	119.5	109.4	81.7	59.3	45.8	21.5	4.0

The cash ratio (the amount of cash available to cover the liabilities that are due in one year or less), has remained static of the System with slight fluctuations in individual organisations. Only holding enough cash to cover half of the amount of liabilities held by JUCD, further indicating the potential cash issues in the forecast.

Table 7.3 *Cash Ratio*

Cash ratio	Cash Balance Month 04	Current Liabilities Month 04	Cash Ratio
Month 04 Position	£m's	£m's	£m's
Chesterfield Royal Hospital	15.0	(51.6)	0.3
Derbyshire Community Health Services	31.3	(31.9)	1.0
Derbyshire Healthcare	40.2	(47.9)	0.8
EMAS	26.8	(48.8)	0.5
University Hospital of Derby and Burton	55.3	(172.9)	0.3
JUCD Total	168.5	(353.1)	0.5

To cover the cash needed to keep the acute providers in a positive balance, it is essential to transact cash releasing efficiencies. Other options include provider-to-provider cash support and asking the department of health for additional funding, which one provider is currently re-applying after being turned down in the initial request.

8. Recommendations

The ICB Board are asked to **NOTE**:

- The variance to plan at the end of month four.
- The risks driving most likely and worse case forecast positions that requires urgent action to mitigate.
- The slow development of plans and the deterioration in efficiency delivery
- The cashflow problems facing our acute providers.
- EMAS's forecast of an overspend on the full year capital plan relating to operating leases which were not identified at the planning stage.
- The risk to the systems financial position based on current ERF performance against target.

To:
- ICB:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
- NHS acute, community and mental health trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
- Primary care networks

cc.
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

27 July 2023

Dear Colleagues,

Delivering operational resilience across the NHS this winter

This letter sets out our national approach to 2023/24 winter planning, and the key steps we must take together across all parts of the system to meet the challenges ahead.

In January, we published our delivery plan for recovering Urgent and Emergency Care (UEC) services: an ambitious two-year plan to deliver improvements for patients across the integrated Urgent and Emergency Care (iUEC) pathway. This plan, along with the Primary Care Recovery Plan, Elective Recovery Plan and the broader strategic and operational plans and priorities for the NHS, provides a strong basis to prepare for this winter.

The publication of the UEC Recovery Plan followed an incredibly challenging winter – with high rates of infectious disease, industrial action, and capacity constraints due to challenges discharging patients, especially to social and community care. We know these challenges have continued but want to thank you for the work you have done in the face of this to ensure that there have nonetheless been significant improvements in performance. Thanks

to these improvements, we are in a significantly better place compared to last summer. Compared to last June, A&E performance has improved and Category 2 performance is 14 minutes faster.

This progress and the plan we are today setting out for winter preparedness are key steps in helping us achieve our two key ambitions for UEC recovery of:

- 76% of patients being admitted, transferred, or discharged within four hours by March 2024, with further improvement in 2024/25.
- Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25.

To help achieve these ambitions, we have ensured that systems have had clarity over finances well before winter to allow them to plan effectively and further roll-out the measures that we know will improve services for patients. We have invested extensively in this, including:

- £1 billion of dedicated funding to support capacity in urgent and emergency services, building on the £500 million used last winter.
- £250 million worth of capital investment to deliver additional capacity.
- £200 million for ambulance services to increase the number of ambulance hours on the road.
- Together with DHSC, an additional £1.6 billion of discharge funding over 2023/24 and 2024/25, building on the £500 million Adult Social Care Discharge Fund.

While we are making good progress towards achieving our overall ambitions, we want to encourage providers to achieve even better performance over the second half of the year. We will therefore be launching an **incentive scheme** for those providers with a Type 1 A&E department to overachieve on their planned performance in return for receiving a share of a £150 million capital fund in 2024/25. We are asking providers to meet two thresholds to secure a share of this money:

- Achieving an average of 80% A&E 4-hour performance over Q4 of 2023/24.
- Completing at least 90% of ambulance handovers within 30 minutes during Q3 and Q4 of 2023/24.

We recognise that these are stretching targets but know that many providers will be able to achieve these to help the NHS as a whole make greater headway towards improving care for patients. Providers should already be putting measures in place which will contribute towards reaching these, including a greater focus on the longest times in department, particularly those spending longer than 12-hours, and wider system flow. We will communicate more details on this shortly, including how we will be working with you to improve data quality.

Turning to our wider planning for winter, we are clear that the challenges are not just in ambulance services or emergency departments, and recovery requires all types of providers to work together to provide joined-up care for patients. ICBs will play a vital role in system leadership but the actions we take need to extend across the wider health and care system including mental health services, services for children and young people, community health services, primary care and the voluntary, community and social enterprise (VCSE) sector.

We are therefore setting out four areas of focus for systems to help prepare for winter:

1. Continue to deliver on the UEC Recovery Plan by **ensuring high-impact interventions are in place**

Together with systems, providers, and clinical and operational experts we have identified 10 evidence-based high-impact interventions. These are focused around reducing waiting times for patients and crowding in A&E departments, improving flow and reducing length of stay in hospital settings. Delivering on these will be key to improving resilience in winter. We have recently written to all systems to ask that they assess their maturity against these areas as part of the universal improvement offer for the UEC Recovery Plan. Systems will then receive dedicated support on the four areas they choose to focus their improvement for winter.

More detail on these areas can be found at Appendix A and on the NHS IMPACT website.

2. **Completing operational and surge planning** to prepare for different winter scenarios

We have already collectively carried out a detailed operational planning round for 2023/24 but we are now asking each system to review their operational plans, including whether the assumptions regarding demand and capacity remain accurate. Although this will cover surge planning for the whole winter, specific plans should be made for the Christmas/New Year/early-January period which we know is often the most challenging time of the entire year.

In addition to this, and recognising the importance of planning for multiple scenarios, we are asking systems to identify how they will mobilise additional capacity across all parts of the NHS should it be required to respond to peaks in demand driven by external factors eg, very high rates of influenza or COVID-19, potential further industrial action.

This planning is essential to ensure winter plans protect and deliver elective and cancer recovery objectives, as well as deliver the primary care access programme, and proactive care for those most at risk of hospital admission (guidance on proactive care will be published shortly).

Next week, we will be issuing each ICB with a template to capture their surge plan and overall winter plan. We will work with those areas that are facing the greatest challenges across the UEC pathway via our tiering programme to support them in completing these returns. If you think you require additional support, please contact england.uec-operations@nhs.net.

All returns should be sent to england.uec-operations@nhs.net by **11 September 2023**.

3. **ICBs should ensure effective system working across all parts of the system**, including acute trusts and community care, elective care, children and young people, mental health, primary, community, intermediate and social care and the VCSE sector.

ICBs will play a vital role in system leadership and co-ordination but it is important that all parts of the system play their role. The NHS England operating framework describes the roles that NHS England, ICBs and NHS providers should play, working alongside our partners in the wider health and care system. It outlines our collective accountabilities and responsibilities to ensure we deliver a health service that maximises outcomes for patients.

To help systems plan, we have developed a set of recommended winter roles and responsibilities (**Appendix B**) to ensure clarity on what actions should be undertaken by each part of the system. These will require broad clinical leadership to implement, and systems should be using these to develop their winter planning return, reflecting how these relate to the circumstances within their individual system.

DHSC is also writing to local authorities and the adult social care sector shortly to set out priority actions for improving winter resilience and encouraging cross-system working with the NHS on winter planning.

To assist system working this winter, next week, we will also be publishing an updated specification for System Co-Ordination Centres and an updated Operational Pressures Escalation (OPEL) Framework to ensure we are taking a consistent and co-ordinated approach to managing pressures across all systems.

4. **Supporting our workforce** to deliver over winter

This year colleagues have continued to work incredibly hard in the face of increased demand. We know how much supporting your workforce matters to you, and it is crucial that employers ensure that they take steps to protect and improve the wellbeing of the workforce.

Last winter, we saw flu return at scale. It is vitally important that we protect the public and the health and care workforce against flu and other infectious diseases, and the best way of doing this is to ensure they are vaccinated. Providers should also ensure that they have an

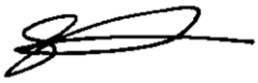
established pathway for identifying patients at-risk of COVID-19 and flu in their care, including those who are immunosuppressed.

Systems and providers should also continue to improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise, as set out in 2023/24 priorities and operational planning guidance and more recently in the NHS Long Term Workforce Plan, and ensure continued supply through maintaining education and training.

We want to thank you and everyone across the NHS for your continued hard work this year, we have again faced some unprecedented challenges but through strong partnership working we have once again risen to these.

The coming months will undoubtably be difficult, but we will continue to support you to ensure that we collectively deliver a high-quality of health service to patients and support our workforce. Thank you again for all your efforts as we work to build a more resilient NHS ahead of winter.

Yours sincerely,



Sarah-Jane Marsh
National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Julian Kelly
Chief Financial Officer
NHS England

Appendix A: 10 High-Impact Interventions

Action	
1.	**Same Day Emergency Care**: reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2.	**Frailty**: reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3.	**Inpatient flow and length of stay (acute)**: reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.
4.	**Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.
5.	**Care transfer hubs**: implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
6.	**Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
7.	**Virtual wards**: standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and help with discharge.
8.	**Urgent Community Response**: increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission.
9.	**Single point of access**: driving standardisation of urgent integrated care co-ordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time. This should include mental health crisis pathways and alternatives to admission, eg home treatment
10.	**Acute Respiratory Infection Hubs**: support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

Working together to deliver a resilient winter

System roles and responsibilities

The NHS England operating framework describes the roles that NHS England, integrated care boards (ICBs) and NHS providers should play, working alongside our partners in the wider health and care system. It outlines our collective accountabilities and responsibilities to ensure we deliver a health service that maximises outcomes for patients.

As we continue planning for winter it is important that we are clear on the actions that each part of the NHS system must now take to ensure that we are collectively pulling in the right direction to deliver for patients.

To support this, we have developed a set of recommended winter roles and responsibilities for each part of the system, which are included in this document, largely taken from existing guidance and recovery plans. These build on the core objectives outlined in the winter letter and provide a platform for systems to be clear on how actions are taken in all areas to deliver a resilient winter period.

The roles and responsibilities are designed to be supportive and provide clarity but are by no means exhaustive – each system should use these to develop their winter planning return and consider how these relate to the circumstances within their individual system.

Integrated care boards

- Ensure that the system winter operating plan incorporates all the high-impact interventions and actions for the entire health and social care economy. This should include specific operating actions for all system partners across acute, community, mental health, primary care aa well as links with local authority services. Systems should ensure that plans reflect the needs of all age groups, including services for children and young people.
- Facilitate partnership working – ensuring that all system partners are pulling in the same direction to deliver a resilient system this winter, and appropriately manage risk to ensure that it is balanced across the entire system, ensuring all parts of the system are held to account for delivery of their responsibilities.
- Be accountable for the delivery of capacity in line with agreed 2023/24 ICB Operating Plan – including additional capacity identified via the winter planning exercise.
- Ensure that arrangements are in place to lead the system through winter – including:
- maintaining 24/7 oversight of system pressures through the System Co-ordination Centre (SCC)
- implementing the revised SCC specification to ensure appropriate structures, systems and process are in place to maintain operational oversight and delivery
- implementing the revised Operating Pressures Escalation Levels (OPEL) Framework in a consistent manner across all acute sites as the key clinical safety indicator of system pressure
- leading the development of a comprehensive winter operating plan underpinned by a locally agreed operating model.
- Ensure infection prevention and control (IPC) colleagues are involved in winter planning and that they continue to be involved in responding to winter.
- Lead the liaison and engagement with the voluntary, community and social enterprise partners to ensure that they are fully engaged in winter planning and their support maximised.
- Ensure the continued workforce supply through early planning of actions to mitigate any loss of education and training during the periods of greatest winter service pressures.

Lead the delivery of high-impact interventions 5-10

- **Care transfer hubs**: In partnership with local authorities, implement a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and reablement

services and prevent unnecessary re-admission to a hospital bed. Improve the operation of current care transfer hubs from the baseline assessment, including operation throughout the winter holiday period.

- **Intermediate care demand and capacity**: With local authorities, commission sufficient capacity to meet projected demand for step-down care, including both home-based and bed-based care, to facilitate the timely discharge of patients from across acute and community hospitals and services.

  Make effective use of the Better Care Fund, including the Discharge Fund, to support patients to leave hospital with a package of care where needed.

  Ensure that capacity and resource gaps are escalated, and actions progressed; all data is submitted for all commissioned beds to the Community Discharge and Acute Discharge SitReps and the Capacity Tracker.

  Ensure data sharing arrangements are in place to enable rehabilitation/recovery plans to be shared by partners providing services and to streamline pathways and reduce duplication.

  Embed mechanisms to enable monitoring of the impact of intermediate care interventions on people's functional outcomes and their long-term care needs.

- **Virtual wards**: Be accountable for the delivery of virtual ward capacity and maximising virtual ward use, ensuring 80% occupancy across VWs is maintained over the winter period. Systems should ensure appropriate step-up and down capacity is in place at scale for frailty, respiratory and for heart failure, ensuring capacity is tightly aligned to winter flow priorities. This includes:

  - All step-up virtual wards should be accepting admission alternative referrals from care homes, ambulance trusts, primary care, and urgent community response ahead of winter and should ensure there are clear agreed processes in place between partners.

  - **Urgent Community Response (UCR)**: Ensure full geographical coverage with a minimum of 7 days a week and 08.00-20.00 operating times – going beyond the 9 clinical conditions/needs set out in the national specification to meet all appropriate community-based demand. Ensure, through working with the ambulance service, that plans are in place for most clinically appropriate Cat 3 or 4 calls to be diverted to UCR or community-based falls services.
  - **Advanced clinical support**: You should also ensure that care homes have access to advanced clinical decision-making support outside of UCR operational hours (eg 8pm to 8am) to ensure residents receive treatment and care in the right setting, and to enable clinical risk sharing across the system.
  - **Single point of access**: driving standardisation of urgent integrated care co-ordination which will support whole system management of patients into the right care setting, with the right clinician or team, at the right time. This includes

increasing the number and breadth of services profiled on the directory of services (DoS) and ensure steps are in place to maximise the use of the DoS.

- **Acute respiratory infection (ARI) hubs**: support consistent roll out of services for adults and children and young people, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in emergency departments and general practice to support system pressures.
- Through commissioning actions, ensure that **NHS 111** clinical input is prioritised where it will have most impact – in particular, maximising the assessment of NHS 111 Category 3 or 4 ambulance dispositions. Ensure that robust workforce plans are in place for NHS 111 service advisors, health advisors and clinical advisors. This should include using home working opportunities to the full.
- Support the delivery of key actions from the **Primary Care Recovery Plan** that will support winter pressures, including over the Christmas/New Year Period by improving access to general practice – particularly:
- Increasing support for self-directed care
- Expanding community pharmacy services
- Implementing modern general practice by:
- engaging and nominating their practices and PCNs to join the national general practice improvement programme
- supporting practices to move to cloud-based digital telephony and to access the right digital tools
- improving online patient journeys, including practice websites
- understanding general practice transformation maturity and support needs, via completion of the support level framework to enable ongoing local support to continue improvement:
- to make online channels easy to use
- to enhance navigation and triage processes
- to improve the experience of access
- to understand and better match demand and capacity.

Increasing capacity with larger multidisciplinary teams, including over the Christmas period

Improving the primary-secondary care interface.

Acute and specialist NHS trusts

Lead the delivery of high-impact interventions 1-4

1. **Same day emergency care (SDEC)**: Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2. **Frailty**: Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3. **Inpatient flow and length of stay**: Reducing variation in inpatient care and length of stay for key integrated urgent and emergency care (iUEC) pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients. This includes through:
    a. Delivering improvements in ambulance handover times

    b. Ensure documented internal professional standards are in place for rapid specialty in-reach to urgent and emergency care pathways 24/7 – ensuring that patients requiring admission are moved from the emergency department in line with these standards. Put in place mechanisms to monitor performance against these standards and take action to course correct delivery where required.
4. **Community bed productivity and flow**: Reducing variation in inpatient care and length of stay by maximising therapeutic interventions to reduce deconditioning and bringing forward discharge processes.

    - Ensure that general and acute beds are available and open in line with the agreed 2023/24 ICB Operating Plan – including escalating the number of beds as needed in line with the winter addendum to this plan. This includes monitoring and reducing occupancy in the run up to Christmas.
    - Focus on improving performance against the four-hour standard for type one attendances, to contribute to the overall A&E performance target of 76%.
    - Continue focused efforts on patients attending A&E who spend more than 12 hours in department from arrival to discharge, admission or transfer.
    - Ensure clear arrangements for early referral to care transfer hubs where patients are likely to require step-down care following hospital discharge. Align processes and protocols with standard operating procedures for care transfer hubs to reduce variation, minimise discharge delays, maximise access to community rehabilitation and reablement and optimise 7-day working. Provide timely data where needed by care transfer hubs to support governance,

operational grip and decision-making and to support intermediate care capacity and demand planning.

- Ensure that sufficient capacity is in place to protect the elective pathway for both adults and children and young people – with clear triggers in place to open additional non-elective capacity in line with the winter addendum to the 2023/24 Operating Plan.
- Ensure actions to improve the primary and secondary care interface set out in the Primary Care Access Recovery Plan are implemented with system wide understanding of pressures across the totality of the UEC pathway including primary care.
- Ensure that robust workforce plans are in place to respond to an increase in demand over the winter period, including planning annual leave to maintain a continuous physician presence throughout the Christmas/New Year period. This should include planning for a possible increase in staff sickness associated with an increase in winter illness, including Covid-19 and influenza.
- Implement flexible mechanisms for staff pooling and utilisation of resources across organisational boundaries, including increasing use of staffing banks to onboard both health and care workers to the right part of the pathway utilising ‘mutual aid’ arrangements where needed and supplemented by digital solutions.
- Ensure that a robust plan is in place for the vaccination of staff, volunteers and patients against influenza and that plans are in place to rapidly respond to any other vaccination programme recommended by the Joint Committee on Vaccination and Immunisation (JCVI)

Primary care

Ensure plans are in place to maintain access to primary care services between 18 December 2023 and 8 January 2024, including ensuring Bank Holiday cover in line with primary care national contracts is in place, so that patients can access services in primary care settings over the Christmas and New Year period.

- Ensure tools are in place to understand demand, activity and capacity in primary care, eg operational pressures escalation levels (OPEL) reporting. This should be shared across the system to give a comprehensive view of primary care pressures and where support may be required that could alleviate pressure on primary care and on the UEC pathway.
- Through working with the ICB and other system providers, ensure additional capacity is in place to respond to a surge in demand for primary care services – including through the development and provision of hot hubs and/ or acute respiratory infection hubs.
- Ensure proactive identification and management of people with complex needs and long-term conditions, so care is optimised ahead of winter and that people are supported to better manage their health, to reduce demand on primary and secondary care.
- Work with the ICB to develop system plans and communication strategies to maximise the role of general practice and community pharmacy.
- Lead delivery of actions from the Primary Care Recovery Plan that will support winter pressures, particularly:
- Support the delivery of key actions from the **Primary Care Recovery Plan** that will support winter pressures, including over the Christmas/New Year Period by improving access to general practice – particularly:
- Increasing support for self-directed care
- Expanding community pharmacy services
- Implementing modern general practice by:
- engaging and nominating their practices and PCNs to join the national general practice improvement programme
- supporting practices to move to cloud-based digital telephony and to access the right digital tools
- improving online patient journeys, including practice websites
- understanding general practice transformation maturity and support needs, via completion of the support level framework to enable ongoing local support to continue improvement:
- to make online channels easy to use

- to enhance navigation and triage processes
- to improve the experience of access
- to understand and better match demand and capacity.

Increasing capacity with larger multidisciplinary teams, including over the Christmas period

Improving the primary-secondary care interface.

Children and young people (CYP) services

Winter plans should reflect the needs of the local children and young people's population, with actions in place to manage pressures in paediatric services.

- **High-impact interventions for children and young people**: ICBs should ensure commissioning arrangements are in place to support scaling of age-appropriate virtual ward models and ARI hubs; building on pilots and plans and targeting areas of greatest needs to effectively manage winter pressures and increases in respiratory infections.
- **Whole-system planning**: embed whole-system approaches to winter planning for paediatric services, linking to paediatric critical care surge planning and Level 2 bed provision expansion, led by operational delivery networks (ODNs) with paediatric ARI hubs and virtual ward development. Disaggregate datasets should be available at ICB level to permit monitoring of CYP data, pressures across paediatric services, as well as the wider system and patient pathway, including primary care, acute and mental health services, immunisation, and school attendance.
- **Paediatric critical care surge planning**: ICBs and ODNs should work in partnership to co-ordinate, implement and oversee robust winter and surge planning, including mitigations to manage the impact of surges in paediatric respiratory infections on CYP services. This should include mutual aid arrangements at regional and national level, particularly for Level 3 paediatric intensive care unit (PICU) bed provision and for children on long term ventilation.
- **Mutual aid**: ensure local winter plans include mutual aid considerations across paediatric and adult teams, between providers within the system, and across systems.
- **Protecting elective capacity for children and young people**: ensure preservation of the standard clinical pathway for CYP elective surgery, critically ill children, emergency, general and specialist services and continue to reduce disparity in elective recovery between adults and CYP. Ensuring close monitoring of paediatric surgery cancellations.
- **Vaccination uptake**: ensure that a robust plan is in place to maximise uptake of childhood and flu vaccinations as part of winter preparedness.
- **Supporting self-care and management of minor illness**: ensure targeted communication and paediatric advice is available to parents/carers. Ensure collaborative approaches with VCSE partners, embedding preventative approaches to support parents/carers in management of minor illness and navigating NHS services, particularly across areas with high attendances and communities that experience the greatest health inequalities.

Community trusts and integrated care providers

Lead and support the delivery of high-impact interventions 4-6

- **Community bed productivity and flow**: reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes. This includes:
    - ensuring actions from daily ward and board rounds have been implemented and are being recorded or escalated in the day
    - discharge planning takes place early on in admission and in conversation with the person and/or next of kin
    - screening, assessment and rehabilitation plans are in place and communicated to the person and/or their next of kin
    - protocols for mobilisation of the individual are in place
    - workforce planning to ensure rehabilitation needs are met with minimum delays.
- Ensure clear arrangements for early referral to **care transfer hubs** where patients are likely to require step-down care following hospital discharge. Align processes and protocols with standard operating procedures for care transfer hubs to reduce variation, minimise discharge delays, maximise access to community rehabilitation and reablement and optimise 7-day working. Provide timely data where needed by care transfer hubs to support governance, operational grip and decision-making and to support intermediate care capacity and demand planning.
- Ensure focus on **admission avoidance**, ensuring 24h access to palliative care services and enhanced join-up between primary, community and social care services through enhanced care in care homes.
- **Data sharing and submission**: Reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes.
    - Submit data for all commissioned community beds to the Community Discharge SitRep.
    - Ensure data sharing arrangements are in place to enable rehabilitation/recovery plans to be shared by partners providing services and to streamline pathways and reduce duplication.
- Ensure there are joint executive leadership and system agreements in place across partner organisations, to ensure shared decision making and governance arrangements.
- Ensure multi-professional teamworking and a partnership approach to discharge, and multi-agency working with local authority partners and the

independent and voluntary sector to review availability of resource, provide access to reablement/pathway services for ongoing recovery support at home, and ensure timely discharge from intermediate care for a person's ongoing and longer-term needs.

- Implement flexible mechanisms for staff pooling and use of resources across organisational boundaries, including increasing use of staffing banks to onboard health and care workers and deployment of therapy capacity to the right part of the pathway using 'mutual aid' arrangements where needed and supported by digital solutions.
- Implement solutions to release therapist time and increase rehabilitation capacity, including through use of digital solutions, admin capacity, streamlining referral processes and utilising support workers to undertake tasks where appropriate.
- Implement data and operational dashboards, including daily oversight of capacity and demand and blocks in the pathway including:
    - demand for therapy workforce to deliver rehabilitation assessment and interventions
    - working with acute hospitals to proactively plan for demand, support timely discharge and enable flexible resource utilisation plans across partners and organisations
    - working with systems to undertake the self-assessment exercise as part of the system maturity evaluation and progress agreed actions to maximise delivery of services through winter.

Ambulance trusts

- Ensure a greater number of deployed hours on the road over winter in line with agreed recruitment and resourcing plans.
- Increase the clinical assessment of calls in every emergency operations centre to deliver the navigation and validation of Cat 2 calls, as well as increasing clinical input to Cat 3 and 4 calls.
- Ensure efficient electronic processes are in place for the transfer of patients who do not need a face-to-face response to services more appropriate for their needs, including urgent community response, urgent treatment centres and SDEC. Note the responsibility for other parts of the system to maximise the number of cat 3 and 4 calls responded to by UCR and falls services.
- Establish sufficient call handling capacity and finalise arrangements for the use of the ‘Intelligent Routing Platform’ in times of surge.
- Ensure mental health professionals are embedded in all emergency operation centres ahead of winter.
- Use the ambulance auxiliary service when needed.

Mental health provider pathways

Lead and support the delivery of high-impact interventions 3, 4 and 9 across mental health provider pathways

- Ensure plans are in place so that individuals know how to access mental health services with access to effective assessment and help in a timely manner and that crisis alternatives are in place to help reduce reliance on A&E (recognising that A&E is still an appropriate way of seeking help and people presenting with mental health issues also may have urgent physical health care needs). This should include making reasonable adjustments to pathways and therapeutic interventions for people with a learning disability and autistic people who seek mental health support.

- Where individuals do seek help for mental health issues via A&E, ensure processes are in place for assessment and onward support, including adjustments to meet the needs of autistic people and people with a learning disability. Ensure there are clear escalation processes for A&E where there is considerable delay in receiving specialist support.

- Mental health, learning disability and autism services should ensure maximum uptake of vaccinations for their populations, both inpatient and community. This is vital given the high incidence of COPD and other co-existing long-term conditions such as diabetes which can compromise response to flu and Covid-19.

- Ensure tools are in place to understand demand, activity, workforce and capacity in mental health provider pathways. This should be shared across the system to give a comprehensive view of mental health pressures and where support may be required that could alleviate pressure on both mental health and UEC pathways.

- Ensure access to emergency housing funds to enable discharge of patients with no fixed abode (NFA) to ensure that they can be supported with follow up crisis / community care and support.

- Lead delivery of actions from the NHS Long Term Plan and Delivery Plan for Recovering Urgent and Emergency Care Services that support winter pressures, particularly:

- Strengthen ambulance response to mental health by deploying multidisciplinary professionals to support 999 mental health demand and preparing for the rollout of mental health response vehicles.
- Optimising flow through mental health inpatient settings through system-wide focus on reducing delayed discharges and avoidably long length of stay in mental health inpatient settings. Work collaboratively with social care and other system partners who play a key role in timely discharge.
- Continuing to raise profile of all-age 24/7 urgent mental health helplines and other complementary crisis support services – including those for people with a learning disability and autistic people, such as intensive support teams, ensuring delivery of

NHS 111 ‘select mental health option’ and working towards crisis text line implementation.

- Supporting children and young people with mental health needs in acute paediatric settings by adopting the new integration framework for systems to support children and young people with mental health needs within acute paediatric settings, and to take up NHS England (Workforce, Training and Education directorate) commissioned CYP crisis telephone training to support crisis mental healthcare staff.

- Maximise the uptake of training on learning disability and autism appropriate to their role, to ensure preparedness to be able to meet the needs of autistic people and people with a learning disability.

Local authorities and social care

Local authorities should continue to work with ICBs to ensure an integrated approach across health and social care.

This includes:

- commissioning intermediate care services that help keep people well at home, prevent avoidable hospital admissions and support timely and effective hospital discharge.
- areas keeping under review their Better Care Fund (BCF) capacity and demand plans for intermediate care, in line with the BCF Policy Framework and planning requirements, considering trends in demand.
- improving data flows where the BCF capacity and demand plans showed limited data or insights available to support local areas' ability to accurately forecast demand for these services throughout the year.
- supporting NHS winter surge planning, including considering contingency arrangements for a significant flu or COVID-19 wave.
- deploying this year's Discharge Fund in ways that have greatest impact in patient safety and experience and in reducing delayed discharges, both to improve outcomes following hospital admission and help prevent avoidable A&E and ambulance delays for patients who need emergency care, alongside planning how to deploy next year's discharge funding.
- systematically embedding good practice in the use of care transfer hubs to manage discharges for patients with more complex needs, focusing on nine priority areas that will be set out as part of the upcoming support offer for the UEC Recovery Plan.
- ensuring systematic involvement of social care and community health providers in planning discharge services and in improving the operation of care transfer hubs.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 076

Report Title	Verdict in the trial of Lucy Letby							
Author	Jo Hunter, Director of Quality James Lunn, Assistant Director of Human Resources and Organisational Development Suzanne Pickering, Head of Governance							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Dr Chris Weiner, Chief Medical Officer Dean Howells, Chief Nurse Officer							
Paper purpose	Decision	☐	Discussion	☒	Assurance	☒	Information	☐
Appendices	Appendix 1 - Verdict in the trail of Lucy Letby – NHS England Letter Appendix 2 – ICB response to 5 urgent areas							
Assurance Report Signed off by Chair	Not applicable							
Which committee has the subject matter been through?	Not applicable							

Recommendations

The ICB Board is recommended to:

- **NOTE** the NHS England letter dated 18 August 2023 and **DISCUSS** the implications for the ICB and Joined Up Care Derbyshire; and
- **DISCUSS** requirement for proper implementation and oversight of the national Freedom to Speak Up (FTSU) policy.

Purpose

The Paper is presented to Board to ensure that members are sighted on the content, the recommendations made which must be actioned by both the ICB and the Derbyshire system and provide a position of the ICB in relation to the five areas stipulated to urgent review/assurance contained therein.

Background

On 18 August 2023, the Integrated Care Board Chief Executive received a letter from Amanda Pritchard, NHS Chief Executive and other Senior NHSE leaders (Appendix 1) in light of the verdict in the Lucy Letby Trial, expressing their concern at the loss of trust that the case has highlighted, their compassion for the families and staff involved and welcoming the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester Hospital on behalf of the NHS.

The letter reminds us of the importance of NHS leaders listening to the concerns of patients, families and staff, and creating an environment where everyone in the health service feels safe to speak up – and confident that it will be followed by a prompt response.

It also confirms the expectation of all NHS organisation to adopt the updated national to Freedom to Speak Up (FTSU) policy by January 2024.

Report Summary

The ICB has adopted the national FTSU Policy, which received approval from the Audit and Governance Committee on 8 June 2023.

Following the approval by the Audit and Governance Committee, the ICB promoted the new Policy at the ICB all staff team talk and the staff bulletin and circulated a request for expressions of interest from ICB colleagues for the FTSU Guardian role and additional FTSU Ambassadors. The closing date for expressions of interest was 22 August 2023 and the ICB is progressing with the appointments to these roles.

The letter dated 18 August 2023 specifically requires NHS leaders and Boards to ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

Appendix 2 below provides a table of the current status within the ICB and the specific details we have in place to demonstrate compliance against above.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐			

No further risks identified.

Financial impact on the ICB or wider Integrated Care System		
Yes ☐	No☐	N/A☒
Details/Findings Not applicable.		**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision making process?
None identified.

Project Dependencies

Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☐	Improved patient access and experience	☐
A representative and supported workforce	☐	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
There are no implications that would affect the ICB's obligations.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable.					

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

Appendix 2 – ICB Response to 5 urgent areas

Area	ICB Status Update
1. All staff have easy access to information on how to speak up.	The ICB has adopted the national FTSU Policy, which received approval from the Audit and Governance Committee on 8 June 2023. The Audit and Governance Committee has responsibility for FTSU. The FTSU Policy and FTSU Managers Handbook was promoted at the weekly ICB Team Talk and in the all staff bulletin in July 2023. There is a section of the staff intranet dedicated to FTSU and how to speak up by contacting the FTSU Ambassadors. Online form on intranet page for staff to submit concerns, anonymous and does directly to FTSU Ambassadors. The FTSU Ambassadors are promoted in each issue of the bi-weekly Human Resources publication – People Matter that is circulated by email to all staff. Access to FTSU Ambassadors and speaking up is also promoted during FTSU week. The induction checklist refers to the FTSU Ambassadors and intranet page. When the staff FTSU Guardian has been appointed, there will be a further promotion of FTSU to all colleagues. <u>Gaps:</u> Induction checklist needs to be updated to refer to the FTSU Policy and Guardian role (when appointed). There are no posters promoting FTSU at either of our ICB sites.

		Include reference to FTSU on the log in screen. Mandate FTSU e-learning for managers and staff.
2.	Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.	The Human Resources team are aware of the National Speaking Up Support Scheme and this was communicated to all staff via the People Matter bulletin on 16 June 2023. Gaps: The ICB has not yet appointed a staff FTSU Guardian. Expressions of interest (EOI) have been received and a selection process is pending. Following appointment FTSU Guardian will complete the national training and promote at Team Talk. The ICB only has two FTSU Ambassadors. EOI's have been received from additional colleagues and following selection/confirmation will undergo the appropriate national training.
3.	Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.	The ICB has two female FTSU Ambassadors in place, one of whom is from a black and minority ethnic background. Gaps Guardian role not yet in place. Requirement for additional FTSU Ambassadors to cover a wider cross section of ICB staff. Explore whether ICB staff can access FSU Ambassadors/ Champions in other Derbyshire health care organisations. Explore approach providers have in place to support people with cultural barriers to speak up.
4.	Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.	ICB has a nominated Non-Executive Director lead for FTSU, Margaret Gildea. ICB has a nominated Executive Lead, Helen Dillistone The Audit and Governance Committee are responsible for reporting FTSU updates to the ICB Board via their Committee Assurance Report.

	<u>Gaps</u> FTSU Ambassadors to collate details of contact with them and report to Board.
5. Boards are regularly reporting, reviewing and acting upon available data	The Audit and Governance Committee receive the FTSU Reports in line with the Committee Forward Planner. The Audit and Governance Committee are responsible for reporting FTSU updates to the ICB Board . This is reported through the Committee Assurance Reporting process.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 077

Report Title	Finance and Estates Committee Assurance Report – July / August 2023							
Author	Jill Dentith, Non-Executive Member – Finance and Estates							
Sponsor (Executive Director)	Keith Griffiths, Chief Finance Officer							
Presenter	Jill Dentith, Non-Executive Member – Finance and Estates							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Jill Dentith, Non-Executive Member – Finance and Estates							
Which committee has the subject matter been through?	System Finance and Estates Committee - 25.7.2023 and 22.8.2023							

Recommendations
The ICB Board is recommended to **NOTE** the System Finance and Estates Committee Assurance Report.
Items to escalate to the ICB Board
Please see Appendix 1 for details relating to the deficit position against plan, efficiency delivery and cash position.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the System Finance and Estates Committee on the 25 July 2023 and 22 August 2023. .
Background
The Finance and Estates Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
The ICB System Finance and Estates Committee's Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate; • decisions made; • major actions commissioned or work underway; • positive assurances received; and

- comments on the effectiveness of the meeting.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☒
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐			

Any risks highlighted and assigned to the Audit & Governance Committee will be linked to the ICB's Board Assurance Framework and Risk Register.

Has this report considered the financial impact on the ICB or wider Integrated Care System?

Yes ☒	No☐	N/A☐

Details/Findings Not applicable.	**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision-making process?

No conflicts of interest were raised.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:

Better health outcomes	☐	Improved patient access and experience	☒
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable to this report.

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

Details/Findings
Not applicable to this report.

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Board Assurance Report

Finance and Estates Committee on 25 July 2023

Matters of concern or key risks to escalate	Decisions made
• As of 30th June 2023, the JUCD year to date position is £18.0m deficit against a £10.5m planned deficit, a £7.5m overspend against the plan. Factors contributing to this are the industrial action, excess inflation, Microsoft licencing costs and efficiency slippage. Consequently, the likely case year end forecast for 2023/24 is a deficit of £27.1m which reflects these pressures that were not known at the time of planning. It also includes a £5m pressure that has not been able to be transacted through the BCF and therefore requires additional system efficiencies to mitigate. • The system efficiency delivery is £1.0m under plan year to date and the efficiencies have been phased based on an increasing rate of delivery as the year progresses. Therefore, it is important that the development of schemes gathers pace to support the delivery of the current forecast position of breakeven. Given at the end of Q1 there is still £43.1m that has not progressed past an opportunity means that there is a low level of assurance on delivery. • The expected delivery of cash-releasing efficiencies is reflected in the JUCD organisation's annual cash flow estimates. The in-year cashflow will be considerably impacted if these do not materialise. Some providers have applied for additional support in this regard which has initially been rejected, however, discussions are ongoing.	• A risk relating to unfunded pay awards would be added to the Risk Register (KG). • As proposed from an internal audit report it was agreed that BAF risk 8 should be split into part A (data / intelligence) and part B (digital). Part A would be monitored by Quality and Performance Committee and part B by SFEC. (DG).

Major actions commissioned or work underway	Positive assurances received
• The Provider Collaborative and Place will be required to make a significant contribution to delivering the in-year and recurrent underlying position. • Activity, workforce and finance triangulation - work is continuing on developing and validating the local productivity tool to bring the three elements of the plan together. It was agreed that a draft would be brought back to October SFEC in conjunction with a deep-dive report of workforce (KG / SM). • Cash releasing efficiencies must be found quickly. If sufficient cash releasing efficiencies are not achieved this may result in problems with provider cash flow. Provider colleagues to lead on this work and feedback to next Committee. • The costs associated with delayed discharges will now be very significant and this operational pressure will also be preventing organisations from delivering on Efficiency commitments. Similarly, the growing health challenges for the communities we serve, across all ages, are also adding financial challenges as well as workforce, performance and quality challenges. • A deep dive on shared records will be presented to the August 2023 meeting of the Committee (JA).	• The system is still committed to delivering a breakeven position at year end. • The DDICB Five Year Forward Plan was shared with the Committee and well received noting the challenges within the system to deliver.

Comments on the effectiveness of the meeting
The meeting was well attended with representatives from all health partners and from a range of disciplines. There was a good discussion around the financial position of the individual organisations and the wider system perspective. There was also a brief discussion and shared learning about possible tools which could be utilised to manage a range of workforce and financial issues.

NHS
Derby and Derbyshire
Integrated Care Board

Board Assurance Report

Finance and Estates Committee on 22 August 2023

Matters of concern or key risks to escalate	Decisions made
• As at 31 July 2023, the JUCD year to date position is £25.5m deficit against a £12.6m planned deficit, a £12.9m overspend against the plan. Factors contributing to this are the industrial action, excess inflation, Microsoft licencing costs (although this issue has now been resolved) and efficiency slippage. • The year end forecast for 2023/24 is a deficit of £37.3m which reflects these pressures that were not known at the time of planning. It also includes a £4m underspend which relates to dental but there is a risk of clawback by NHSE as these are ring-fenced funds. • The worst-case scenario of a £108.1m deficit includes additional risks related to carrying out the financial plan, such as, pressures on capacity and activity, drugs costs, and income reduction. • The system efficiency delivery is £2.9m under plan year to date, this is split £8.1m behind plan on recurrent efficiencies and £5.2m over plan on non-recurrent efficiencies. Unless this is recovered, this will impact in future years. • The efficiencies have been phased based on an increasing rate of delivery as the year progresses, therefore, it is important that the development of schemes gathers pace to support the delivery of the current forecast position of breakeven. At month four, there is still £40m of schemes that are in the opportunity phase or unidentified. As a result, the assurance on delivery of efficiencies is limited. • At month 4 £85.8m of efficiencies with project delivery plans either developed or in implementation have been uploaded on the e-PMO with project delivery plans, compared to a target system efficiency plan of £136m.	• A meeting will be held (23.08.23) with System Transformation Leads and provider Directors of Finance to propose actions to manage the financial and efficiency situation with a report back to System Finance and Estates Committee in September 2023 (TH to lead) • Only 47% of efficiencies have been delivered recurrently to date which is £8.1m behind plan. Further work has been commissioned to identify and deliver transformational change across the system. • A reconciliation between data held by the ePMO and finance will be conducted to ensure a consistent position is reported. Progress will be reported to September meeting (TH/CW) • All organisations must ensure the ePMO is fully up to date for the total value of their programmes, by the end of month 5. The system cannot have assurance on delivery or risks without this single version of the truth. • It was ultimately acknowledged that the programme delivery boards are not delivering the financial agenda, meaning a rethink of our approach to system wide financial transformation is necessary. This action will be led by the Provider Collaborative.

• The e-PMO plan value closely reflects the figure reported by organisations within their RFP returns of £83m and represents the extent of organisational efficiency targets where there are either no schemes identified or where plans are not fully developed. Delivery Boards have not fully identified plans to deliver the £4m of the target that is earmarked for system savings, with less than £1m of concrete plans reported to date. • Unfunded pay awards will be added as a risk to the Risk Register and Board Assurance Framework (KG). This continues to be a significant issue for some local Trusts.	
Major actions commissioned or work underway	**Positive assurances received**
• The Provider Collaborative and Place will be required to make a significant contribution to delivering the in-year and recurrent underlying position. • The cash position for a couple of our Trusts are of concern. An application has been made for central support. It should be noted that interest on any borrowing has not been factored into the position. • Workforce costs continue to be a concern and a deep dive has been commissioned which will report to the September meeting of the Committee. • Electronic Patient Record (ePR) - The evaluation process, system demonstration and site visits are continuing where the supplier systems are in operation. The complexity of the procurement phase has required more time to be taken with the evaluation and moderation process. Also, additional clarification questions relating to the financial scoring have been necessary to assure affordability and value for money.	• The system is still committed to delivering a breakeven position at year end. • To help improve the work on efficiencies the Provider Collaborative is working on standardising processes to deliver corporate efficiencies such as reducing premium workforce costs and collaborative procurement models. • The Derby and Derbyshire System compare relatively well with other systems in our Region; however, significant work is still required across Derby and Derbyshire to achieve breakeven. • The Digital Strategy key programme priorities are at various stages of development and delivery and as key enablers will support service delivery, efficiency, and transformation over the next two to five years. • One Trust has held an “Agency Spend Summit” and has introduced an “on the day offer” process to tackle agency spend.
Comments on the effectiveness of the meeting	
The meeting was well attended with representatives from all health partners and from a range of disciplines. The focus of the meeting was around the financial position, efficiency savings, estates and digital, with contributions from system leads and individual organisations. There was also a brief discussion on proposals to update the Terms of Reference for the Committee.	

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NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 078

Report Title	People and Culture Committee Assurance Report – September 2023							
Author	Linda Garnett, Interim ICB Chief People Officer							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Margaret Gildea, Non-Executive Member and Chair of People & Culture Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Margaret Gildea, Non-Executive Member and Chair of People & Culture Committee							
Which committee has the subject matter been through?	People and Culture Committee – 6th September 2023							

Recommendations
The ICB Board is recommended to **NOTE** the People and Culture Committee Assurance Report.
Items to escalate to the ICB Board
No items to escalate.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the People and Culture Committee on the 6th September 2023.
Background
The People and Culture Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
The People and Culture Committee's Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate; • decisions made; • major actions commissioned or work underway; • positive assurances received; and • comments on the effectiveness of the meeting.

Identification of Key Risks					
SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐			

Any risks highlighted and assigned to the People & Culture Committee will be linked to the ICB's Board Assurance Framework and Risk Register.

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒
Details/Findings Not applicable.		**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision-making process?

None identified.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:

Better health outcomes	☒	Improved patient access and experience	☒

A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
Not applicable.

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

Details/Findings
Not applicable.

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Board Assurance Report

People and Culture Committee on 6th September 2023

Matters of concern or key risks to escalate	Decisions made
No matters of concern or key risks to escalate.	Terms of Reference were accepted and agreed by the Committee and contained recommendations from the 360 Assurance Audit Report.
Major actions commissioned or work underway	**Positive assurances received**
The Committee were presented with a deep dive into the supporting People and Culture Governance structures which coincided with the 360 Assurance Audit Report recommendations. The Committee noted data quality issues with UHDB data within the Workforce Report which is being reviewed. The Committee agreed Chairs of the Peoples Committee in the Trusts needed to discuss within their own organisations how they are contributing and how reporting is done for the best use of time and assurance of figures presented towards the workforce report and plan. The Committee agreed on a development session around BAF.	• Workforce Report shows a slight reduction in the reliance of temporary staffing against M3 figures and the plan. • The agency reduction plan describes current position and next steps and what areas there are to do collaborative work together. • The Committee will be further reviewing governance structures looking into duplicated information and reports, and meeting sequencing. • BAF is to be discussed towards the beginning of future meetings and again at the end when discussions have taken place during the meeting to see if changes can be made.
Comments on the effectiveness of the meeting	
The meeting was well attended and generated a lot of discussion covering several topics.	

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NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 079

Report Title	Audit & Governance Committee Assurance Report – August 2023							
Author	Sue Sunderland, Non-Executive Member (Audit & Governance)							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Sue Sunderland, Non-Executive Member (Audit & Governance)							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Sue Sunderland, Non-Executive Member (Audit & Governance)							
Which committee has the subject matter been through?	Audit and Governance Committee – 10th August 2023							

Recommendations
The ICB Board is recommended to **NOTE** the Audit and Governance Committee Assurance Report.
Items to escalate to the ICB Board
No matters of concern or key risks to escalate.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Audit & Governance Committee on the 10th August 2023. .
Background
The Audit & Governance Committee ensures that the ICB complies with the principles of good governance whilst effectively delivering the statutory functions of the ICB.
Report Summary
The ICB Audit & Governance Committee's Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate • decisions made • major actions commissioned or work underway • positive assurances received • comments on the effectiveness of the meeting

Identification of Key Risks					
SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐			

Any risks highlighted and assigned to the Audit & Governance Committee will be linked to the ICB's Board Assurance Framework and Risk Register.

Has this report considered the financial impact on the ICB or wider Integrated Care System?

Yes ☐	No☐	N/A☒

Details/Findings Not applicable.	**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision-making process?

No conflicts of interest were raised.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:

Better health outcomes	☐	Improved patient access and experience	☒

A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?

Not applicable to this report.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable to this report.

Appendix 1

NHS
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Board Assurance Report

Audit Committee – 10th August 2023

Matters of concern or key risks to escalate	Decisions made
The Committee accepted the full briefing on the review of the ImpACT+ (Specialist Respiratory Services) contract which expired on 31 March 2023 but which was subsequently extended by retrospective Executive decision and awaits retrospective approval by the Population Health and Strategic Commissioning Committee in September 23. The Committee agreed that there are a number of lessons to be learnt from this and a series of improvements have been agreed to improve oversight and management of the procurement process more generally.	1. We approved a few changes to the Internal Audit plan including: a. Deferral of the review of S117 process to Q4 b. Post Payment Verification work would focus on Mental Health Act assessment claims c. Further follow up review of the Transformation & Efficiency review would be undertaken in Q4 2. We approved the revised Committee Terms of Reference for recommendation to the Board. 3. We approved the following policies: a. Complaints handling policy b. Lone worker policy c. EPRR policies and plans: (i) EPRR policy (ii) New and emerging infectious diseases and pandemics plan (iii) Adverse weather plan (iv) On call policy (v) Communications emergency plan (vi) Evacuation and shelter guidance (vii) Fire and emergency evacuation plan
Major actions commissioned or work underway	**Positive assurances received**
1. The proposed follow up of the limited assurance Internal Audit report on transformation and efficiency was originally planned for June. However given the scale of work required revised implementation dates have been agreed. 2. The staff survey 2022 action plan update identified the full discussion of the results by the Board and the subsequent identification and testing with staff networks of the areas for	1. Received internal audit reports as follows: a. 2023/24 Data Security & Protection toolkit – substantial assurance b. Safeguarding – significant assurance 2. Received the ICB Board Assurance Framework Q1 report and Corporate Risk Register report and the risks responsible to the

focused action. The action plan currently lacks details on timescales and measurable outcomes. 3. Further work has been requested to establish whether there is an issue around adult and children safeguarding training where compliance rates appear low. 4. The Committee noted the new requirements of the fit and proper persons test.	Audit and Governance Committee, including the virtual approval received for the decrease in score for risk 15. 3. Received a comprehensive update on EPRR & business continuity including the various plans and policies identified above but also an improved assessment for the ICB against the EPRR core standards 2023/24 which recognises the progress made in developing our EPRR processes to meet the requirements of being a Category 1 responder. 4. Received and update on health and safety and fire arrangements which confirmed compliance with legislation and an effective response to changes in working practices (such as hybrid working). 5. Received a report on the Derbyshire Green Plan and noted the progress made and positive feedback from the regulator noting that some work was exemplary. 6. Received assurance that compliance with mandatory training was generally high. 7. Received assurance from reviewing the regular reports on: c. Aged debts/write offs/losses and special payments d. Single tender waivers e. Financial position (assurance around processes being applied to manage and understand the position rather than the position itself). 8. Received updated on primary care pharmacy, optometry and dental delegated services including the final governance arrangements.

Comments on the effectiveness of the meeting

There was a lot on the agenda including a considerable number of documents relating the EPRR which were quite technical in nature. The reports were well supported by the officers attending who focused on the key elements and responded well to questions from committee members. However it was agreed that it would help to have a commissioning officer present at future meetings to help the CSU officer in responding to procurement queries.

There was a good level of discussion and involvement from all members of the committee.

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 080

Report Title	Derbyshire Public Partnership Committee Assurance Report – August 2023							
Author	Sean Thornton, Deputy Director Communications and Engagement							
Sponsor (Executive Director)	Helen Dillistone, Chief of Staff							
Presenter	Julian Corner, Non-Executive Member (Population Health and Strategic Commissioning)							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Julian Corner, Non-Executive Member (Population Health and Strategic Commissioning)							
Which committee has the subject matter been through?	Public Partnership Committee, 29th August 2023							

Recommendations
The ICB Board are recommended to **NOTE** the Public Partnership Committee Assurance Report.
Items to escalate to the ICB Board
No matters of concern or key risks to escalate.
Purpose
This report provides the ICB Board with highlights from the development meeting of the Public Partnership Committee on the 29th August 2023. The committee alternates its monthly meetings between business, through which project and programme schemes are reviewed for assurance, and development, where the committee discusses structural and process issues in greater depth to support committee establishment and role; the August meeting was a business meeting. Consideration is being given to adjusting this rhythm now that the committee has completed its establishment phase. This report provides a summary of the items transacted for assurance.
Background
The Public Partnership Committee ensures that the ICB effectively delivers the statutory functions of the ICB in relation to patient and public involvement. The committee also seeks, through its terms of reference, to drive citizen engagement in all aspects of the ICB's work to ensure that local people are central to planning and decision-making processes.

Report Summary
The Derbyshire Public Partnership Committee Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate; • decisions made; • major actions commissioned or work underway; • positive assurances received; and • comments on the effectiveness of the meeting.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐			

Any risks highlighted and assigned to the Public Partnership Committee will be linked to the ICB's Board Assurance Framework and Risk Register.

Has this report considered the financial impact on the ICB or wider Integrated Care System?

Yes ☐	No☐	N/A☒
Details/Findings Not applicable.		**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision-making process?

No conflicts of interest were raised.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Summary:**	

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☐	Inclusive leadership	☐

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
None raised as a result of the items reviewed at these meetings.

When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable to this report.					

Appendix 1

NHS
Derby and Derbyshire
Integrated Care Board

Board Assurance Report

Derbyshire Public Partnership Committee on 28th August 2023

Matters of concern or key risks to escalate	Decisions made
A review of Board Assurance Framework mitigations raised the question of whether the proposed actions would mitigate the risk on the ICB/system's engagement with public and stakeholders in delivering its agenda, which has been long-standing. It was proposed that a Board-level discussion was required to help understand the engagement strategy, set ambition and aspiration and determine what the Board believes good should look like.	Learning Disability Short Breaks A comprehensive programme is being developed to involve service users, families and carers in a review of this service. There has been long-running discussion about future provision and this review seeks to bring those conversations to a conclusion. The review will seek to heavily involve service users and their families to ensure individual circumstances are factored into the solution. A case for change has been drafted and a detailed engagement plan and options appraisal process will be created during Autumn 2023. Long Covid Services The ICB is seeking to engage patients who may be affected by service change following a change to the national funding arrangements for long covid (also known as post-covid) services. Digital and face-to-face pre-engagement is taking place during September to help inform the development of options. The committee endorsed the engagement proposal and noted that the approach was a good example of the ICB's engagement model being used in practice. Citizen's Panel The Committee agreed to the closure of the Citizen's Panel due to the breadth of alternative methods now in place for engaging local people and the relative costs of maintaining a system that is no longer useful. Terms of Reference The committee noted two minor amendments to the Terms of Reference, ahead of more substantial amendments in Autumn 2023 to reflect recruitment of additional members to the committee.

Appendix 1

NHS
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Major actions commissioned or work underway	Positive assurances received

• Board Assurance Framework action plan – ongoing delivery of mitigating actions
• Recruitment to committee lay member vacancies
• Review of approach to committee/sub-group diversity.
• Establishment of Lay Reference Group.
• Ongoing development of engagement frameworks
  ○ Insight Framework
  ○ Governance Framework
  ○ Evaluation Framework
  ○ Co-production Framework
  ○ Engagement Framework
	The evidenced use of the ICB's agreed engagement model in the work on Learning Disability Short Breaks and Long Covid service provision was noted. The papers coming to committee on these items also indicated the growing awareness among ICB staff of what the PPC is seeking to achieve and what their brief is when presenting items to committee.
	
	A verbal update was received regarding work undertaken to understand variation of service provision between the Glossop area and former Derbyshire CCG area. Detailed work is underway which is identifying minimal significant variation in service-line assessments made so far. An East Midlands wide review is taking place of fertility services, where we know a difference exists between policy. An update report is being written for the Population Health & Strategic Commissioning Committee and Public Partnership Committees in November.

Comments on the effectiveness of the meeting
The committee reviewed a series of assurance questions and agreed that the meeting had been effective.

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NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 081

Report Title	Quality and Performance Committee Assurance Report – July/August 2023							
Author	Jo Hunter, Director of Quality							
Sponsor (Executive Director)	Professor Dean Howells, Chief Nursing Officer							
Presenter	Dr Adedeji Okubadejo, Clinical (Other) Member and Chair of Quality and Performance Committee							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☐
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Dr Adedeji Okubadejo, Clinical (Other) Member and Chair of Quality and Performance Committee							
Which committee has the subject matter been through?	Quality and Performance Committee – 27/07/23 and 31/08/23							

Recommendations
The ICB Board are recommended to **NOTE** the Quality and Performance Committee Assurance Report.
Items to escalate to the ICB Board
As reported in previous reports the ICB is currently not compliant with any statutory operational targets relating to the urgent care and planned care and cancer programme. The 2023/24 NHS Operational Plan developed by the Derby and Derbyshire System addresses these issues of underperformance.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Quality and Performance Committee on the 27th July 2023 and 31st August 2023.
Background
The Quality and Performance Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
The System Quality and Performance Committee Assurance Report highlights to the ICB Board any: • matters of concern or key risks to escalate. • decisions made. • major actions commissioned or work underway. • positive assurances received; and • comments on the effectiveness of the meeting.

Identification of Key Risks					
SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐			

Any risks highlighted and assigned to the Public Partnership Committee will be linked to the ICB's Board Assurance Framework and Risk Register.

Has this report considered the financial impact on the ICB or wider Integrated Care System?		
Yes ☐	No☒	N/A☒
Details/Findings Not applicable.		**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision-making process?

None identified.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:

Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
None noted.

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

Details/Findings
Not applicable to this report.

Appendix 1

Derby and Derbyshire Integrated Care Board

ICB Board Assurance Report

ICB Quality and Performance Committee on 27th July 2023

Matters of concern or key risks to escalate	Decisions made
The ICB is currently not compliant with any statutory operational targets relating to the urgent care and planned care and cancer programme. The 2023/24 NHS Operational Plan developed by the Derby and Derbyshire System addresses these issues of underperformance.	No papers were presented for decision.
Major actions commissioned or work underway	**Positive assurances received**
Deep Dives will be regularly presented to the Committee (please see final page of assurance report).	The following papers were presented for assurance: • Integrated Performance Report • Deep Dive – Cancer 62 day waits • Board Assurance Framework (BAF) • System Quality Group Assurance Report • Q4 Risk Stratification • Quality Accounts submitted by the JUCD Providers
Comments on the effectiveness of the meeting	
Those present agreed that the meeting had been effective, with sufficient opportunity for discussion and that the papers presented were appropriate.	

Appendix 1

Derby and Derbyshire Integrated Care Board

ICB Board Assurance Report

ICB Quality and Performance Committee on 31st August 2023

Matters of concern or key risks to escalate	Decisions made
The ICB is currently not compliant with any statutory operational targets relating to the urgent care and planned care & cancer programme. The 2023/24 NHS Operational Plan developed by the Derby and Derbyshire System addresses these issues of underperformance. The Committee continues to have significant concerns regarding maternity and neonatal services across JUCD but particularly at UHDB. Other areas of concern are the impact of delayed discharges across the system and the underutilisation of the virtual wards.	The following items were approved by the Group: • Schedule of Deep Dives for System Quality and Performance Committee (See page 2) • Quality & Performance Committee Terms of Reference – agreed with minor amendments. • Derby & Derbyshire ICB Quality Framework 2022/23 and 2023/24
Major actions commissioned or work underway	**Positive assurances received**
Deep Dives will be regularly presented to the Committee (please see final page of assurance report). The Committee has commissioned work to develop an early warning system initially for use in primary care services.	The following papers were presented for assurance: • Integrated Performance Report • Deep Dive – Making room for dignity programme - Eradication of dormitory accommodation in MH units • Board Assurance Framework (BAF) • System Quality Group Assurance Report
Comments on the effectiveness of the meeting	
Those present agreed that the meeting had been effective, with sufficient opportunity for discussion and that the papers presented were appropriate.	

Appendix 1

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SCHEDULE OF DEEP DIVES AGREED

Please note these may be subject to change based on discussions within the Committee:

Meeting	Deep Dive
August	Eradication of dormitory accommodation in MH units which links to out of area placements.
September	Infection control (especially CDiff), Virtual Wards
October	Safeguarding
November	Health Inequalities and the prevention agenda, LMNS maternity update
December	Improvement of Category 2 Response Times (move to NHS Pathways), Discharge
January	Personal Health Budgets
Feb	Stroke Services
March	Right Care Right Person

Derby and Derbyshire
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NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 082

Report Title	Public Population Health & Strategic Commissioning Committee Assurance Report – September 2023							
Author	Julian Corner, (Chair) Non-Executive Member for Population Health and Strategic Commissioning and Public Partnerships							
Sponsor (Executive Director)	Zara Jones, Executive Director of Strategy & Planning							
Presenter	Julian Corner, (Chair) Non-Executive Member for Population Health and Strategic Commissioning and Public Partnerships							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☒
Appendices	Appendix 1 – Committee Assurance Report							
Assurance Report agreed by:	Julian Corner, (Chair) Non-Executive Member for Population Health and Strategic Commissioning and Public Partnerships							
Which committee has the subject matter been through?	Population Health & Strategic Commissioning Committee, 14th September 2023.							

Recommendations
The ICB Board are recommended to **NOTE** the Population Health & Strategic Commissioning Committee Assurance Report.
Items to escalate to the ICB Board
As detailed within the report.
Purpose
This report provides the Board with a brief summary of the items transacted at the meeting of the Population Health & Strategic Commissioning Committee on the 14th September 2023.
Background
The Population Health & Strategic Commissioning Committee ensures that the ICB effectively delivers the statutory functions of the ICB.
Report Summary
The Population Health & Strategic Commissioning Committee Assurance Report (Appendix 1) highlights to the ICB Board any: • matters of concern or key risks to escalate; • decisions made;

- major actions commissioned or work underway;
- positive assurances received; and
- comments on the effectiveness of the meeting.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☒	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☒
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐			

Any risks highlighted and assigned to the Population Health & Strategic Commissioning Committee will be linked to the ICB's Board Assurance Framework and Risk Register.

Has this report considered the financial impact on the ICB or wider Integrated Care System?

Yes ☐	No☐	N/A☒

Details/Findings	**Has this been signed off by a finance team member?**
Not applicable.	Not applicable.

Have any conflicts of interest been identified throughout the decision-making process?

None raised.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable

Yes ☐	No☐	N/A☒	**Summary:**

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒
Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?			
Not applicable to this report.			
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?			

Carbon reduction	☐	Air Pollution	☐	Waste	☐

Details/Findings
Not applicable to this report.

Appendix 1

Derby and Derbyshire Integrated Care Board

Board Assurance Report

Population Health & Strategic Commissioning Committee on 14th September 2023

Matters of concern or key risks to escalate	Decisions made
No matters to escalate.	All decisions were confidential.
Major actions commissioned or work underway	**Positive assurances received**
None to report.	1. Risk Register Reports RECEIVED and DISCUSSED the risks responsible to the Committee; • NOTED the revised risk description for Risk 01 and updated mitigations and actions; • APPROVED the closure of confidential Risk 05C relating to the Cavell Centre project; • APPROVED new confidential Risk 09C relating to the Post COVID Syndrome Service. 2. The following items were received for information: • Ethical Framework for Decision making Policy (to be discussed in more detail at the October PHSCC Strategy meeting) • CPAG Updates • Derbyshire Prescribing Group report/minutes • JAPC June & July Minutes & Bulletin • CPLG July minutes
Comments on the effectiveness of the meeting	
This was Zara Jones's last PHSCC meeting. The Chair thanked her for setting up the committee and commended her on her ability to shift from operational demand to developing an ICB wide strategy approach. He thanked her for clarity during meetings and care and support of colleagues. He wished her luck with her new role.	

Derby and Derbyshire Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 083

Report Title	National Patient Safety Strategy – Derbyshire Position Statement – September 2023							
Author	Letitia Harris, Assistant Director of Nursing and Quality							
Sponsor (Executive Director)	Prof Dean Howells, Chief Nurse Officer							
Presenter	Prof Dean Howells, Chief Nurse Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☒	Information	☒
Appendices	Appendix 1 – National Priorities							
Assurance Report Signed off by Chair	Not applicable.							
Which committee has the subject matter been through?	DDICB Executive Team Meeting – August 2023							

Recommendations

The ICB Board are recommended to **NOTE** for **ASSURANCE** and **INFORMATION** the content of the report.

Purpose

This report provides an update of the progress of the Patient Safety Agenda, both nationally and locally, and how the Derby and Derbyshire ICB Patient Safety Team are engaging with other System partners supporting the drive for a system-based approach to patient safety across Derbyshire.

Background

In July 2019, the National Patient Safety Strategy was launched and updated in 2021, with some more recently updated objectives. The Strategy described how the NHS will continuously improve quality and patient safety by building on the foundations of safer systems and culture working towards a shared vision for patient safety in the NHS.

Within the initial Strategy, key deliverables for relevant agencies were identified, for implementation nationally, regionally, and locally. There was an expectation to see some significant progress milestones in 2021, acknowledging the challenges that healthcare faced during and following the Covid 19 pandemic.

The ethos of the Patient Safety Strategy is to change the culture around patient safety, with a focus on proportionate investigations, using insight and data information available to

organisations, moving away from the focus of Serious Incidents (as defined by the NHS Serious Incident Framework, 2015 and the perpetuated industry which arose.

To change that approach, the Patient Safety Incident Framework (PSIRF) has been introduced, allowing an increased breadth of scope and describes incident management as part of a system-based methodology, with an emphasis on learning and improvement. To support the identification and implementation of learning, each organisation following PSIRF, will develop a Patient Safety Improvement Plan (PSIRP). The PSIRP will be developed in line with each organisations themes of learning and identified priorities.

The national launch of PSIRF occurred in Autumn 2022; however, Derby and Derbyshire ICB, along with our main Provider organisations were identified as early adopter sites for implementing PSIRF since 2019.

Report Summary

As a Derbyshire System, the progress of implementation and embedding the ethos of the NHS Patient Safety Strategy is underway and provides a level of assurance that the focus and drive to change and improve quality and safety is well underway.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☐	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☐
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☐	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☒			

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒
Details/Findings Not applicable.		**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision making process?

None identified.

Project Dependencies

Completion of Impact Assessments

Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable			
Yes ☐	No☒	N/A☐	**Summary:** Introduction of Patient Safety Partners

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?
None identified.

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

Details/Findings
Not applicable to this report.

National Patient Safety Strategy – Derbyshire Position Statement – September 2023

Introduction and Background

Patient safety is the avoidance of unintended or unexpected harm to people during the provision of health care. It is recognised that that higher quality care is both safer and beneficial for patients and offers better value for money.

In July 2019, the National Patient Safety Strategy was launched and updated in 2021, with some more recently updated objectives. The Strategy described how the NHS will continuously improve quality and patient safety by building on the foundations of safer systems and culture working towards a shared vision for patient safety in the NHS.

Within the initial Strategy, key deliverables for relevant agencies were identified, for implementation nationally, regionally, and locally. There was an expectation to see some significant progress milestones in 2021, acknowledging the challenges that healthcare faced during and following the Covid 19 pandemic.

he ethos of the Patient Safety Strategy is to change the culture around patient safety, with a focus on proportionate investigations, using insight and data information available to organisations, moving away from the focus of Serious Incidents (as defined by the NHS Serious Incident Framework, 2015 and the perpetuated industry of individual investigations from which it arose.

Nationally, since the publication of the Strategy, NHS trusts and ICBs have been planning their introduction of the framework to their organisations and initial feedback has been that the revised approach and focus of patient safety has enhanced harm reduction, improved safety cultures, whilst identifying more effective risk reduction strategies.

The vision is to build on two foundations: a patient safety culture and a patient safety system.

The aim of the strategy is to reform the whole system of safety with a focus on prevention, better identification, investigation, acting on findings, and creating and maintaining improvement. To support this, 3 strategic aims have been identified:

- Insight - improving understanding of safety by drawing intelligence from multiple sources of patient safety information.
- Involvement - equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system.
- Improvement - designing and supporting programmes that deliver effective and sustainable change in the most important areas.

This report provides an update of the progress of the Patient Safety Agenda, both nationally and locally, and how the Derby and Derbyshire ICB Patient Safety Team are engaging with other System partners supporting the drive for a system based approach to patient safety across Derbyshire.

This report includes appendices within the report provide more in-depth detail of the National Patient Safety Priorities.

This report will be presented to the Board and other Committees as required.

Key Areas for Patient Safety Across the Derbyshire System

- Patient Safety Training

The NHS Patient Safety Strategy highlights the need for a standardised NHS healthcare approach to patient safety training. NHS England and NHS Improvement have devised a patient safety syllabus and training programme which, when complete, will contain 5 levels of training which will build on each other. Currently, levels 1 and 2 are available, with further training in all aspects of patient safety being developed. The availability of the additional levels was delayed due to the impact of the Covid 19 pandemic and release dates are awaited.

Each level is designed to help NHS employees take all the necessary steps to ensure patients are safe while they are in our NHS care. It is appropriate for all staff to undertake Level 1 training.

The first level contains 2 parts, '*Essentials for patient Safety*', is the starting point for all NHS staff, and, an additional session, '*Essentials of Patient Safety for Boards and Senior Leadership Teams'* for Boards and senior leadership teams.

The focus for Level 1 is:

- Listening to patients and raising concerns.
- Creating a just culture that prioritises safety and is open to learning about risk and safety.
- Systems approach to safety to improve the way we work.
- Avoiding inappropriate blame when things don't go well.
- Costs of patient safety -human, organisational and financial
- Framework for governance in patient safety.
- Understanding the need for proactive safety management and a focus on risk. in addition to past harm.
- Leadership for patient safety.
- Harmful effects of safety incidents on staff at all levels.

Level 2 is '*Access to Practice'* is intended for those who have an interest in understanding more about patient safety or who want to go on to access the higher levels of training. There are 2 sessions within this level.

The focus for Level 2 is:

- First Session - introduces systems thinking and risk expertise.
- Second session - introduces human factors and safety culture.

The training can be accessed via ESR and E-learning for Health using the words 'patient safety' in the search bar option. Each level takes approximately 20 to 45 minutes to complete. (Direct link NHS Patient Safety Syllabus training - elearning for healthcare (e-lfh.org.uk))

The role out of the training across the Derbyshire Providers are at varying stages, with ongoing discussions as to which designation of staff should undertake level 2 training.

Monthly progress updates are given at the Patient Safety Specialist meeting. At present, the training is not within the suite of mandatory training for ICB staff; however, this will be explored in the coming year.

At UHDB, over the last 12 months, there have been many changes within their Executive and senior leadership teams, and in view of this, the Trust are arranging a Provider Board session to share knowledge and insight gained in respect of the Patient Safety Incident Framework, along with the learning and challenges faced.

Similarly, there have been changes within the ICB Executive and senior leadership teams, there would be value in the training (and costs) are widened to offer the opportunity for a Derbyshire System approach for this session. The suggested training Provider is Facere Melius at a cost of £3000, further details are awaited.

Patient Safety Incident Framework (PSIRF)

The national launch of PSIRF occurred in Autumn 2022; however, Derby and Derbyshire ICB, along with our main Provider organisations were identified as early adopter sites for implementing PSIRF since 2019. These were Chesterfield Royal NHS Foundation Trust (CRHFT), University of Derby and Burton NHS Foundation Trust (UHDB), Derbyshire Healthcare Foundation Trust (DHcFT), Derbyshire Community Healthcare Services (DCHS) and Derbyshire Health United (DHU).

It should be noted that East Midlands Ambulance Service (EMAS) have recently adopted the PSIRF approach in line with the national implementation for other organisations across the country. Primary Care Services, predominantly GP practices, will continue to follow the SI Framework in the interim.

Systems based principles and approaches to patient safety assist the identification of strategies for improvement focussing on learning from incidents and events where things go well (Safety II methodology), as well those that do not go so well (System I methodology).

To support the changes in approach, the Patient Safety Incident Framework (PSIRF) has been introduced. This allows an increased breadth of scope and describes incident management as part of a system-based methodology, with an emphasis on learning and improvement. In line with PSIRF, and to aid the identification and implementation of learning, each organisation, will develop their Patient Safety Improvement Plan (PSIRP).

The PSIRP will be developed in line with each organisations themes of learning and identified local priorities collated from the various data sources (incidents, complaints, compliments, claims, Coronial processes, service user/staff experiences).

As with other aspects of the workstreams, each Providers' PSIRP is at a different stage of completion. At present, those Providers who were early adopters, have developed their second PSIRP.

The CRH plan was approved by their Trust Board early 2023, and UHDB have recently has recently been approved by their Trust Board; however, a revision has been made to include maternity services (which will be supported by their maternity improvement plan).

EMAS and DHU have developed their first PSIRPs, and they are due for their Board approval in the next couple of months. Progress of the PSIRP development and completion is monitored via monthly PSIRF meetings between ICB and Provider colleagues.

National Priorities

Alongside their Local Priorities, the Providers must complete Patient Safety Incident Investigations (PSIIs) for all the categories identified within the list of national priorities (see Appendix 1). In contrast to the SI Framework, which specified a 60 day timescale for completion of the investigation, PSIRF does not identify a timescale. It is anticipated that investigations are completed within a 6 month period (from identification of the incident).

It had been noted that Providers within Derbyshire have encountered some recent challenges with compliance of the timescale due to staffing capacity challenges, staff leaving the organisations and recent industrial actions. Progress updates are monitored via monthly PSIRF meetings between ICB and Provider colleagues.

Patient Safety Specialists

The role of the Patient Safety Specialist is to provide expert support to their organisation and is expected to have direct access to their executive team. This direct access facilitates the escalation of patient safety issues or concerns in a timely manner.

They should play a key role in the development of a patient safety culture, safety systems and improvement activity within their organisation by coordinating and supporting local patient safety priorities, the implementation of the NHS Patient Safety Strategy and other national safety priorities.

Each Provider within and supporting the Derbyshire System, including the ICB have an identified Patient Safety Specialist.

Patient Involvement

PSIRF stresses the importance of involving patients in patient safety and considers it relevant to all NHS trusts and commissioning organisations. Consideration for other NHS settings, including primary care and community services to take this approach forward would add value to safety governance processes as they develop and mature, as it is recognised that implementation takes time, and often at differing pace.

The involvement of patients/service users is two-fold:

- Patient Safety Partners involvement in organisational safety
- Involving patients in their own safety
- Patient Safety Partners

This role relates to the role that lay people, patients, and carers can play in supporting and contributing to an organisation's governance and management processes for patient safety and may include membership of safety and quality committees to review and analyse of safety data; involvement in patient safety improvement projects; involvement in staff patient safety training and participation in investigation oversight groups.

As a System, it was agreed to collectively recruit Patient Safety Partners with an identified Provider as the host for coordination of those recruited.

The recruitment and involvement of Patient Safety Partners is in its infancy. At present, 5 Partners have been recruited on a voluntary level 3 basis, and the advertisement to recruit more is ongoing/continuous. The review of their workload, and training will be undertaken by December 2023 and the need for level 4, will also be considered at this time.

It should be noted that all Providers should be including a minimum of 2 Patient Safety Partners on their safety related clinical governance committees. It is intended this will become a contractual requirement in the NHS Standard Contract for next year (2024/2025).

Patient and Family Involvement/Just Culture

Compassionate engagement with those affected by a patient safety incident must be a priority after an incident occurs, which involves working with those affected. Whilst staff engagement with patients takes place with those affected by moderate or severe harm, there is significant work required to promote a safety culture where patients are encouraged, feel safe to raise concerns or challenges around safety within their care.

Ensuring a just culture guide or equivalent is in place alongside learning from best practice and monitoring safety cultures is needed to as a key action. This cultural change will evolve over time when there is a fully endorsed 'Just Culture' in organisations which promote and encourage psychological safety for their staff and move to a restorative rather than blame culture. Consequently, this will enable staff and patients to feel comfortable in raising concerns without unfounded, or inappropriate action taking place. This is an area for focus by the ICB and Providers in the coming year.

Learning From Patient Safety Events (LPFSE)

LFPSE service is a national NHS service for recording and analysing patient safety events that occur in healthcare. LFPSE is currently being introduced across the NHS as organisations switch to recording patient safety events onto the new LFPSE service, rather than the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) it is replacing.

Each Provider Trust has an account for LPFSE and have downloaded the test platform, whilst smaller Providers have been contacted provided with information on how to use the LPFSE platform. Those who need to access the platform as a standalone are doing so.

Future arrangements are that those who have local risk management systems in place will migrate over to LPFSE when necessary, migration arrangements have been completed in conjunction with local risk management system companies roll out of LPFSE Version 6 by the Autumn.

The ICB are already set up on LFPSE and are in regular discussions with Primary care colleagues to ensure GP practices are ready for the transition.

Medical Examiners

Nationally, the medical examiner role in the scrutiny of deaths has now been extended from deaths in the acute setting to deaths in non-acute settings.

UHDB and CRHFT introduced the medical examiner role and have highlighted the benefits of ensuring that information and intelligence from medical examiner offices is feeding into their patient safety, quality surveillance processes, clinical governance, and quality improvement programmes. Learning and feedback is shared with ICB colleagues on a Quarterly basis at the Clinical Quality Review meetings.

Currently, there is no separate ICB or System wide mortality oversight meetings that take place.

National Patient Safety Alerts

A change to the oversight of National Patient Safety Alerts came with the introduction of the Patient Safety Strategy was the need for Executive oversight and for senior leaders in each organisation to manage the implementation of all relevant actions for each alert.

The Provider Trusts for which we have oversight each have the right systems and process in place to ensure alert implementation is centrally managed, the required actions are embedded into practice and compliance sign-off has executive oversight and sign off for their National Safety Alerts.

National Patient Safety Improvement Programmes

National safety improvement priorities are aligned to the delivery of the Patient Safety Strategy, the NHS Long Term Plan and the NHS Operational Planning Guidance. The priorities for delivery in 2022/2023 were deterioration, maternity, medication, mental health, and PSIRF, some of which continue through 2023/2024.

The ICB Patient Safety Team have been involved in events relating to the National Patient Safety Improvement Programmes, and AHSN colleagues attend the monthly Derbyshire PSIRF meetings. There is a need for the engagement and with frequent progress updates to be strengthened going forward.

Regional NHSE Patient Safety Team Visit

The Regional NHSE Patient Safety Team have been conducting a series of visits to ICBs across the region to capture the experiences, progress and learning identified during the implementation of the core elements of the National NHS Patient Safety Strategy (as described above).

Fruitful interactive discussions were had in respect of our progress as an ICB and wider system. Initial feedback from the regional team was positive and there was recognition that our future areas of focus were not unique to our system; others had shared similar experiences.

Once all visits are concluded, the overarching themes will be captured and shared with the ICB.

Next Steps

Reviewing Policies and Protocols

A comprehensive review of all existing patient safety policies and protocols is essential and need to ensure that they align with the latest best practices and regulatory requirements. The current patient safety policy is out of date and relates to Serious incidents alone. The ICB draft policy is has written to reflect the changes in line with the NHS Patient Safety Strategy, the Patient Safety Framework, and other frameworks that align to them, and is being circulated for comments and feedback before being shared with the ICB Executive Team and System Quality Group in October/November 2023.

Staff Training and Education

It is vital to provide our staff with the necessary training and education to ensure they are well-versed in the latest patient safety guidelines. Regular training sessions will help reinforce best practices and foster a culture of safety throughout the organisation.

Incident Reporting and Analysis

We must enhance our incident reporting and analysis systems to capture patient safety issues across the System promptly. Regularly reviewing reported incidents will help us identify patterns or recurring problems, allowing us to implement preventive measures.

Collaborative Approach for Safety Culture and Just Culture

Preparing for the ongoing progress of improving patient safety requires a collaborative effort from many teams and departments who are working together to address any issues and improve patient safety across the System.

Documentation and Record-Keeping

Accurate and organised documentation is essential for the visit and will have relevant information to showcase our commitment to patient safety.

Appendix 1 – National Priorities

The National Priorities are:

a. incidents that meet the criteria set in the Never Events list 2018

b. deaths thought more likely than not due to problems in care (incidents meeting the 'Learning from Deaths criteria'

c. Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the 'Learning from deaths' criteria).

d. maternity and neonatal incidents:

- incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation;
- all cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme;
- all perinatal and maternal deaths must be referred to MBRRACE;

e. mental health-related homicides by persons in receipt of mental health services or within six months of their discharge must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)

f. child deaths (Child death review statutory and operational guidance):

- incidents must be referred to child death panels for investigation

g. deaths of persons with learning disabilities:

- incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme

h. safeguarding incidents:

- incidents must be referred to the local authority safeguarding lead. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards;

i. incidents in screening programmes:

- incidents must be reported to UK Health Security Agency and Office for Health Improvement and Disparities (UKSA) in the first instance for advice on reporting and investigation (UKSA's Regional Screening Quality Assurance Service (SQAS) and commissioners of the service)

j. deaths of patients in custody, in prison or on probation where healthcare is/was NHS funded and delivered through an NHS contract:

- incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

NHS
Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD

MEETING IN PUBLIC

21st September 2023

Item: 084

Report Title	2022/23 Quality Account ICB Statements							
Author	Philip Sugden, Assistant Director of Quality							
Sponsor (Executive Director)	Dean Howells, Chief Nursing Officer							
Presenter	Dean Howells, Chief Nursing Officer							
Paper purpose	Decision	☐	Discussion	☐	Assurance	☐	Information	☒
Appendices	Appendix 1 – Provider Quality Account Statements 2022/23							
Assurance Report Signed off by Chair	Not applicable.							
Which committee has the subject matter been through?	Presented at System Quality Group on 4th July 2023.							

Recommendations
The ICB Board is recommended to **NOTE** the 2022/23 Quality Account ICB Statements.
Purpose
The paper is presented to ensure that the ICB Board is sighted on the In line with national expectations to provide evidence of ICB feedback to induvial Quality Accounts.
Background
Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum. These are required to be published by 30 June 2023. The processes for producing Quality Accounts remain the same as previous years, with the following exceptions to NHS providers: • NHS foundation trusts are no longer required to produce a Quality Report as part of their Annual Report. NHS foundation trusts will continue to produce a separate Quality Account for 2022-23; and • there is no national requirement for NHS trusts or NHS foundation trusts to obtain external auditor assurance on the quality account or quality report, with the latter no longer prepared. Any NHS trust or NHS foundation trust may choose to locally commission assurance over the quality account; this is a matter for local discussion between the Trust (or governors for an NHS foundation trust) and its auditor. For quality accounts approval from within the Trust's own governance procedures is sufficient.

Integrated care boards (ICBs) have assumed responsibilities for the review and scrutiny of Quality Accounts. ICBs must clarify with providers where they are expected to send their Quality Account. NHS providers may find it helpful, when producing their Quality Account, to refer to the relevant 2022/23 priorities and operational planning guidance.

Report Summary

The NHS.uk website no longer allows NHS organisations to upload reports. Therefore, just as last year, all providers producing Quality Accounts (NHS and non-NHS) to upload their Quality Account to an appropriate page on your organisation's website.
Quality Accounts have been received from:

- United Hospitals of Derby & Burton Foundation Trust
- Chesterfield Royal Hospital Foundation NHS Trust
- Derbyshire Healthcare Foundation NHS Trust
- Derbyshire Community Health Services NHS Foundation Trust
- East Midland Ambulance NHS Trust
- Derbyshire Health United
- Barlborough Hospital

Statements in response to each Quality Account have been written, approved by the DDICB Chief Nursing Officer and included by the Providers in all instances in their final documents. Statements are appended to this document.

Copies of individual Provider Quality Account reports are available on their public facing websites after no later than the 30th June 2023.

The National Quality Board has been undertaking a review of Quality Accounts to determine how they could be improved and updated. This review does not affect the 2022-23 Quality Accounts requirements; however, it is anticipated that changes may come into effect for the 2023-24 requirements.

Identification of Key Risks

SR1	The increasing need for healthcare intervention is not met in most appropriate and timely way, and inadequate capacity impacts the ability of the NHS in Derby and Derbyshire and upper tier Councils to deliver consistently safe services with appropriate levels of care.	☒	**SR2**	Short term operational needs hinder the pace and scale required to improve health outcomes and life expectancy.	☒
SR3	The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.	☐	**SR4**	The NHS in Derbyshire is unable to reduce costs and improve productivity to enable the ICB to move into a sustainable financial position and achieve best value from the £3.1bn available funding.	☐
SR5	The system is not able to recruit and retain sufficient workforce to meet the strategic objectives and deliver the operational plans.	☐	**SR6**	The system does not create and enable One Workforce to facilitate integrated care.	☐
SR7	Decisions and actions taken by individual organisations are not aligned with the strategic aims of the system, impacting on the scale of transformation and change required.	☐	**SR8**	The system does not: (a) establish intelligence and analytical solutions to support effective decision making. (b) deliver digital transformation.	☐
SR9	The gap in health and care widens due to a range of factors (recognising that not all factors may be within the direct control of the system) which limits the ability of the system to reduce health inequalities and improve outcome.	☐			

No further risks identified.

Financial impact on the ICB or wider Integrated Care System

Yes ☐	No☐	N/A☒
Details/Findings Not applicable.		**Has this been signed off by a finance team member?** Not applicable.

Have any conflicts of interest been identified throughout the decision making process?				
None identified.				
Project Dependencies				
Completion of Impact Assessments				
Data Protection Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Quality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**
Equality Impact Assessment	Yes ☐	No☐	N/A☒	**Details/Findings**

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Risk Rating:**	**Summary:**
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below, if applicable				
Yes ☐	No☐	N/A☒	**Summary:**	

Implementation of the Equality Delivery System is a mandated requirement for the ICB, please indicate which of the following goals this report supports:			
Better health outcomes	☒	Improved patient access and experience	☒
A representative and supported workforce	☒	Inclusive leadership	☒

Are there any equality and diversity implications or risks that would affect the ICB's obligations under the Public Sector Equality Duty that should be discussed as part of this report?					
Not applicable to this report.					
When developing this project, has consideration been given to the Derbyshire ICS Greener Plan targets?					
Carbon reduction	☐	Air Pollution	☐	Waste	☐
Details/Findings Not applicable to this report.					

Appendix 1

University Hospitals of Derby and Burton NHS Foundation Trust

Commissioner Statement

NHS Derby and Derbyshire Integrated Care Board (DDICB) are pleased to comment on University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) Quality Account 2022/23.

DDICB would like to thank the Trust for their ongoing productive collaboration to support both patients and stake holders despite the demand and capacity pressures following the Covid 19 pandemic. The Trust and DDICB continued with their regular Clinical Quality Review Group Meetings via virtual methods and the detail within this Quality Account reflects the information available to us.

Notable areas:

- The Quality Account outlines the renewed focus on quality priorities for 2023/24 which includes delivery of harm free care, the aim to implement and embed understanding of the Care Quality Commission (CQC) domains and fundamentals of care, and to transition from being an early adopter of the Patient Safety Incident Response Framework (PSIRF) to 'Version 1' which has been published following learning from UHDB and other early adopters experience. It is positive to note the work undertaken over the last twelve months in relation to patient safety indicators such as Infection, Prevention, and Control (IPC), falls reduction, tissue viability, sepsis, and incident management, and DDICB now look forward to seeing improved outcomes and embedding of related processes. DDICB welcome the focus and commitment to the quality and safety of care to support patient experiences.

- It is positive to note key achievements via quality improvement projects delivered during 2022/23 such as a project to increase awareness, identification, and improve management of delirium in older surgical patients. This resulted in improved completion rates for a short delirium detection tool (4AT) and an increase in staff knowledge scores from 43% to 92% following teaching. Another project centred on introducing the pain only pathway for breast clinics which provides a breast cancer risk assessment and early detection of significant breast cancer family history as per the National Institute for Health and Care Excellence (NICE) guidelines. It is commendable to note that the improvement team were runners up at the National Health Service Journal (HSJ) awards in the Community Innovation category.

- The Trusts commitment to participation in National and Clinical Audits is evident with 93% (67) National Clinical Audits and 100% (6) National Confidential Enquiries the Trust were eligible to participate in and undertook. This is alongside 91 local clinical audits reviewed by the Trust in 2022/23 leading to identified actions to improve the quality of healthcare provided.

- There is a clear drive and focus by the Trust, as detailed in the Quality Account, to develop their Learning from Deaths process and maintain robust oversight of their mortality data. Increasing the recruitment for Medical Examiners (ME) supports the completion of transparent and independent scrutiny of the death certification process through SJR's (Structured Judgement Reviews), which ensures the correct referrals are made to the Coroner. DDICB welcome the appointment of the first General Practitioner

(GP) into this team and look forward to seeing the impact of plans to extending scrutiny into the community.

- Improvements to patient flow and discharge include the opening of Phillip Ward in November 2022, and increased opening of the Discharge Assessment Unit at Queens Hospital Burton to 24 hours a day/seven days a week, has been received positively by patients and stakeholders.

- A key achievement in End of Life Care (EOLC) relates to the education and training programme which is aligned to the End of Life Care Educational Standards. To standardise the education across Derbyshire and ensure that core principles of EOLC are delivered across all care settings the Trust are working collaboratively with the Derbyshire Alliance for EOLC and Joined Up Care Derbyshire. This methodology has resulted in 79% of ward based registered nurses and health care support workers having attended the face-face EOLC tier one training.

- Key achievements in patient experience and staff engagement are positively represented in the Quality Account and DDICB look forward to the further development in support and learning from these areas over the next 12 months to further improve the patients and staff experience.

Areas identified for improvement:

- The Trust recognise that their 51.5% achievement for March 2023 against the maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers is a challenging position to be in and falls short of the national average of 75.6%. The Trust note that cancer waiting times are particularly challenging in Lower Gastrointestinal (GI), Urology, and Gynaecology where there has been a high level of referrals with less capacity available. The Trust and System partners are working on improving the quality of cancer referrals to support referral optimisation. The Trust have also increased histopathology capacity as a response to the increased demand for tests. It is welcome to note that the Trusts Cancer Improvement Group receives reviews of breaches of the 62-day target to gain assurance that patients have not been harmed as a result of any delays.

- Emergency Department wait times have proved challenging for the Trust with March 2023 figures demonstrating that 61.5% of patients waited no more than 4 hours from arrival before a decision to admit, transfer, or discharge was made. This is against a national average of 70.8%. Several improvements to support this area have been introduced throughout the year including DDICB's commissioning of the Urgent Care Treatment Centre at Derby, and an expansion of Same Day Emergency Care pathways. System partner support is crucial to continued improvements and DDICB welcome this approach.

- DDICB understand the Trust Boards disappointment in reporting that Maternity Services have not always delivered the highest standard of care the Trust would want to deliver. DDICB will continue to support the Board to make improvements that achieve the high-quality patients should expect. Commitment to learning and transparency is evident via the Trust commissioning independent reviews from NHS England (NHSE) and the Healthcare Safety Investigation Branch (HSIB) which have been discussed at the Public

Trust Board meetings and published on the Trust website. The key steps taken in 2022/23 and the aims for 2023/24 are clear and support quality improvement.

The Trust have provided a Quality Account that reflects the achievements over the last twelve months whilst acknowledging the challenges. It reflects an organisation that in supporting the wider System has set appropriate priorities for the coming year, with good measurable indicators. The DDICB look forward to supporting the Trust along their continuing improvement journey.

Brigid Stacey
Chief Nursing Officer
On behalf of DDICB

Appendix 1

Chesterfield Royal Hospital Quality Account 2022/23

Derby and Derbyshire Integrated Care Board Statement

NHS Derby and Derbyshire Integrated Care Board (DDICB) would like to thank Chesterfield Royal Hospital NHS Foundation Trust (CRH) for their ongoing productive collaboration despite the demand and capacity pressures following the Covid 19 pandemic. The Trust and DDICB continued with their regular Clinical Quality Review Group Meetings via virtual methods and the detail within this Account reflects the information available to us.

The Trust's achievements set out in the Quality Account are reflective of their Trust Values, and compliance against national, regional, and local standards.

Notable areas:

- The Trust received an impressive response to the National Staff Survey which demonstrated that 67.8% of colleagues would recommend the Trust as a place to work, and 70.5% of colleagues would be happy with the standard of care provided should their friend or relative need it.
- Health and Wellbeing has evolved significantly at the Trust through a collaborative approach with Joined Up Care Derbyshire. This work was enabled by an allocation of national contingency funding provided to support NHS colleagues throughout the Covid 19 pandemic.
- The Trust's Royal Academy of Improvement has supported many initiatives to advance patient care and services for local communities. The examples within the Account demonstrate developments in educational training of quality improvement methodology, increases in efficiencies, and collaborative working with relevant stakeholders.
- The extension of opening hours of the Medical Day Case Unit (MDCU) from 8am to 8:30pm created an additional 108 hours per week, which increased patient capacity by 68%.
- From the National Maternity Survey 2022, which was published in January 2023, the Trust's results were extremely positive. The Trust scores were better than other Trusts for 25 of the questions and were similar scores for the remaining 26 questions. The Trust was amongst the top-ranking Trusts for the categories of 'Antenatal Check-ups', 'During your Pregnancy', 'Staff Caring for You', 'Care in Hospital after Birth' and 'Care at Home After Birth' sections. The Trust achieved the highest regional score for these sections.
- The Trust noted they had a significant typing backlog of clinical letters, which was cleared, and because of the processes they have put in place, and their typing of letters is below national target at three days.

The Trust recognised that there are areas where their improvements were not as effective as they had anticipated.

Areas identified for improvement:

- The six-week diagnostic wait was initially introduced as a 'milestone' towards achieving the standard Referral to Treatment wait of 18 weeks. The Trust recognised that their

achievement of this target was 71.6% and fell short of the national target. The Trust intends to take action to improve this score and the quality of services by maximising productivity in all areas with a specific focus on the areas that have not returned to the national performance standard. Action plans and trajectories will be developed to ensure delivery of the Trust's ambition of more than 80% of patients seen within 6 weeks.

- The Trust aimed to ensure that 95% or more of their patients waited no more than 4 hours before a decision to treat, admit or discharge was made. In March 2023, the Trust achieved 67.4% against the national target of 95%. The Trust have changed their Emergency Department footprint to an amalgamation model and has been noted an overall increase in activity, especially through Ambulatory Majors and, due to capacity and flow issues they have been unable to run a frailty ambulatory model. Improvement plans are in place to improve their performance to achieve 76% performance by March 2024.

The Trust have clearly identified focussed plans for improvement in the coming year. The ICB look forward to supporting the Trust along their continuing improvement journey.

Brigid Stacey
Chief Nursing Officer
On behalf of DDICB

Appendix 1

Derbyshire Healthcare NHS Foundation Trust (DHcFT) Quality Account 2022/23

Derby and Derbyshire Integrated Care Board Statement

The Derby and Derbyshire Integrated Care Board (DDICB) welcome the opportunity to provide a statement in response to the 2022/23 Quality Account from Derbyshire Healthcare NHS Foundation Trust (DHcFT). DDICB has worked closely with the Trust throughout the year to gain assurances that commissioned services delivered were safe, effective, and personalised to service users. The data presented has been reviewed and is in line with information provided and reviewed through the quality monitoring mechanisms.

Measuring and Improving Performance

Despite the operational pressures throughout the year, DDICB noted the progress and achievement of their quality priorities set out last year. There are examples with relevant evidence to support statements of implementation and we recognise that in 2023/24 the Trust will focus on their continual development and integration into practice. The Quality Account clearly evidences where the Trust will target its resources to deliver service improvements in the next twelve months.

Commissioners agree that the Quality Account provides an overview of the Trust's strategy, vision, values, and work. These are now embedded within the Trust Strategy, as a way of integrating them more firmly into core business. Within the Trust Strategy there were four key priorities for 2022/23:

1. Sexual Safety;
2. Implementation of a Trauma Sensitive Services Strategy;
3. Implementation of the new Mental Health Legislation, including the Mental Health Act (MHA) and Liberty Protection Safeguards (LPS);
4. Implementation and delivery of all named CQUINs or contractual targets.

Commissioners supported these priorities and thanked DHcFT for their flexible and pragmatic approach to embedding these into clinical practice. The Quality Account reflects the hard work that has taken place to achieve these priorities. As recognised in the Quality Account, the Trust moved all its wards except two, into a Same Sex Accommodation approach. This saw all wards move to populations of all Male or all Female and fit in line with the Trust Sexual Safety work. In 2022/23, the Trust saw no breaches and was compliant.

It would have been helpful to provide a brief narrative around performance in the Quality Dashboard on pages 110-112.

The Trust has collaborated closely with Commissioners in their implementation and quality assurance mechanisms. Whilst CQUIN targets were not achieved Commissioners note the Trusts continued commitment to the program.

Patient Safety and Clinical Effectiveness

The Trust continues to ensure that there is continuous improvement regarding the quality of incident investigations and Trust-wide learning. The Trust is compliant with the national requirements set by NHS England/Improvement about collecting patient safety data and its use in improving patient safety. However, several assurances given about patient safety are data heavy with limited analysis or narrative. For example, the Trust's performance with

LeDeR, which again is presented as data rather than objective analysis of its successes and areas for improvement. Outside of this Quality Account Commissioners are aware of the great strides taken by the Trust to embed LeDeR into practice, but these are not reflected in the account.

Comparatively, over the last year the Crisis Resolution Home Treatment Service (Adults and Older Adults) has mapped its services against national Fidelity standards for provision of mental health crisis services. A keen focus of the work has been to engage with and work in collaboration with service users and external partners in gaining feedback on what the service aimed to achieve through working towards the Fidelity standards. Commissioners welcome this work and congratulate the team on their achievements.

Additionally, agreement has been reached with Derbyshire Police to reinstate and expand the Street Triage programme in collaboration with the DHcFT Crisis Helpline and Support Services. The agreement follows a pilot that was undertaken during 2022, which showed positive results in reducing police time on scene and police conveyance where mental health issues were involved. The initial pilot involved one car staffed with a police officer and a member of the Helpline clinical team, but the new service will expand to include two jointly staffed cars to cover both the north and south of the county. The service will operate at peak times of 4pm-12 midnight seven days a week and the aim will be to facilitate face to face clinical assessments on site where police are called out, reducing Section 136 detentions and police conveyance to ED, ensuring people with mental health problems are assessed and seen by the right service in the first instance. The service will begin operations from beginning March 2023 and will run initially for one year. Commissioners welcome this work and thank the Trust for reinstating this valuable programme.

Patient and Staff Experience

The Patient Experience Strategy was reviewed by the Trust Quality & Safeguarding Committee in 2023/24. Commissioners note that progress continues, and areas of improvement include:

- the EQUAL developments including feedback through ‘Bright Ideas’ leading to investments in ward-based activity;
- texting and feedback service;
- pathway specific tools such as Helpline;
- the community mental health survey;
- up-take and impact of Family and Friends Test.

Commissioners will monitor further improvement in these areas over 2023/24 and will support the Trust in this ongoing work.

To ensure the Trust understand the experiences and satisfaction of people who receive care and treatment in its community mental health services, it takes part in the annual national Mental Health Community Service User Survey. In 2022/23 71% of respondents were over the age of 51 and the majority were white with a relatively even split between males and females. Going forward, the Trust will adopt a targeted approach to increase feedback from younger service users and a more diverse range of ethnic groups will be prioritised.

Commissioners acknowledge the positive feedback received for Talking Therapies, Support and Wellbeing, Reviewing Care, Crisis Care and Medicines Management. Comparatively, areas for improvement are patients being offered opportunity to feedback on care, participation in a care review meeting, and a named patient care coordinator or lead professional. Commissioners will work with the Trust in addressing these areas of improvement.

The 2022 Staff Survey presented a response rate of 48% (2% below the median) and a total of 1,412 questionnaires completed, a drop from 1,703 in 2021. Whilst the documented feedback is positive, the Quality Account does not explain why uptake in 2022 was less than half the workforce nor the drop in respondents from 2021. Additionally, there is no plan to increase uptake in 2023.

Care Quality Commissioner (CQC)

In the last four years DHcFT has undergone a full Trust-wide inspection. Visits highlighted an area of 'Outstanding' in Children and Young Peoples Services (Derby City and South)

Currently, CQC rate the Trust as 'Good' which is a positive continuation from 2022/23. Commissioners are eager for DHcFT maintain this rating.

Commissioners feel that it would have been useful to include an update in relation to the implementation of the areas of improvement previously identified by CQC that are either closed or ongoing. As well as compliance against recommendations/actions which were raised following the mock CQC inspections. The outstanding actions continue to report to the Trust Board and the Clinical Quality Review Group.

Quality Priorities for 2023/24

In addition to restoration and recovery of services, the Trust has identified five key priorities for 2023/24.

1. Implementation and development of Expert by Experience and Carer Engagement Strategy
2. Focused improvement in the Reduction of Self Harm and Ligature incidents
3. Focused improvement on Care planning and Patient Centred Care
4. Focused improvement in Risk Assessment and Formulation
5. Focused and improved use of Outcome measures

Commissioners recognise the importance the Trust attaches to each of these priorities.

Looking Ahead

This Quality Account (2023/24) statement provides assurance to members of the public that the ICB is committed to ensuring it assesses and provides a high quality of care across its commissioned services. Within this statement DDICB recognise and thank DHcFT for working positively and collaboratively with commissioners and key stakeholders to ensure our service users receive a high quality of care at the right time and in the right care setting.

The Trusts role is fundamental to system development and transformation of Derbyshire Healthcare It plays a leading role within the development of the Mental Health and Learning Disability and Autism Integrated Delivery Board and management of the Transforming Care Programme. This provides a valuable opportunity to coordinate and lead partnerships and relationships across Joined Up Cared Derbyshire.

Appendix 1

Commissioners welcome the investment and construction of the new Psychiatric Intensive Care Unit (PICU) and the planned redevelopment of the adult inpatient services which are financed from the Trust capital plan. This will allow Derbyshire to provide a local PICU facility within the county. This supports the system commitment to the 'Long Term Plan' and bringing care closer to home.

As we move towards further system integration DDICB looks forward to working with the Trust to build system collaborative services that facilitate the four priorities highlighted in this Quality Account.

Brigid Stacey
Chief Nursing Officer and Deputy Chief Executive
On behalf of Derby and Derbyshire Clinical Integrated Care Board
28th April 2023

Appendix 1

Derbyshire Community Health Services NHS Foundation Trust Quality Account 2022/23

Derby and Derbyshire Integrated Care Board Statement

General Comments

On behalf of the Host Coordinating Commissioner Derby and Derbyshire Integrated Care Board) (DDICB) welcome the opportunity to respond to the 2022/23 Quality Account from DCHS. Commissioners worked closely with DCHS throughout the year to gain assurances that commissioned services delivered were safe, effective, and personalised to service users. The data presented has been reviewed and is in line with information provided and reviewed through the quality monitoring mechanisms.

Measuring and Improving Performance

Despite the operational pressures throughout the year, Commissioners noted the progress and achievement of their quality priorities set out last year. There are examples with relevant evidence to support statements of implementation and we recognise that in 2023/24 DCHS will focus on their continual development and integration into practice. The Quality Account clearly evidences where DCHS will target its resources to deliver service improvements in the next twelve months.

Commissioners agree that the Quality Account provides an overview of DCHS's strategy, vision, values, and work. These are now embedded within the Trust Strategy, as a way of integrating them more firmly into core business. DCHS has collaborated closely with Commissioners in their implementation and quality assurance mechanisms.

Patient Safety and Clinical Effectiveness

DCHS continues to ensure that there is continuous improvement regarding the quality of incident investigations and organisation-wide learning. DCHS is compliant with the national requirements set by NHS England about collecting patient safety data and its use in improving patient safety.

Commissioners are assured with DCHS Serious Incident reporting processes and welcome its transition to and implementation of PSIRF.

Patient Experience

The Quality Account provides clear analysis of performance improvements in the patient experience.

Care Quality Commissioner (CQC)

Commissioners are assured the Organisation is fully compliant with the registration requirements of the Care Quality Commission and has arrangements in place for ongoing monitoring of compliance with these requirements and ensuring that actions are implemented.

Looking Ahead

This Quality Account (2023/24) statement provides assurance to members of the public that ICBs are committed to ensuring we assess and provide a high quality of care across

commissioned services. Within this statement Commissioners recognise and thank DCHS for working positively and collaboratively with system colleagues and stakeholders to ensure service users receive a high quality of care at the right time and in the right care setting.

As we move towards further system integration Commissioners look forward to working with DCHS to build system collaborative services that facilitate priorities highlighted in this Quality Account.

Brigid Stacey
Chief Nursing Officer and Deputy Chief Executive
On behalf of Derby and Derbyshire Clinical Integrated Care Board
5th June 2023

Appendix 1

East Midlands Ambulance Service Trust Quality Account 2022/23

Derby and Derbyshire Integrated Care Board Statement

On behalf of the Host Coordinating Commissioner Derby and Derbyshire Integrated Care Board) (DDICB) welcome the opportunity to respond to the 2022/23 Quality Account from East Midlands Ambulance Service NHS Trust (EMAS). Commissioners worked closely with the Trust throughout the year to gain assurances that commissioned services delivered were safe, effective, and personalised to service users. The data presented has been reviewed and is in line with information provided and reviewed through the quality monitoring mechanisms.

Measuring and Improving Performance

Despite the operational pressures throughout the year, Commissioners noted the progress and achievement of their quality priorities set out last year. There are examples with relevant evidence to support statements of implementation and we recognise that in 2023/24 the Trust will focus on their continual development and integration into practice. The Quality Account clearly evidences where the Trust will target its resources to deliver service improvements in the next twelve months.

Commissioners agree that the Quality Account provides an overview of the Trust's strategy, vision, values, and work. These are now embedded within the Trust Strategy, as a way of integrating them more firmly into core business. Within the Trust Strategy there were four key priorities for 2022/23:

- Priority 1: To work with the National Ambulance Service Patient Experience Group to develop a metric to measure dignity and compassion.
- Priority 2: To promote the safe and appropriate use of alternatives to Emergency Departments by ensuring staff have the necessary knowledge, skills, experience and confidence to do so. This includes ensuring that staff have digital access to shared records and to senior clinical support where required.
- Priority 3: To improve our performance against the nationally reported Ambulance System Indicators and Clinical Outcomes, with a particular focus on cardiac arrest.
- Priority 4: To learn from when things go well as well as when they go wrong, ensuring that learning is shared both internally and externally to improve the quality of care we provide to our patients.

The Trust has collaborated closely with Commissioners in their implementation and quality assurance mechanisms.

Commissioning for Quality and Innovation (CQUIN)

For the 2022/23 contract only one national CQUIN scheme was mandated for ambulance services, but Commissioners acknowledge the proactive steps taken by the Trust develop an additional local CQUIN scheme and continued to monitor progress against a previous CQUIN scheme. In Lincolnshire an additional local CQUIN, (Extending skills of paramedics in relation to wound care / closure to enable discharge on scene) was trialled. It proved successful and will be a CQUIN in 2023/24 in regional ICBs.

Appendix 1

Patient Safety and Clinical Effectiveness

The Trust continues to ensure that there is continuous improvement regarding the quality of incident investigations and Trust-wide learning. The Trust is compliant with the national requirements set by NHS England about collecting patient safety data and its use in improving patient safety.

The breakdown of Serious Incidents by category in 2022/23 (Diagram 1.0) demonstrates the impact of system pressures on ambulatory care. Alongside the Trust Commissioners acknowledge delays in transfer of care account for 67% of Serious Incidents, which is attributable to system flow. Commissioners' welcome steps taken by the Trust to engage with system stakeholders to mitigate delays in transfers of care and harm reviews.

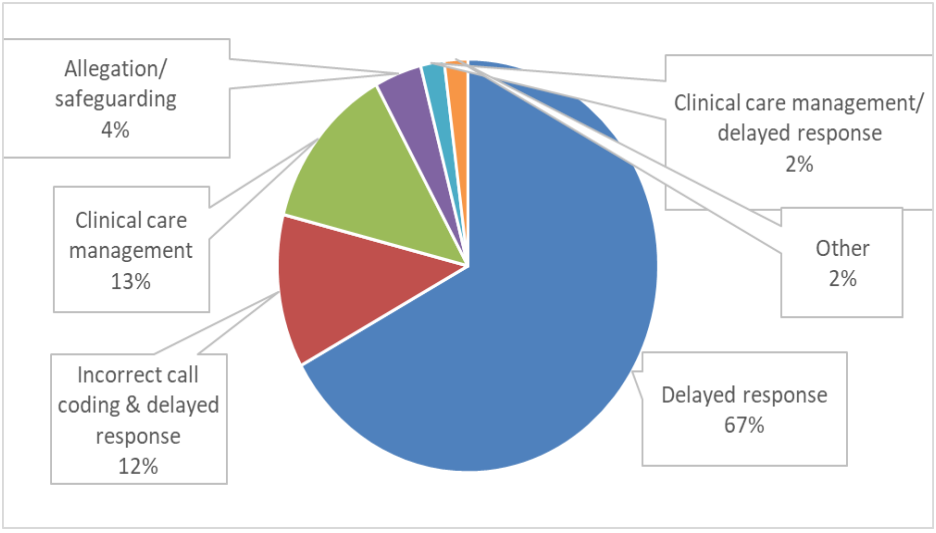

Figure 1: Breakdown of Serious Incidents by Category 2022/23, ©EMAS.

Commissioners are assured with the Trusts Serious Incident reporting processes and welcome its transition to and implementation of PSIRF.

Patient Experience

During 2022/23, EMAS received 1,045 expressions of appreciation from patients or members of the public, compared to 1,308 in the previous year and 1,985 Excellence compliments compared to 1,856 in 2021/22, which is an increase of 129.

The Quality Account provides clear analysis of performance improvements in the patient experience. During 2022/23 EMAS identified 125 formal complaints requiring investigation compared to 160 in 2021/22, a decrease of 35. Commissioners, note that due to the significant delays in attending scenes and with hospital handovers there was an increase in serious incidents being reported which may explain the reduction in formal complaints.

Care Quality Commissioner (CQC)

The Trust continues to be rated by the Care Quality Commission (CQC) rated us as ‘Good’ overall and ‘Outstanding’ for caring.

Appendix 1

Commissioners are assured the Trust is fully compliant with the registration requirements of the Care Quality Commission and has arrangements in place for ongoing monitoring of compliance with these requirements and ensuring that actions are implemented. During 2022/23 the Trust held regular virtual meetings with the CQC relationship manager to provide ongoing assurance of quality.

Quality Priorities for 2023/24

The Trust has identified five key priorities for 2023/24.

Priority 1: To increase response rates to patient satisfaction surveys to enable more effective analysis to drive improvement.

Priority 2: To promote the safe and appropriate use of alternatives to Emergency Departments by ensuring staff have the necessary knowledge, skills, experience, and confidence to do so. This will include ensuring that staff have digital access to shared records and to senior clinical support where required

Priority 3: To improve both medicines optimization (ensuring the best possible outcomes from medicine usage in a safe and cost-effective way) and the robustness of medicines' governance arrangements, with a particular focus on controlled drugs.

Priority 4: To implement and embed the recommendations in the NHS Patient Safety Strategy, including continued development of Patient Safety Specialists and Partners, delivery of the patient safety national syllabus and transition to the Patient Safety Incident Response Framework.

Priority 5: To implement the national Violence Reduction Standards, with particular emphasis on ensuring staff have the necessary skills and knowledge to effectively diffuse potentially violent situations and increase the uptake of Body Worn Cameras to facilitate appropriate investigation and prosecution where appropriate.

Commissioners recognise the importance the Trust attaches to each priority. The continuance of CQUINs offers both parties the opportunity to develop key service lines that benefit patient experience and safety.

Integrated Care Board Position Statements

All associate commissioners were offered the opportunity to respond the Quality Account. Their responses are below.

Leicestershire

LLR ICB welcome this EMAS quality account and acknowledge the partnership role the organisation has in our System. EMAS's commitment to sustained quality is evident, particularly during the challenging periods. This account demonstrates continued quality achievements and together with commitment to their quality priorities, challenges, and collaboration to achieve demonstrable quality outcomes for the patients of Leicester, Leicestershire and Rutland.

Appendix 1

LincoInshire

As a Co-Commissioner, NHS LincoInshire Integrated Care Board (LICB) welcomes the opportunity to comment on the East Midlands Ambulance Service NHS Trust Quality Account 2022/23.

We recognise the Host Coordinating Commissioner's continued close working and agree with their comments regarding the Trust's Quality Account's accuracy of information including identification of the Trust's five priorities in 2023/24.

The Trust have identified they will need to continue to develop, collaborate and target resources across the region going forward.

Reviewing the Quality Account 2022/23 has given LICB the opportunity to obtain a further overview of the good work the Trust has carried out to date.

We look forward to further conversation and continued exemplary working together for development of pro-active and alternative clinical pathways within an evolving integrated care system.

Looking Ahead

This Quality Account (2023/24) statement provides assurance to members of the public that ICBs are committed to ensuring we assess and provide a high quality of care across commissioned services. Within this statement Commissioners recognise and thank EMAS for working positively and collaboratively with system colleagues and stakeholders to ensure service users receive a high quality of care at the right time and in the right care setting.

As we move towards further system integration Commissioners look forward to working with the Trust to build system collaborative services that facilitate the five priorities highlighted in this Quality Account.

Brigid Stacey
Chief Nursing Officer and Deputy Chief Executive
On behalf of Derby and Derbyshire Clinical Integrated Care Board (Coordinating Commissioner)
9th May 2023

Appendix 1

DHU/111 Quality Account 2022/23

Derby and Derbyshire Integrated Care Board Statement

On behalf of the Host Coordinating Commissioner Derby and Derbyshire Integrated Care Board) (DDICB) welcome the opportunity to respond to the 2022/23 Quality Account from DHU. Commissioners worked closely with DHU throughout the year to gain assurances that commissioned services delivered were safe, effective, and personalised to service users. The data presented has been reviewed and is in line with information provided and reviewed through the quality monitoring mechanisms.

Measuring and Improving Performance

Despite the operational pressures throughout the year, Commissioners noted the progress and achievement of their quality priorities set out last year. There are examples with relevant evidence to support statements of implementation and we recognise that in 2023/24 DHU will focus on their continual development and integration into practice. The Quality Account clearly evidences where DHU will target its resources to deliver service improvements in the next twelve months.

Commissioners agree that the Quality Account provides an overview of DHU's strategy, vision, values, and work. These are now embedded within your Strategy, as a way of integrating them more firmly into core business. DHU has collaborated closely with Commissioners in their implementation and quality assurance mechanisms.

Patient Safety and Clinical Effectiveness

DHU continues to ensure that there is continuous improvement regarding the quality of incident investigations and organisation-wide learning. DHU is compliant with the national requirements set by NHS England about collecting patient safety data and its use in improving patient safety.

Commissioners are assured with DHU's Serious Incident reporting processes and welcome its transition to and implementation of PSIRF.

Patient Experience

The Quality Account provides clear analysis of performance improvements in the patient experience.

Care Quality Commissioner (CQC)

In July 2022 DHU were one of the first organisations to have a CQC “touchpoint inspection” as part of a wider systems inspection and was rated as “outstanding”.

Commissioners are assured the Organisation is fully compliant with the registration requirements of the Care Quality Commission and has arrangements in place for ongoing monitoring of compliance with these requirements and ensuring that actions are implemented.

Looking Ahead

This Quality Account (2023/24) statement provides assurance to members of the public that ICBs are committed to ensuring we assess and provide a high quality of care across

commissioned services. Within this statement Commissioners recognise and thank DHU for working positively and collaboratively with system colleagues and stakeholders to ensure service users receive a high quality of care at the right time and in the right care setting.

As we move towards further system integration Commissioners look forward to working with DHU to build system collaborative services that facilitate priorities highlighted in this Quality Account.

Brigid Stacey
Chief Nursing Officer and Deputy Chief Executive
On behalf of Derby and Derbyshire Clinical Integrated Care Board (Coordinating Commissioner)
24th May 2023

Appendix 1

Barlborough Quality Account 2022/23

Derby and Derbyshire Integrated Care Board Statement

General Comments

NHS Derby and Derbyshire Integrated Care Board (DDICB) are pleased to comment on Practice Plus Group's (PPG) Quality Account for 2022/23.

Firstly the DDICB would like to thank the Practice Plus Group for their continued efforts to support patients and partners in the local and surrounding areas.

Whilst we note that not all of the priorities for 22/23 were achieved, there has been good progress against the targets PPG set themselves and those that have been carried forward should continue to build on the work already completed. Further work to fully implement the Patient Safety Incident Response Framework (PSIRF) will undoubtedly complement the Quality Academy Approach and local quality initiatives.

For DDICB specifically, it was encouraging to read the views of the team at Barlborough regarding the good relationship with DDICB and it is hoped this will continue. The excellent patient comments, good external relationships, and positive quality indicators are certainly reflective of what is consistently observed during quality visits.

The DDICB look forward to supporting Barlborough on their continuing improvement journey.

Brigid Stacey
Chief Nursing Officer and Deputy Chief Executive
On behalf of Derby and Derbyshire Clinical Integrated Care Board (Coordinating Commissioner)
15th June 2023

Time Commenced: 13:00pm
Time Finished: 14.30pm

Health and Wellbeing Board
16 March 2023

Present:

Statutory Members Chair: Councillor Webb (Chair), Sue Cowlishaw (Derby Healthwatch), Robyn Dewis, Director of Public Health, Chris Clayton (CEO Derby & Derbyshire ICB),

Elected members: Councillors Martin

Appointees of other organisations: Amjad Ashraf (Derby Health Inequalities Partnership), Steve Bateman (CEX DHU Healthcare), Paul Brookhouse (Derby Poverty Commission), Lucy Cocker (Derbyshire Community Healthcare Services), Gino DiStefano, (Director of Strategy Derby Hospitals NHS Trust), Ian Fullagar, (Head of Strategic Housing, City Development and Growth DCC), James Joyce, (Head of Housing Options and Homelessness)

Non board members in attendance: Celia Edwards-Grant (Public Health Support Co-ordinator DCC), Zara Jones, (Executive Director Strategy & Planning DDICB), Angela Odell (Public Health Manager DCC), Katie Ross (Senior Commissioning Officer Adults Social Care), Robert Smithers (Livewell, DCC), Karielle Webster (Speciality Registrar in Public Health), Michael Rose (Lead Commissioner LD/MH/Austism DCC), Victoria Whittaker-Stokes (DDICB), Alison Wynn, (Assistant Director Public Health)

45/22 Apologies for Absence

Apologies were received from: Councillors Poulter, Whitby and Lonsdale, David Cox (Derbyshire Constabulary), Fran Fuller (Derby University), Michael Kay (Head of Environment Protection, Housing Standards, Licensing and Emergency Planning DCC), John MacDonald (Vice Chair), Jane Needham (Derbyshire Community Healthcare Services), Rachel North (Strategic Director of Communities and Place), Andy Smith Strategic Director of Peoples Services, Clive Stanbrook (Derbyshire Fire and Rescue Service)

46/22 Late Items

There were none.

47/22 Declarations of Interest

There were none.

48/22 Minutes of the meeting held on 19 January 2023

The minutes of the meeting on 19 January 2023 were agreed.

49/22 Joined Up Care Derbyshire Update – Report of the ICB 5 Year Plan

The Board received a report and presentation from the Chief Executive of Derby & Derbyshire ICB. The report and presentation gave an overview of the Joint Forward Plan – 5 Year Plan and of the proposed process to develop the Plan. It was also to ask for the HWBs engagement in the development of the Plan.

The Plan will set out how the ICB intend to meet the physical and mental needs of the local population of Derby and Derbyshire through the provision of NHS Services. This includes setting out how universal NHS commitments will be met and address the four core purposes of the ICS:

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

The timeline for publishing and sharing the first joint plan with NHS England, ICPs and HWBs is 30th June 2023. The relevant HWBs must be involved in preparing or revising the JFP. A draft JFP must be shared with each relevant HWB and consultation must take place with HWBs on whether the JFP takes account of their joint health and wellbeing strategy (JLHWS).

The approach to engagement was detailed:

- ICP partner engagement in framework and content
- Formal discussion and review at both Derby & Derbyshire HWBs between March and June
- Engagement through ICP sub-committees particularly Population Health, Public Partnerships, People & Culture and Finance
- Consideration of public consultation requirements and engagement activities with approach developed accordingly
- Impact Assessments undertaken for relevant content, underpinned by appropriate risk management/documented risks and mitigations
- Development of a “what the JFP means for me” guide alongside the publication to ensure well considered alignment and meaning to a range of stakeholders and organisations.

The JFP Framework was outlined, it was developed as an NHS/ICB Plan, it would be a five year plan with more detail in the first two years. The main focus would be on the local priorities, blended with JFP guidance requirements (duties). A very draft version would be prepared in March, with a more refined version for April/June.

The local priorities are based on:

- Access, prevention and productivity to support managing urgent and emergency care risks
- Productivity challenge opportunities
- How the the ICB can support delivery of the ICP Integrated Care Strategy priorities.
- Addressing health inequalities in year one

- A population health approach, targeted improvement plan for groups in the local population.

Key areas which need direction and development include:

- The local priority areas for population health, linked to the ICP strategy but specific to NHS contribution
- A prioritisation process
- Strategic milestones for each of the 5 years
- Direction on what Population Health Strategy Committee (PHSC) would like to see between now and June and the role in will play in finalising the JFP

The Chair raised the issue of poor housing and the impact on general population health. Partnership in dealing with issues was the best way forward and highlighted that community and voluntary involvement was an important role. The Head of Strategic Housing, City Development and Growth (DCC) offered assistance to the Health Authority.

The HWB Board resolved:

1. **to note the contents of this report**

2. **to give their support for the effective development and delivery of Derby and Derbyshire ICBs Joint Forward Plan noting that the plan was not static but a rolling plan**

50/22 Derbyshire Joint Health and Social Care All Age Autism Strategy 2023-28

The Board received a report and presentation from the Director of Integration and Direct Services. The report was to ask for HWB and member organisations endorsement and support for the new Joint Derby and Derbyshire Integrated Care All Age Autism Strategy. It was a statutory requirement for DCC to have an Autism Strategy in place.

Autism was defined as a range of conditions that are characterised by difficulties in social interaction and communication and by restrictive or repetitive patterns of thought and behaviour. Autism is a spectrum condition (ASC), while all autistic people share certain difficulties, their condition will affect them different ways.

In the UK more than 1 in 100 people live with an ASC, around 8700 people in Derby and Derbyshire are autistic. In Derby City by 2030 1566 people will have a diagnosis of autism. It must be recognised that every autistic person is different.

Some of the achievements from the 2017-20 Strategy were highlighted:

- Commissioning of a new Autism Information and Advice Service (CAMM)
- Autism Task and Finish Group to map out existing autism training provision in Derby and Derbyshire
- Increased provision of accommodation, care and support for autistic people
- Commissioned Services to increase independence Living Well with Autism
- A growth in membership of the Experts by Experience (EBE) group
- Local evidence that businesses are working towards being more Autism inclusive

- A Specialist Autism Team (SAT) created in the NHS.

The new Strategy 2023-28 was co-produced by Autistic individuals. Three system wide workshops took place and there were monthly task and finish workshops for each of the five prioirities of the strategy. Autistic people were listened to through their health and social care assessments. The monthly Autism Partnership Board gave updates to the HWB, their membership consists of EBE.

The five key aims of the new Strategy are:

- Earlier diagnosis
- Increased Preventative Services
- A Stronger professional peer support offer
- Increasing meaningful employment opportunities
- Delivering training beyond awareness raising

The Board discussed the new strategy. The comments from the Board were positive, it was noted that Council Cabinet had approved a second phase of a capital project to bring about "Living my Best Life" for supporting young people in schools and specialist accommodation.

The early diagnosis of ASC has been a challenge for many years, the earlier a diagnosis is done the better the outcomes.

Officers explained that the new Strategy would be cost-effective at the moment less than 10% of autistic people are in work, most are accessing benefits. Autistic people are more likely to attempt suicide, become homeless, and they are eight times more likely to be in the criminal justice system.

Partnership organisations offered their support to assist people with autism to access services. It was asked how the services were currently promoted. The officer advised that promotion took place by usual channels such as websites, GPs, Children and Young People Local Offer, SEND colleagues. The main challenge was reaching people who were currently undiagnosed. The service will accept people who are undiagnosed.

The service was aware of the need to contact hard to reach groups and felt that communication was the key, raising awareness of Autism and encouraging people to be more inclusive was important. Any ideas to help reach the wider population were welcomed. A Board member suggested that DCC Communications Team should be approached, and the best media to use would be radio or television as they undertake specific programmes around autism. There are Autism Days/Weeks which can be used to promote local services. It was easier to reach ethnic minorities using local radio stations.

A Board member asked if the new Strategy was in an accessible format. The officer confimed that work had been undertaken to ensure that it was accessible.

The Board resolved that:

1. **The HWB and its member organisations join the City Council in endorsing and confirming their support for the new Strategy.**

2. **The Board receive updates on progress to deliver the strategy.**

51/22 Derby Tobacco Control Health Needs Assessment

The Board received a report and presentation from the Director of Public Health which gave an opportunity for the Board to discuss the findings and recommendations of a recent tobacco control health needs assessment. The report sought approval from the HWB for proposed further action to reduce the impact of tobacco use in the City.

Tobacco use was a significant public health challenge. Smoking was the leading cause of preventable illness and premature death in England. It was also a significant driver of health inequalities, it accounts for half the differences in life expectancy between the richest and poorest in society.

The Tobacco Control Health Needs Assessment identified the health needs and impacts of tobacco use in Derby and assessed current tobacco control activities. It made recommendations to improve health and reduce health inequalities.

Key findings: national insights:

- Smoking prevalence was higher in men compared to women
- Smoking rates are higher in the 25-34 age group and lower for those aged 65 and over

Key at risk and priority groups are:

- People who are pregnant
- People with long term mental health conditions
- Routine and manual workers
- Children and young people
- People living in social housing
- People living in the most deprived areas
- Certain minority ethnic groups
- LGBTQI+ groups

Key findings: local outcomes

- 13.2% of adults in Derby smoke, the national average is 13%.
- There was a strong association between smoking and socio-economic disadvantage
- At 11.9% smoking rates in pregnancy are significantly higher than the national average of 9.1%
- In Derby smoking was estimated to cost society £108 million per year, £89m in lost productivity, £17.4m in NHS and social care costs, £19m in fire related costs. 300,000 cigarettes are smoked in Derby every day generating 16 tonnes of waste annually of which 7 tonnes was street litter.

Nationally there was a vision to create a smokefree society by 2030 (a national smoking prevalence of 5% or less). In Derby the Health Needs Assessment identified that to be effective there must be partnership working to apply a broad range of evidence based interventions and initiatives such as prevention, promoting quitting, treating dependance creating smokefree environments, and tackling illegal tobacco. An extensive program of local work was ongoing including: Livewell Stop Smoking Services, Smokefree policies and legislation. However, there was still a need to strengthen local action to reduce further the impact and harm of tobacco.

The Board discussed the findings of the report. One member asked at what point smoking became a health inequality rather than a social practice. In response the DoPH explained the inequality of risk of being a smoker, some people are less susceptible because their personal circumstances are better, they are relatively affluent, mentally well and have a good employment whilst others living in social deprivation are likely to be more susceptible to health issues. The biggest causes of mortality are cancer, and heart disease and the main cause was smoking and this was the most modiafible risk factor.

The challenge was not just Derby's, Derbyshire had the same issues so both City and County should be working together. The ICS had a vested interest in supporting this work. The issue of vaping was raised especially around younger people, around 9% of young people between the age of 11 and 19 are vaping. The products of vaping are affordable and are marketed towards younger people. Vaping was addictive and the full impact on health was not yet known. There were also concerns about the number of pregnant people who smoke. Members of the Board offered their help and support from their organisations.

The Board resolved

1. **to note the findings and recommendations of the health needs assessment**
2. **to support a collaborative whole-systems approach to tobacco control, with strategic responsibility overseen by a Derby Tobacco Control Strategic Group**
3. **Agree an ambition to provide a focus and shared commitment for tobacco control efforts**

51/22 Joint Local Health and Wellbeing Strategy Update

The Board received a report and presentation from the Director of Public Health which gave an overview of plans to update the Joint Health and Wellbeing Strategy (JLHWS)

After the implementation of the Health and Care Act 2022 HWBs are still responsible for the development of Joint Strategic Needs Assessments (JSNAs) and Joint Local Health and Wellbeing Strategies (JLHWs). They must also consider the Integrated Care Strategy when preparing their JLHWs.

The Derby Place Alliance set its vision in September 2022 to deliver local services to try and help people live full and healthy lives.

After the COVID 19 Pandemic, health inequalities in Derby came into focuse and gaps were identified in health planning within communities. Derby City Council and Community Action Derby became partners to the create the Derby Health Inequalities Partnership (DHIP).

The DHIP community consultation in 2022 identified 4 themes:

- Health behaviours
- Health services
- Wider determinants
- Information

The JLHWS will be reviewed and refreshed through a series of workshops with key partners over the next 6 months. There will be a joint workshop with the Place Partnership and the

HWB on 6th June 2023.

The Board resolved:

1. **Note and support the intention to refresh the JLHWS following the publication of the Integrated Care Strategy**

2. **To support the proposal to develop the strategy in collaboration with the Derby Place Partnership, Derby Health Inequalities Partnership and other key partners and stakeholders**

3. **That HWB members actively participate in the development of the Strategy**

Items for Information

52/22 Healthwatch Derby Health and Social Care Experiences of the LGBTQ+ Community 2022

The Board received a report from the Chair of Healthwatch Derby. The report's purpose was to provide the HWB with an overview of the Healthwatch Derby Health and Social Care Experience oof the LGBT+ Community 2022

Key themes identified were:

Access to
- GP Surgeries
- Mental Health Services
- Hospital services
- Sexual Health services

Support and lack of communication
- Poor support from GPs when asked for help

- Referral to Gender Identity Clinics (GICs)
- Poor or lack of communication from the GIC whilst waiting for an initial appointment

Lack of understanding
- 32% felt their identity was not respected and understood by healthcare professionals
- 31% stated their identity was brought up when seeking support for an unrelated health issue
- 43% felt their identity was a barrier to accessing a health and social care service
- 36% have experienced a poor or discriminatory healthcare experience based on their identity.

The most suggestions on what could be improved were staff awareness and knowledge of LGBTQ+ issues, staff attitudes and behaviour around making assumptions or allowing their own personal bias to affect a patients treatment, and access and waiting times for Gender Identity Clinics.

The Chair was concerned at the sobering figures which suggested the need for education for services across Health in the City to improve recognition of LBGT+.

A Board member suggested that part of the challenge was data capture, this should be taken forward through the ICS to better capture and understand data.

The Board looked forward to an update report in 12 -18 months times to see if improvements had been made.

The Board considered and noted the contents of the report.

53/22 Outbreak Engagement Board and Health Protection Board Update

The Board received a report of the Director of Public Health which provided an update and overview of the key discussions and messages from the Outbreak Engagement Board and Derbyshire Health Protection Board

The Health Protection Board met on 10th February 2023, Key points of note for information of the HWB:

- Infection Prevention and Contol (IPC) an update on the needs assessment was provided. The Pandemic had illustrated the gaps in care service

- Vaccination – there some discussion on the COVID Programme update. There were plans to end the autumn booster campaign and guidance was awaited on the extent of the planned spring and autumn campaigns for 2023. First and second doses are still available. Re-opening of the programme for the most vulnerable was likely.

- The Health Protection of the ICS draft strategy was reviewed and agreed.

- The Chief Medical Officer's Annual Report on air quality was discussed.

The chair queried the position on all vaccine uptake and whether herd immunity had been achieved. According to the DoPH this was challenging, there had been a dip in vaccine uptake since the Pandemic. The Vaccine Inequalities Group are looking at areas of poor update and what can be improved, butt will take time to recover and regain confidence of people.

The Board resolved to note the report.

Private Items

None submitted.

MINUTES END

Time Commenced: 13:00pm
Time Finished: 15.00pm

Health and Wellbeing Board
27 July 2023

Present:

Statutory Members Chair: Councillor Martin (Chair), Sue Cowlishaw (Derby Healthwatch), Richard Wright Vice Chair (Chair of ICB), Andy Smith (Strategic Director of Peoples Services) Alison Wynn (Assistant Director of Public Health) representing Robyn Dewis, Director of Public Health

Elected members: Councillors Ashby and Care

Appointees of other organisations: Denise Baker, (University of Derby), Paul Brookhouse (Derby Poverty Commission), Chris Clayton (CEO Derby & Derbyshire ICB), Lucy Cocker (Derbyshire Community Healthcare Services), Gino Distefano (Director of Strategy Derby Hospitals NHS Foundation Trust), Ian Fullagar, (Head of Strategic Housing, City Development and Growth DCC, rep for Health, Housing & Homelessness Board), Perveez Sadiq (Director Adult Social Care Services), Rachel North (Director of Communities & Place), Clive Stanbrook (Derbyshire Fire & Rescue Service)

Non board members in attendance: DCC, Stuart Batchelor (Active Partner Trust), Gurmail Nizzer (Director of Commissioning and Delivery DCC), Margaret Gildea (ICB) Owen Swift (Participation Pathway Manager DCC).

01/23 Apologies for Absence

Apologies were received from: Cllr Lonsdale, Amjad Ashraf (Community Action Derby), Emma Aldred (Derbyshire Constabulary), Stephen Bateman (CEO Derbyshire Healthcare United), Robyn Dewis, Director of Public Health, Michael Kay (Head of Environment Protection, Housing Standards, Licensing and Emergency Planning DCC), Clare Mehrbani (Director of Housing Services Derby Homes), Stephen Posey (CEX Derby Hospitals NHS Trust)

02/23 Late Items

There were none.

03/23 Declarations of Interest

There were none.

04/23 Minutes of the meeting held on 16 March 2023

The minutes of the meeting on 16 March 2023 were noted and agreed.

05/22 Joined Up Care Derbyshire Update

5a Derby & Derbyshire Integrated Care Strategy

The Board received a report from the Director of Public Health, Derby. The report gave an update on progress of the Integrated Care Strategy.

The officer reported that Integrated Care Partnerships (ICPs) have a statutory responsibility to prepare an Integrated Care Strategy. The purpose of the strategy was to set out how the Local Authority, NHS, Healthwatch, and voluntary, community and social enterprise (VCSE) sector organsiations would work together to improve the health of Derby and Derbyshire citizens and further the transforming change needed to tackle system-level health and care challenges.

The key areas of focus of the strategy were; Start Well, Stay Well , Age Well and Die Well.

The officer reported that on the 26th June 2023 the VCSE sector organised and led a partnership event to launch the Memorandum of Understanding (MoU), which provided the opportunity for 200 plus attendees to feed in questions and suggestions in sessions focused around Start Well, Stay Well and Age/Die Well. The outputs were being collated and would provide a source of information for each of the partnership groups leading on the development of plans.

The lack of fully aligned capacity with knowledge and skills to deliver against the ambitions was a potential barrier to implementation. The leaders for the three areas were working through these challgenges; some of the issues and opportunities were highlighted:

The challenge of **supporting service improvement and change management resources** where needed and enabling staff to work across organisations

There was a **strong local community and voluntary sector** which promoted “listening” to the communities and hearing about personal experiences enabling co-production of services and solutions

There was an opportunity to make the most of established **providers of prevention interventions** to increase the benefits they offer to communities.

The HWB commented on the report, observations included recognition of the value of input from the private and voluntary sector. The officer confirmed that the VCSE perspective was already involved; the feedback from the event on 26 June 2023 was really helpful. The suggestion of workshops and joint meetings of the HWB would be useful. The role of the public sector was to be an anchor institution, rooted in place and thinking about how to work best with the community, also trying to engage private businesses across the city.

Another officer described the complicated and complex improvements being developed which needed at least six months of mapping to avoid duplication; there was a need to have clarity on the roles of the different organisations involved. The mapping would be done and then brought back to the HWB for review.

A Board member suggested that some areas would need more funding and queried the decision making process. The officer explained the work was insight led, there were also statutory requirements to be undertaken and pressure from regulators. A councillor was concerned that there would be complex cross sector grievance processes and suggested that "enabling resource needs support to shift from focusing on organisational priorities **to focusing on geographies and integration"** and should also include "**outcomes**".

The officer thanked the Board for their comments and explained that the report was to inform the HWB of the Integrated Care Strategy and enable them to contribute to its effective implementation to ensure alignment and joint effort on shared priorities.

The Board agreed to note the report

5b Update from the Integrated Care Board (ICB)

The Board received a report the Chief Executive Officer NHS Derby and Derbyshire ICB. The report provided the HWB with an update on current priorities of NHS Derby & Derbyshire ICB and broader policy matters affecting the NHS.

The officer highlighted the current priorities of the NHS:

The NHS had been working on the first version of **the NHS Joint Forward Plan** which had been published on 30th June 2023. The Joint Forward Plan (The Derby and Derbyshire NHS' Five Year Plan), was a statutory requirement of ICBs and describes a medium term plan for the delivery of Joined Up Care Derbyshire (JUCD) strategic aims and priorities alongside other strategic priorities for the NHS. The HWB contributed to its creation and will be asked to contribute again when the plan was refreshed, the alignment between it and other partnerships plans.

The NHS system in Derbyshire had submitted a **balanced Financial Plan for the 2023/24 year**. The Plan required the delivery of £136.1m of in-year efficiencies and these have been phased based on an increasing rate of deliver as the year goes on. It was expected that ongoing industrial action will impact on the position.

The NHS Workforce Plan sets out an expansion in training, changes to ways of working, and improvements to culture that will increase the NHS permanent workforce over 15 years. There will also be an expansion in the number of new roles, like physician and nursing associates.

The GP Access Recovery Plan published on 9 May 2023 sets out NHS England's commitments to providing solutions to early morning difficulties for patients getting GP appointments and making it easier for patients to access primary care.

NHS England has published new guidance on its **Annual Assessment of ICBs**.

The **ICB Board new appointments** were detailed.

The HWB congratulated the NHS on its 75th Birthday and also noted and welcomed the new ICB Board appointees. The HWB asked for an update on NHS@75 which aimed to help

shape the future NHS. The officer explained it was a survey circulated across the NHS and partners seeking views on past successes, what worked well now, and what should be the future focus. All colleagues needed to be clear on the view to work for prevention and how to change in line with care needs now. A Board Member asked what retention was like in the current NHS workforce, do we retain local nurses? The officer explained that retention was a challenging and varied according to specialism. The Board member was invited to join meetings of an ICB Committee looking at retention and development of staff.

The officer asked the HWB to note the report and changes in NHS locally.

The Board agreed to note the report.

06/23 Update on Move More Derby, the physical activity plan for Derby

The Board received a report and presentation from the Director of Public Health which gave an update to the HWB on the refresh of Move More Derby's Physical Activity & Sport Strategy which was due to end in 2023.

The officer reported that the refresh of Move More Derby would re-energise local local ambitions around physical activity, after the impact of the Pandemic, and would prioritise moving over traditional sport and exercise. It would provide an opportunity to work together across Derby to deliver joint goals and a compatible approach for physical activity.

In Derby during 2021/22, 29.3% of adults did less than 30 minutes of activity per week. Derby currently has significantly higher levels of inactivity than the national average of 25.8%. For children during 2021/22 the average was 48.8% who do not achieve the recommended 60 minutes per day.

The Move More Derby Plan was a designed to deliver against the HWB outcome indicators to "improve participation in physical activity" and to "Improve the number of children and adults who are a healthy weight; Improve mental health & emotional wellbeing; and Improve air quality".

The development of Move More Derby and its whole-systems approach led to the development and delivery of place-based approaches and locality working. The approach did not use individual intervention to tackle behaviour but used environmental and social factors together, such as giving people access to high quality green space where they could be active.

There are five priority areas in the plan:

- **Communities** – create and promote access to opportunities and programmes across multiple settings to help people of all ages and abilities to engage in regular physical activity.

- **Environments** – creating and maintaining accessible, safe, and inclusive places and environments for physical activity.

- **Partnerships** – work collaboratively across organisation and community boundaries

with local sports and physical activity organisations, health providers, community organisations, promoting joined up activity to support local residents to access physical and mental health benefits of a healthy lifestyle.

- **People** – focus on enabling local and accessible opportunities for everyone to be active, particularly supporting older and disabled people and people with long term health conditions.

- **Sport and Leisure** – ensure residents have access to local high quality indoor and outdoor sport and leisure facilities

The Board welcomed the report and presentation. They asked if the project would involve private provision. The officer explained the aim was to connect capability, capacity, and assets to bring people together to benefit the health and wellbeing of people in local communties, creating HWB Hubs rather than just sports centres. A committee member gave positive feedback on experience of a similar scheme provided in a different city. The officer highlighted that the way of working was more integrated with information sharing between partnership organisations.

The Board suggested that the preferred option of governance arrangement was not articulated in the report and the authors were asked to amend the report accordingly. However, they did agree both recommendations.

The Board agreed:

1. **To proceed with the preferred option for the govenance arrangement for the Move More Derby delivery plan as the plan to deliver against the priority population outcome indicators of the Derby Health & Wellbeing Board and Joined Up Care Derbyshire.**

2. **To approve the proposed priority themes for the Move More Derby delivery plan of Communities Environment Partnerships People and Sport & Leisure.**

07/23 Better Care Fund Update

The Board received a report from the Strategic Director of People Services which provided the HWB with the proposed plan for the Derby Integration and Better Care Fund (BCF) for 2023-25.

The officer reported that this was a well established fund in the city. It was one of the government's national vehicles to drive health and social care integration. There were 2 core objectives, which were to enable people to stay well, safe and independent at home for longer, and to provide people with the right care and the right place and right time. The NHS and local authorities work together to achieve these objectives. The BCF requires Integrated Care Boards and local government to agree the Better Care Plan and create a pooled budget to support integration between health and social care.

There are a number of national conditions that must be satisfied for the BCF plans to be assured by DHSC. The assurance process was ongoing. The national conditions for the BCF in 2023 to 2025 are:

- There was a jointly agreed plan between health and social care commissioners, signed off by the HWB
- The plan implements BCF Objectives 1 and 2
- The plan demonstrates maintenance of the NHS's contribution to the BCF and investment in the NHS commissioned out of hospital services.

Appendix 1 to the report gives a summary of the "Planning Submission" which was submitted to the Department of Health and Social Care (DHSC) in June 2023, and Appendix 2 provides a copy of the "Narrative Plan" which was also submitted. In Appendix 1 the new Performance Metrics were detailed, they would be used to define the performance of the BCF and included Discharges, Hospital Admissions, Falls and Re-ablement.

Board Members made the following comments and questions. They asked about communications and information and if there were communication gaps. The officer confirmed that getting information and understanding out to people about where to access services, was challenging. They have a statutory duty to provide information and advice which was discharged through a variety of means, including information websites, GP Surgeries and Libraries and Local Area Co-ordinators (LAC). A Board Member explained that older people might need more help as they cannot use technology. An officer explained that the BCF was a major pooled budget between NHS and Local Authorities; this would be the vehicle used to deliver the Integrated Care Strategy. It involved communication as well as providing services. There was a complicated care landscape, perhaps the BCF for next year should place more emphasis on communications. Another Board member suggested providing a crib sheet of vital services and how to reach them for the Voluntary and Faith Services. The pressures on the housing area were highlighted. It was explained that there was not sufficient funding to cover all issues but the housing area could be considered in the review. The officer explained that BCF funding was heavily prescribed about what services are allowable, but there was a definite commitment to a review with the caveat that government prescribed services must be undertaken. A Board member felt the BCF was a good vehicle, the report aligns well to age well/die well. The BCF approach was endorsed. The officer accepted all the views and recommendations suggested and would welcome further discussion.

The Board resolved to approve the proposed spend and performance objectives for the Better Care Fund for 2023-25 in line with the national expectations for the programme set by the Department of Health and Social Care (DHSC).

Items for Information

08/23 Recent Healthwatch Publications

The Board received two reports from the Chair of Healthwatch Derby. The reports purpose was to provide the HWB with an overview of the Healthwatch Derby Patient Advice and Liaison Service (PALS) experiences 2023 mini report and Healthwatch Medicine Order Line experience 2022

8a Patient Advice and Liaison Service (PALS)

The officer reported that the report was a snapshop of experiences based on a relatively small sample of people (20).

56% called to raise a complaint about a service provider
28% called for advice about a bad experience
50% used the telephone to contact PALs
33% used email to contact PALs
44% said that experienced difficulty contacting PALs
44% said they found it easy to contact PALs

The report was shared with PALs and the wider Health and Social Care system to raise awareness.

The situation regarding telephone contact had been resolved and no further issues had been reported. Staffing levels have been increased to support contacts.

Due to the size of the sample it was difficult to form conclusions, but a further survey was recommended.

Healthwatch Derby were thanked for the report

The Board noted the report.

8b Medicine Order Line Experiences 2022

The officer reported that the Medicine Order Line (MOL) was a way for patients to order repeat prescriptions over the phone. The aim of the project was to work with the MOL Team to find specific information to assist them to improve the way the service was run.

Overall the results were positive, the majority of people who used the service said they would recommend it to others. The staff were helpful and friendly and the speed of service was good.

Areas highlighted for improvement were:

- The length of time to get through to the service on the phone
- Increased staffing levels
- General communications
- Accessibility for the hard of hearing.

The survey was open between December and January 2022-23 and 87 responses were received. The report was being discussed and used for learning purposes with MOL; a follow up was planned for later this year.

The HWB thanked Healthwatch Derby for the report. MOL was an important service built over many years and was a success story in reducing waste of medicines. The report was commensurate with the ICB view of the service.

Healthwatch Derby should bring a follow up report to the HWB for a formal response.

The Board considered and noted the contents of the report.

09/23 Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28

The Board received a report of the Executive Director of Strategy and Planning which provided a summary overview of the Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28.

The officer explained that the summary overview and content of the Plan built upon a previous briefing shared with the Derby Health and Wellbeing Board. The HWB will be asked to contribute again when the Plan was refreshed in the Autumn. The alignment between this plan and other partnerships plans was noted.

The HWB received the initial Derby and Derbyshire NHS Five year Plan and would respond to the draft version of the updated plan in Autumn 2023 to the ICB and its partner trusts.

The Board noted the report and would respond to the draft version of the updated Derby and Derbyshire NHS' Five Year Plan in Autumn 2023

10/23 Update of the Derbyshire Health Protection Board

The Board received a report of the Director of Public Health which provided an update and overview of the key discussions and messages from the Derbyshire Health Protection Board.

The officer reported that the Derbyshire Health Protection Board met on the 23rd June 2023. The key points of note for information were highlighted for the HWB.

- An update to the Derby and Derbyshire Air Quality strategy was reviewed
- Work has begun to develop the Health and Protection Strategy
- An update was provided on the pathway for people with tuberculosis
- The planned delegation of Immunisation Services was discussed
- It was noted that a new provider for school aged immunisations would be in place from the Autumn Term
- A system-wide Infection Prevention and Control Implementation Group was being established.
- The Flu vaccination uptake for pre-school children was lower nationally and locally thant 2018/19. The Vaccination and Immunisation Delivery Board will focus on improving this alongside the MMR uptake.
- The spring COVID booster programme achieved around a 70% uptake so far.
- Work was underway to improve the MMR vaccine uptake across the City

The Board resolved to note the report.

Private Items

None were submitted.

MINUTES END

PUBLIC

MINUTES of a meeting of **HEALTH AND WELLBEING BOARD** held on Thursday, 13 July 2023 at Council Chamber, County Hall, Matlock, DE4 3AG.

PRESENT

Councillor C Hart (in the Chair)

Councillors M Burfoot, N Hoy, J Patten, K Rouse, E Sherman, A Archer and A McKeown.

C Cammiss, Dr C Clayton, E Houlston, and H Henderson.

Also in attendance were, T Braund, S Bostock, Ja Davies, Jo Davies, H Denness, T Dunn, H Gleeson, E Langton, S Lee, I Little, K Monk, S Lee, A White, and R Wright.

Apologies for absence were submitted for Councillor Dooley, J Corner, S Scott, G Smith, H McDougall, and B Webster.

24/23 MINUTES

RESOLVED that the minutes of the meeting of the Board held on 29 March 2023 be confirmed after the following amendments;

J Corner (in the Chair)

Minute 14/23 – The Health and Wellbeing Board had been asked to note the contents of the Draft Derby and Derbyshire Integrated Care Strategy and propose any changes to the content of the Draft Strategy to the Integrated Care Partnership. In addition, the Health and Wellbeing Board are asked to comment on how the Board and its partners roles in mobilising the strategy and the work plans for the Start Well, Stay Well and Age/Die Well key areas of focus and consider and discuss the implications of the Integrated Care Strategy on the development of the Joint Local Health and Wellbeing Strategy.

Minute 21/23 – Resolved to Note the update report from the Health Protection Board.

25/23 PUBLIC QUESTION

Question received from Mr Ingham:

I note within Appendix 2 (Measuring Success) of the Health and Wellbeing Round Up Report that Derbyshire is ranked the worst for unemployment albeit there is no CIPFA range or percentage rate stated for Derbyshire. It also appears that in the previous two reports, Derbyshire was reported in

exactly the same way despite the absence of comparator ranges. I'm not therefore sure why Derbyshire has received this rating.

However, unemployment/employment levels, whatever they are in Derbyshire, can be influenced by carer responsibilities, I'm concerned when cross referencing to learn of the significant changes to the reported position concerning adult carers with enough social contact in 2021/22 - post pandemic. Derbyshire now ranks most worst. What has led to this worrying change (dropping from rank order 8 in 2018/19 to worst) and what steps are being undertaken to support adult carers accordingly and address any related mental health/wellbeing concerns?

Response provided by Councillor Hart:

Firstly, the data regarding unemployment in Derbyshire and the CIPFA neighbours has been removed from the OHID website for this indicator, therefore there is no data showing on the report. When no data is available, the CIPFA ranking defaults to 1 (worst). This indicator will be removed from the dataset for the next report.

Secondly, the 2020/21 Survey of Adult Carers in England (SACE) was not conducted in the post pandemic period, but took place in autumn 2021, when Coronavirus measures including face masks, mandatory NHS Covid passes (for specific settings) and an accelerated vaccination programme were in place.

Carers are more likely than the general population, to report loneliness and evidence suggests social contact reduces as the number of hours spent caring increases. There has been a local increase between 2011 and 2021 in the number of carers providing over 50 hours of care per week, with 47.4% of those responding to the 2021 SACE citing they provide 100 hours a week or more of care and it is this group who are more likely to feel socially isolated and unable to leave the house as a result. There are a range of steps being undertaken to support adult carer which include:

- Derbyshire Health and Social Care invests £2.1m per year, in supporting unpaid family carers, through commissioned carer support, carer personal budgets, emergency planning and support for the person depending on care, to enable carer breaks
- The commissioned carer's service creates a wide range of social opportunities for carers to connect with others e.g., befriending, physical activities, themed sessions, training and learning and help for carers to become digitally connected, etc.
- Adult Social Care provides support and opportunities, to facilitate carer breaks, so that carers have the support they need to keep up connections
- Many carers do not understand the services available to them, what they are entitled to and how to access support. The Council has a comms

strategy for carers, which sets out to increase the number of those identifying as a carer, raise the profile of carer support, increase general awareness of caring in our communities and help make life less lonely for carers

- Healthy Workplaces are providing dedicated information and training resources to supporting small businesses to effectively support carers in the workforce
- There are many universal health and wellbeing services available, that carers can access, e.g., TimeSwap, together with mental health and emotional wellbeing provision
- The Carers Strategy 2020- 2025 sets out the system wide, strategic priorities that require collective responsibility in delivering effective carer support

26/23 JOINT STRATEGIC NEEDS ASSESSMENT

The Health and Wellbeing Board were provided with a report and presentation, providing an update on the key health and wellbeing insights identified from the interim JSNA.

RESOLVED to

1) Note the updates to the JSNA, the State of Derbyshire report and development of interim tools; and

2) Provide data, intelligence, and insight into the JSNA via nomination of a strategic lead for each HWB partner.

27/23 UPDATE ON THE JOINT LOCAL HEALTH AND WELLBEING STRATEGY

The Health and Wellbeing Board were provided with a report verbal update, providing an update on the proposed approach to the development of a new Joint Local Health and Wellbeing Strategy, and asked the Board to agree to engage and collate feedback from districts and boroughs on community need.

RESOLVED to

1) Note the update on the proposed approach to the development of a new Joint Local Health and Wellbeing Strategy;

2) Agree to engage in the process of supporting the development of the strategy, along with representatives from the local health and wellbeing partnerships; and

3) Collate feedback from districts and boroughs on community need to feed into the strategy.

28/23 HEALTH AND HOUSING

The Health and Wellbeing Board were provided with a report and presentation, asking the Board to approve publication of the Derbyshire Housing and Health Impact Assessment, agree to endorse and actively share the key findings and recommendations, and consider any specific issues highlighted in the report.

Officers were to take away comments made by Board members on enforcement on landlords and access to information for tenants to the housing systems group. As well as taking away questions on how feedback was given to the planning of new build properties.

RESOLVED to

1) Approve publication of the Derbyshire Housing and Health Impact Assessment (2023);

2) Agree to endorse and actively share the key findings and recommendations contained within the publication through local health and wellbeing partnerships; and

3) Consider any specific issues highlighted in the report that the Health and Wellbeing Board can champion in the new Joint Local Health and Wellbeing Strategy.

29/23 WHOLE SYSTEM APPROACH TO TACKLE CHILDHOOD OBESITY ACROSS DERBY AND DERBYSHIRE

The Health and Wellbeing Board were provided with a report and presentation, asking the Board to acknowledge the significant progress made so far as part of the Derby and Derbyshire Childhood Obesity Plan - Time for Action 2020-2030, provide ongoing board level scrutiny and help leverage engagement and support.

RESOLVED to

1) Acknowledge the significant progress made so far as part of the Derby and Derbyshire Childhood Obesity Plan -Time for Action 2020-2030;

2) Provide ongoing board level scrutiny of future progress of the Derby and Derbyshire Childhood Obesity Plan – Time for Action 2020-2030; and

3) Help leverage engagement and support from the Board and wider system partners in the development of our whole systems approach to childhood obesity.

30/23 BETTER CARE FUND OUTTURN REPORT AND BETTER CARE FUND PLANNING SUBMISSION

The Health and Wellbeing Board were provided with a report, asking the Board to sign off the update on the outturn position of the Discharge Grant and Better Care Fund, agree to review the governance and terms and approve a change to the governance and delegation.

RESOLVED to

1) Receive and sign off the report and note the responses provided in the Statutory Return;

2) Continue to receive reports of the Integration and Better Care Fund in 2023-24;

3) Agree to review the governance and terms in the S75 for 24/25; and

4) Agree to change the delegation of members in order to sign off interim reports where required.

31/23 HEALTH PROTECTION BOARD UPDATE

The Health and Wellbeing Board were provided with a report, providing an update of the key messages arising from the Derbyshire Health Protection Board from its meeting on 21 April 2023.

RESOLVED to

1) Note the update report from the Health Protection Board.

32/23 HEALTH AND WELLBEING ROUND UP

The Health and Wellbeing Board were provided with a report, providing the Board with a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda.

RESOLVED to

a) Note the information contained in the round-up report.

33/23 RATIFICATION OF DECISION TO SUPPORT THE JOINED UP CARE DERBYSHIRE JOINT FORWARD PLAN

The Health and Wellbeing Board were provided with an update on the ratification of the decision to support the Derby and Derbyshire NHS Joint Forward Plan.

The Derby and Derbyshire NHS Joint Forward Plan had been signed off in June and circulated for comment, no comments had been received. Councillor Hart had written a letter of support, and this had been sent to Zara Jones at the NHS Derby and Derbyshire Integrated Care Board. Councillor Hart had received a response in respect to the comments made in the letter. Following this, the Derby and Derbyshire NHS Joint Forward Plan had now been published.

34/23 CARE EXPERIENCED YOUNG PEOPLE UPDATE

The Health and Wellbeing Board were provided with a presentation in relation to care experienced young people. The purpose of the presentation was to inform the board about the importance of free prescriptions for non-eligible Care Experienced Young People following concern from Derbyshire's Corporate Parenting Board.

The Board provided advice for officers regarding next steps and would consider including this cohort into the Health and Wellbeing Strategy refresh and bring it back to the Board.

35/23 ANY OTHER BUSINESS

There was no other business.

NHS
Derby and Derbyshire
Integrated Care Board

MINUTES OF THE AUDIT AND GOVERNANCE COMMITTEE

HELD ON 8 JUNE 2023 VIA MS TEAMS AT 2.00PM

Present:		
Sue Sunderland	SS	Non-Executive Director/Audit Chair
Richard Wright	RW	Non-Executive Director
In Attendance:		
Jim Austin	JA	Chief Information & Transformation Officer, DCHS Chief Digital Information Officer, (JUCD)
Andrew Cardoza	AC	Audit Director, KPMG
Dr Chris Clayton	CC	Chief Executive Officer (ICB)
Ged Connolly-Thompson	GCT	Head of Digital Development & Digital Health Skills Development Network Lead
Liam Daley	LD	Finance Manager
Helen Dillistone	HD	Executive Director of Corporate Affairs (part)
Debbie Donaldson	DD	EA to Chief Finance Officer (note taker)
Darran Green	DG	Acting Operational Director of Finance
Keith Griffiths	KG	Chief Finance Officer
Donna Johnson	DJ	Acting Assistant Chief Finance Officer
James Lunn	JL	Head of Human Resources and Organisational Development
Martin Ndoro	MN	Audit Manager, KPMG
Glynis Onley	GO	Assistant Director, 360 Assurance
Fran Palmer	FP	Corporate Governance Manager
Suzanne Pickering	SP	Head of Governance
Arpit Sarraf	AS	KPMG
Raghav Sikka	RS	KPMG
Craig Stephens	CS	Senior Procurement Manager (part)
Chrissy Tucker	CT	Director of Corporate Delivery
Kevin Watkins	KW	Business Associate, 360 Assurance
Rosalie Whitehead	RH	Risk Management & Legal Assurance Manager
Apologies:		

Item No.	Item	Action
AG/2324/190	**Welcome, introductions and apologies** Sue Sunderland as Chair welcomed all members to the meeting. No apologies were received.	
AG/2324/191	**Confirmation of Quoracy** The Chair declared the meeting quorate.	
AG/2324/192	**Declarations of Interest** The Chair reminded Committee members of their obligation to declare any interest they may have on any issues arising at	

	committee meetings which might conflict with the business of the Integrated Care Board (ICB). Declarations declared by members of the Audit and Governance Committee are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: www.derbyandderbyshire.icb.nhs.uk The following declaration was made: Richard Wright declared that he was now Deputy Chair of the ICB and would become Interim Chair Designate of the ICB from 1 July 2023. It was noted that this would be his last Audit Committee.	
	AUDIT	
AG/2324/193	**External Audit** Andrew Cardoza apologised for providing KPMGs reports to Committee after the required cut off for papers. He thanked both Donna Johnson and Liam Daly from the Finance Team for their help with the Audit. Andrew Cardoza reported two sets of accounts had been required this year, namely 3 months for the CCG and 9 months for the ICB; all of which was done to the same timescales. He reported that there was still work to do, and that it had been a robust and challenging audit. He thanked the KPMG Team, for all their hard work during this audit. **CCG ISA260 Report:** Andrew Cardoza highlighted the following: • This Audit report covered a 3-month period ending 30 June 2022. • The intention was that Andrew Cardoza would sign an unqualified opinion on the financial statements. • KPMG had not done a VfM review of the CCG and its arrangements, as this was done as part of the transfer to the ICB; it was noted that no significant weaknesses were found. • The Audit was not yet complete, and matters communicated in this report may change pending signature of the Audit report. • KPMG highlighted that the following work was still outstanding: – Audit of the remuneration report – Support for few accruals (Non-NHS and Other WGA payables and other payables and accruals) samples – Final review of updated financial statements, including the front-end annual report – Final review of financial performance target (Revenue Resource Allocation) – Review of remaining audit procedures	

	– Receipt of signed management representation letter – Final review of updated ACT pack and consistency statements. • KPMG had until 30 June to complete the work. • Management override of controls – there were no instances of management override of controls identified. • KPMG intended to issue an unqualified Audit Assurance Certificate to the NAO regarding the Whole of Government Accounts submission, made through the submission of the summarisation schedules to the Department of Health and Social Care. • It was noted that at end of May, just before the final close of the accounts, the Derbyshire System was offered the use of £15m of additional resource allocation. Because of this the ICB went over the resource allocation limit, which meant that it was in breach. • KPMG were required to issue an opinion as to whether the expenditure incurred by the CCG was within its delegated authorities. KPMG as a result had to identify a regularity exception. • There were no unadjusted audit differences in the financial statements. • There were no controlled deficiencies to report, and one had been remediated from the previous year. • Regarding the section on 'Going Concern', KPMG confirmed that sufficient disclosure had been provided to explain that the CCG had been wound down and why the accounts had continued to be prepared on a going concern basis. • KPMG had reviewed the basis of the CCG's going concern assessment to confirm that it was appropriate for the accounts to be prepared as a going concern as the functions of the CCG were transferred to the ICB, another public sector entity based in the same geography. • KPMG confirmed that sufficient disclosure had been included within the subsequent events note to set out the details of the passage of the Health and Care Bill and the impact it had on confirming that the CCG wound up on 30 June 2022. • KPMG had included an additional paragraph within the going concern section of the audit opinion to confirm the CCG had been dissolved and its services transferred to the NHS Derby and Derbyshire ICB. This did not represent a qualification to their opinion. • Regularity: The CCG had a statutory duty under Section 223GC of the National Health Service Act 2006 to ensure that its expenditure incurred in a financial year did not exceed the amount specified by direction of NHS England. KPMG noted that the CCG's total expenditure for the three months ended 30 June 2022 exceeded its revenue resource allocation by £12k, therefore the CCG breached its statutory target. • As the CCG spent £12k in excess of the amount directed by NHS England for the three months to 30 June 2022 KPMG had	

	a duty to make a referral under section 30(1)(b) of the 2014 Act to the Secretary of Health. • The work on regularity had not identified any other reportable issues. • The Remuneration Report work was still ongoing. • Annual Audit Report – no inconsistences had been found. • The AGS was consistent with what KPMG knew of the CCG at the time. • The Audit Committee and the governance of the Committee was good. • Government Accounts: no issues had been identified. • The Audit fee was £145,200. • KPMG had also completed non-audit work at the CCG during the year on MHIS FY 21/22 and had included in Appendix 4 confirmation of safeguards that had been put in place to preserve their independence. This work amounted to £15k • P15 was highlighted and it was noted that there were no recommendations. There had been one recommendation from the previous year regarding journal control. KPMG were satisfied that management were dealing with this. • P17 there were no identified unadjusted and no identified adjusted and just minor presentational adjustments. • The agreement of balances exercise – It was noted that there were always differences, but these were not huge in terms of how much was transferred between bodies within Derbyshire. • KPMG confirmed that, in their professional judgement, KPMG LLP was independent within the meaning of regulatory and professional requirements and the objectivity of the partner and audit staff was not impaired. • Keith Griffiths acknowledged the hard and late-night working undertaken by KPMG Audit Team. • Keith Griffiths referred to the late adjustment referenced by KPMG. This issue had been raised on a number of occasions with the ICB Board and the System Finance and Estates Committee. Regarding the Section 30, he had spoken with the regional team and made them aware that this was to be raised and was not a management failing. The additional resource allocation was offered to the ICB as part of a planned and measured decision taken in conjunction with the national and regional teams. **ICB ISA260 Report** Andrew Cardoza highlighted the following: • This Audit report covered a 9-month Audit of the ICB. • Andrew Cardoza would be imminently sign this report off, once the final pieces were in place. It was noted that it would likely be an unqualified opinion with no significant weaknesses to report. • It was noted that this was a fantastic achievement on two sets of accounts in one year.	

- The audit was not yet complete, and matters communicated in this report may change pending signature of this audit report. The following work was still outstanding:

Financial Statements Audit:

- Support for few accruals (Non-NHS and Other WGA payables and other payables and accruals) samples
- Audit of the remuneration report
- Agreement of balances mismatch samples
- Support for NHS Block contract expenditure items
- Final review of updated financial statements, including the front-end annual report
- Final review of financial performance target (Revenue Resource Allocation) notes
- Review of remaining audit procedures and reviews
- Receipt of signed management representation letter.

Whole of Government Accounts:

- Final review of updated ACT pack and consistency statements.

Significant Audit risks for the ICB:

- Expenditure recognition: work was ongoing, but results from testing to date were satisfactory
- Management override of controls: work was ongoing, but results from testing to date were satisfactory with no issues to raise.
- VfM: there were no significant weaknesses identified.
- Whole of Government Accounts: KPMG intended to issue an Unqualified Group Audit Assurance Certificate. There were no issues to report.
- Regularity: As with the CCG, KPMG had identified breach of ICB's Revenue Resource Allocation performance target of £14.8m (small in comparison to the overall ICB resource allocation) and a referral would be issued. KPMG were required under Section 30 (s30) of the Local Audit and Accountability Act to make a referral to the Secretary of State for Health and Social Care if they identified that the ICB had or was about to enter into unlawful expenditure. A s30 referral was made relating to the ICB's breach of Revenue Resource Allocation. There had been no reports made in the public interest.
- Uncorrected Audit Misstatements: work to date had not identified unadjusted audit differences in the financial statements.
- Control Deficiencies: there were no control deficiencies, and just one prior year control deficiencies remediated.
- Management Override of Controls: KPMG had not identified any significant unusual transactions.
- Annual Report: KPMG had not identified any inconsistencies between the contents of the Accountability, Performance and Director's Reports and the financial statements.
- Remuneration Report was still outstanding.

	• AGS: The AGS was consistent with the financial statements and complied with relevant guidance, subject to updates. • ISA 260 required KPMG to make an annual declaration that they were in a position of sufficient independence and objectivity to act as the ICBs auditors, which was completed at planning, and it was noted that no further work or matters had arisen since then. • KPMGs audit fee for the audit was £145,200 plus VAT (£159,800 in 2021/22). KPMG had also completed non-audit work at the ICB during the year on CCG's MHIS FY 21/22 (£ 15,000) and had included in Appendix 4 confirmation of safeguards that had been put in place to preserve their independence. • Audit Differences: KPMG reported that their work to date had not identified unadjusted audit differences in the financial statements. • Annual Report: KPMG had raised minor presentational adjustments to the Annual Report and Financial Statements, for example, minor differences noted within the financial performance target note which had been shared with management during the audit. • Agreement of Balances Exercise: P19 detailed the inconsistencies that KPMG were reporting to the NAO, which were minor in comparison to £2bn worth of spend income and expenditure that the ICB had. It was noted that the ICB were pursuing this through the normal management of the ICB and other organisations it worked with. • KPMG reported that they would continue to work with Donna Johnson, Liam Daly, Darran Green and Keith Griffiths to complete the work outstanding. • Andrew Cardoza suggested that a meeting be convened between KPMG, the Audit Chair and Keith Griffiths when the audit work was complete. It was noted that if there was something significant to report there may be a need to reconvene Audit Committee. • The Chair thanked KPMG, Donna Johnson, and the Finance Team for all their hard work during this audit. She agreed with Andrew Cardoza's suggestion regarding convening a meeting when the work was complete and if there were no significant issues to raise from the work remaining, a virtual approval could be arranged before 30 June 2023. • The Chair reported that regarding the s30, the ICB had found itself in a difficult position, but the option to have the additional resource allocation for the population of Derbyshire was the lesser of two evils. • The Chair referred to the agreement in balances, she agreed that they were not looking significant, but what stood out for her was quite a lot of them were with our partner Trusts. She was hoping it was timing issue, but where it stated that we had not received a response from a partner Trust she felt this was a concern. It was noted that we had good communication and relationships with our partner Trusts regarding financial	

	planning and hoped that this was something we could build upon. • Donna Johnson reported that we were in constant contact with partner Trusts, and we did have another chance for all NHS organisations to resubmit agreement of balances, and whilst we had highlighted the differences, conversations had not concluded, and she was hopeful that by the final stage that balances would be rectified. The ICB was confident that we had reported as we should have, and we would try to agree those differences. • The Chair referred to page 8 of the ICB report, first paragraph of KPMGs findings, she thought that they had the resource limit and the ICBs expenditure the wrong way round, it was a minor point, but she asked that this be amended. • The Chair confirmed that Audit Committee were happy to receive both these reports and looked forward to the finalisation of the Audit and the sign off of the accounts. • Keith Griffiths wanted to publicly acknowledge the work of Donna Johnson and Liam Daly, which had been outstanding. **Audit and Governance Committee RECEIVED the ISA260 for the DDCCG and the ISA260 for DDICB.**	
AG/2324/194	**Internal Audit:** **Draft 2023-26 Internal Audit Strategic Plan** Kevin Watkins reported that the Draft 2023-26 Internal Audit Strategic Plan had been presented to this Committee in March and small amendments had been made, namely a reduction in the overall days, in acknowledgement of the announcement regarding the cut in running costs for the ICB. The reduction was 225 days down from 250 days; this had mostly affected the policy management framework piece of work, which would be deferred to a future year. It was noted that there were one or two other minor changes in the Plan, but other than that, it was the same as presented to Committee at its March meeting. **Progress Report** Glynis Onley presented the progress report and highlighted the following key messages: • Issued the final report resulting from the General Ledger and Financial Reporting review – substantial assurance • Issued the final report resulting from our PPV work following a meeting with the ICB's Assistant Director GP Commissioning and Development – advisory review • Issued first of 23/24 pieces of Internal Audit work on the Data Security Standards – substantial assurance • In terms of follow up rate, that was 67% at the end of the year and this would be referred to in the HOIAO – significant assurance	

	• Developed and agreed the Terms of Reference for the Committee Effectiveness Review and the fieldwork was ongoing • Developed and agreed the Terms of Reference for the Data Security and Protection Toolkit review from the 2023/24 Internal Audit Plan and the fieldwork is ongoing and • Developed and agreed the Terms of Reference for the Safeguarding review from the 2023/24 Internal Audit Plan. • The Plan for 22/23 was now 96% complete, with just one item of work ongoing, namely, Committee Effectiveness, which Kevin Watkins was concluding. It was noted that the fieldwork was substantially complete, and a draft report would hopefully be produced by the end of this month. • The Chair referred to the cross-system work which was scheduled to be done in quarters one/two, she was keen to know whether the TOR had been drawn up and when the work would commence. • Glynis Onley reported that planning discussions were currently taking place. 360 Assurance did not tend to put a time frame on those System-wide pieces of work as they recognised this work could be more involved as it was more difficult to get agreement across partners to finalise those reports but confirmed that the TOR had not been issued in draft yet. • The Chair reported that she had spoken to other Audit Chairs in the System and there was a degree of enthusiasm for getting this piece done. In terms of doing cross cutting audits going forwards, this was the first year of the new arrangements, and if we did not deliver on this, it could influence how receptive partners would be to work going forward. The Chair reported that this was a key area that was important to all of us looking at discharge arrangements, she encouraged 360 Assurance to keep moving that piece of work along. The Chair reported that she had spoken to Kevin Watkins about inviting Elaine Dower to the next Audit Chairs meeting so she could talk to them about it. • Kevin Watkins reported that this was a very active issue currently. 360 Assurance were aware of the work that was taking place in Derbyshire regarding discharges. He hoped to get this piece signed off so that 360 Assurance could start work as soon as possible. It was noted that some other external work had been commissioned on this which was hoped to be concluded and reported on by October. Kevin Watkins reported that he would try and bring their work alongside that if possible. **DDCCG Final Head of Internal Audit Opinion** Kevin Watkins reported that DDCCG Final Head of Internal Audit Opinion was Significant Assurance. **DDICB Final Head of Internal Audit Opinion** Kevin Watkins presented the DDICB Final Head of Internal Audit Opinion; the Committee had seen several drafts of this document	

	at previous meetings and reported that he would need to make another minor adjustment to this, but not to the opinion level. This was due to the late adjustment made at NHSE's request to the financial position of the ICB discussed earlier in the meeting. This would ensure that the HOIAO harmonised with what had been reported in the Annual Report and what KPMG had reflected in their work. It was noted that the HOIAO was Significant Assurance. Kevin Watkins highlighted the following high-risk issue: • Transformation Efficiency Report: The review identified significant weaknesses in respect of the governance, delegated authority and assurance framework pertaining to the delivery of transformation; the resourcing of the Project Management Office function supporting the process of identifying and implementing transformation projects across the system and particularly in the ICB; and the prioritisation of resources to where they were most needed and where the maximum Transformation and Efficiency Plans (TEPs) benefits would be realised. There were a number of recommendations from this report. • A detailed follow-up of recommendations in the Transformation and Efficiency Planning report would be undertaken in June 2023. • Implementation of Internal Audit actions: It was noted that as part of an established process, 360 Assurance regularly liaises with nominated officers within the organisation in relation to actions due using the online tracker. 360 Assurance provided a summary of follow up work as part of their progress reports to the Audit and Governance Committee. Since 1 April 2022, they had tracked 6 recommendations that fell due for completion. The current position demonstrated a first follow up implementation rate of 67% and an overall implementation rate of 67%. • 360 Assurance provided an opinion of Significant Assurance for the follow up of actions, however, it was noted that they had not received evidence for two medium risk actions in relation to the HFMA Financial Sustainability review which was nationally mandated. • 360 Assurance reported that they would track these actions to completion in 2023/24. • It was noted that at the time of writing this report, there were no actions outstanding from assignments reported during previous financial years. • 360 Assurance were able to conclude that the ICB was effective in respect of the implementation of agreed actions within agreed timescales and that the Audit and Governance Committee was robust in its monitoring of these. • Helen Dillistone thanked Kevin Watkins and other members of his team for their hard work in producing the two HOIAOs. It had been a complex process to wind down the CCG and create the ICB.	

	• Helen Dillistone welcomed the extra recommendations, which she felt would help with the ICBs overall development. • Helen Dillistone reported that she and Keith Griffiths had been working closely on the Transformation and Efficiency Review with Tamsin Hooton. They were all keen to invite 360 Assurance back to do a follow up on that review. It was hoped they would see some significant movements in those recommendations when they did the follow up review. • Kevin Watkins reported that the ICB had a good stable corporate governance team, who had done a huge amount of work especially on the BAF, which was developing well. **The Audit and Governance Committee:** • **APPROVED the draft 2023-26 Internal Audit Strategic Plan** • **NOTED the Internal Audit Progress Report** • **NOTED the CCG Head of Internal Audit Opinion – 1st April to 30th June 2022** • **NOTED the ICB Head of Internal Audit Opinion and Annual Report – 1st July 2022 to 31st March 2023.**	
FOR DECISION		
AG/2223/195	**CCG Annual Report and Annual Accounts – 1 April 2022 to 30 June 2022** **ICB Annual Report and Annual Accounts – 1 July 2022 to 31 March 2023** Donna Johnson reported that the Derby and Derbyshire ICB and CCG draft Accounts for 2022-23 had been presented to the Audit Committee on 4 May 2023. Since then, the accounts had gone under audit. Following comments at the previous Audit Committee, local management reviews and external audit, adjustments had been made to the accounts. Adjustments were either changes to figures; reclassifications; changes to or additional narrative disclosures; new disclosures and rounding adjustments. It was noted that as the Audit continued, further minor amendments may be required. • P327, Table 1: ICB Audited Adjustments to 2022-23 Annual Accounts. This table identified the adjustments to the Annual Accounts made since the previous Audit Committee and which had been audited. • P328, Table 2: CCG Audited Adjustments to 2022-23 Annual Accounts. This table identified the adjustments to the Annual Accounts made since the previous Audit Committee and which had been audited. • P330 Table 3: Audited Adjustments to 2022-23 Annual Report. This table identified adjustments, since the previous Audit	

	Committee, made to financial values identified in the Annual Report and subject to Audit. • The above adjustments had been included in the CCG and ICB Accounts for the 2022/23 periods. Should the audit identify any further changes before their submission, anything of significance would be shared with the Audit & Governance Committee virtually before submission on 30 June 2023. • Going Concern Disclosure, as advised by NHSE we had to reference the s30 letter and state we continued to be a going concern. It was noted that a s30 letter had been received for both the CCG and ICB and would be referenced on both sets of accounts. We had been instructed on the form of words that should be used for this. • The Chair referred to the s30 and asked whether an explanation of why this had happened would be referenced. • Donna Johnson reported that it would not, the form of words to be used stated 'on 6th June 2023 the auditors issued a referral to the Secretary of State and NHSE under Section 30 of the Local Audit and Accountability Act 2014 in respect of the ICB's breach of its revenue resource limit.' • The Chair asked whether we could put a disclosure into the Accounts which would explain that we received additional resources from region. • Andrew Cardoza reported that the place for this explanation would be in the Annual Report with a reference back to that sentence in the Annual Accounts. The Accounts should not stray into conversations that taken place, which were not formal. • Keith Griffiths reported that he had sent a short paragraph to Andrew Cardoza describing the situation to see whether it was appropriate to use. Hopefully this would describe the context that it had not been a management failure, but a management decision. • Donna Johnson reported that the Audit was continuing, and we did not expect any further changes, if there were, Committee would be informed. **The Audit Committee APPROVED the changes to the Derby and Derbyshire Integrated Care Board and Derby and Derbyshire Clinical Commissioning Group 2022-23 Annual Accounts presented to Committee.**	
AG/2324/196	**CCG Annual Report - 1st April 2022 to 30th June 2022 and ICB Annual Report – 1 July 2022 to 31 March 2023** Suzanne Pickering reported that the Annual Reports had been received by Committee in May and no further material changes had been made to either the CCG or ICB Annual Reports. Suzanne Pickering reported, however, that minor changes had been made to the ICB Annual Report. This included the validated Q4 performance data, and changes to the narrative for the Head of Internal Audit Opinion and the Governance Statement and the Remuneration and the Financial Review Section.	

	The Chair reported that Committee was initially asked to approve both the CCG and ICB Annual Report and Accounts, this could not be done at this stage, but Committee could approve the changes presented so far. She was conscious that there may be other changes when the audit work had been concluded. It was agreed that if there no substantial changes the CCG and ICB Annual Reports and Accounts would be signed off virtually. If there were any major changes an Extraordinary Audit Committee would be called. **The Audit and Governance Committee APPROVED the changes presented so far to the Integrated Care Board and Clinical Commissioning Group 2022-23 Annual Reports and Accounts.**	
AG/2324/197	**Audit and Governance Committee Policies** **Procurement Policy:** Chrissy Tucker reported that the Procurement Policy was drafted for the ICB as a 'lift and shift' from the CCG and had been originally presented to the Audit & Governance Committee on the 23 March 2023. At the request of the Committee, the following amendments had been made and were shown in tracked changes within the policy: • Paragraph 2.1.2 – for the purpose of this policy, references to Monitor would remain and a note to this effect was included on page 6. • Paragraph 9.2.1 (Decommissioning Services) – reference to the 'support from GP Commissioners' had been removed. • Paragraphs 23.5 and 23.6 (section 2) – this section had been expanded in accordance with the NHS net zero ambitions. The Chair was content that the changes detailed above reflected the points that were raised at the meeting on 23 March 2023. **The Audit and Governance Committee APPROVED the Procurement Policy.** **<u>Human Resources Policies</u>** **Learning and Development Policy:** James Lunn reported that the Learning and Development Policy was largely a 'lift and shift' from the CCG to the ICB but had been updated to address identified issues and provide greater clarity: • There was an anomaly in the current L&D Policy as it provides for an application for external L&D over £1000 and Executive Director approval where under £1000. We received an application for exactly £1000. Updated to state external L&D that is '£1000 or over'. • The requirement for colleagues to repay monies if leaving the ICB within 2 years of completing the external L&D £1000 or over	

	has been questioned a few times by colleagues, particularly with the move to more system working and the NHS Leadership Academy courses requiring individuals to commit to remaining in the NHS for a period of 2 years after completing the course. Policy updated to only require an individual to repay the monies if leaving the NHS within 2 years of completing the course. • The contradiction relating to reimbursement of costs:_Section 6.7.9 of the Learning & Development Policy stated, 'any financial approval does not include subsidiary expenses such as travel, accommodation or course materials associated with a course of study'. Later in the policy, under Appendix 4, where the training was determined to be a job requirement it stated that the employer would fund 100% of the direct and indirect costs (reasonable costs such as 'travel, accommodation, and similar reasonable costs required to enable the individual to attend the programme'). The Chair referred to the Appendix of Statutory Mandatory Training, she understood that module 1 of the COI had been removed as it had been dropped nationally, but she had noticed that modules 2 and 3 were still sitting there as applicable to Board members. She asked whether modules 2 and 3 were still applicable, and if they were, whether they were applicable to all Board members of just some of them? James Lunn reported that he would need to update this policy as modules 2 and 3 needed to be removed also. It was noted that the ICB were looking to develop something that meets our obligations in terms of making people aware of their responsibilities regarding COI. He agreed to remove those from the list of mandatory training. Chrissy Tucker reported that NHSE were in the process of updating the module currently and suggested before James Lunn made this amendment, she obtains that update so it could be incorporate into the policy. The Chair reported that she would be content for the amendments to be made to this policy without it having to come back to Committee for approval. **Audit and Governance Committee APPROVED the Learning and Development Policy.** **Dignity, Civility and Respect Policy:** James Lunn reported that this was a new Policy and replaced the existing Dignity at Work Policy and Grievance Policy. The policy detailed how the ICB would develop and promote a positive workplace culture where all employees and third-party individuals are treated with dignity, civility, and respect, free from harassment or other forms of bullying at work. It set out examples of the type of conduct that may constitute bullying or harassment and our commitment to eliminating such conduct. The aim and intent of this policy was to enable the ICB to ensure that any problems, complaints, or concerns raised by employees were dealt	JL CT

	with in a fair, timely and consistent manner. The Dignity, Civility and Respect at Work Policy gives direction and guidance on what to do when issues emerge in relation to disrespectful behaviour or bullying or, harassment or victimisation. The policy aligned with the approach adopted by our NHS system partners and aimed to improve and promote a culture of dignity, civility, and respect at work. The policy uses a preventative approach, with practical resources to raise awareness. **The Audit and Governance Committee APPROVED the Dignity, Civility and Respect Policy.** **Freedom to Speak Up Policy (FTSU):** The vision of FTSU was to promote and create an open and transparent culture where members of staff could speak up safely, at the time and to the person who was most likely to address the issues and offer support. This would lead to learning and improvements which would result in better working environments and positive experiences. A FTSU policy had been developed to align with the new national FTSU policy and replace the existing Raising Concerns at Work (Whistleblowing) Policy. The Policy introduced a staff FTSU Guardian and sets out the structure for FTSU within the ICB. The purpose of the FTSU Guardian was to advocate speaking up, lead the way, provide guidance to the board, prepare, and collate information for the board and national Guardian's office. They would raise awareness of speaking up, respond to requests of support, support the Ambassadors, and share learning. FTSU Ambassadors signpost, communicate, engage, and promote the FTSU culture. The FTSU Guardian would provide assurance that we were on track with implementing the resultant FTSU improvement plan. It was noted that if the ICB engaged a contractor to undertake work for the ICB, then they would be covered by our policy if they had concerns that they felt they needed to be raised; this included GP clinical leads and agency staff, but the largest proportion of people captured by this policy would be our ICB employed staff. James Lunn reported that if someone from one of our Provider organisations wanted to raise an issue with our FTSU Guardian, they would be referred back through their own FTSU Guardian/Ambassadors. The Chair referred to page 678 of the pack under 7.1 supporting policies, this needed updating to include the new Dignity, Civility, and Respect Policy and taking the Grievance and Dignity ones out. James Lunn agreed to update the policy. **The Audit and Governance Committee APPROVED the Freedom to Speak up Policy, subject to the above amendment.**	JL

	Disclosure and Barring Policy: James Lunn reported that the Disclosure and Barring Policy had been updated to ensure and highlight a clear inclusive approach for all categories of workers and applicants, with the addition of the Transgender application process, and the inclusion of the DBS process for Temporary Workers and Agency workers. In addition, the information relating to basic disclosures, had been removed as the ICB required only standard and enhanced DBS checks to be undertaken. **Audit and Governance Committee APPROVED the Disclosure and Barring Policy.**	
ITEMS FOR DISCUSSION		
AG/2324/198	**Risk Management Deep Dive - Data and Digital Development** The Chair explained that Committee would be receiving over the coming months, Deep Dives from responsible Executive Officers, on their BAF Strategic and Operational ICB Risks. The first of these Deep Dives was on Data and Digital Development. Jim Austin presented a Risk Management Deep Dive on Strategic Risk SR8, the following was highlighted: • There was a risk that the system does not: A. Establish intelligence and analytical solutions to support effective decision making and B. Deliver digital transformation. • Risk SR8 was currently scored as a 3 x 4. • This Risk was split into two parts A and B, one part related to data and our ability or not to service and effectively use the data that we should have access to as an ICB or as a broader system. • The second part related to the digital and technology side of things and whether we could use that effectively to transform the way that we delivered our services and at the same time realise the efficiency benefits and patient safety and quality improvements that we would expect to see as technology progresses. • During last year, we had grouped those two together as it was felt there was a very clear link to those two elements. • The Executive Team had divided our accountabilities to play to our strengths. Chris Weiner, Chief Medical Officer, was taking Executive responsibility for data, the realisation of data, the use of data and then feeding into population health management, and strategic. • It was noted that Jim Austin would continue to look after the digital technology transformation element. • Jim Austin reported that he would value a discussion around whether we should divide this into two separate BAF risks and whether they were both as serious as to need to be a BAF risk or fall to a lower level of severity. • Jim Austin reported that we were making progress on the mitigation around the threats that had been identified in the risk paper in both fields (data and in digital).	

	• Jim Austin felt that the critical area of concern, in his view, was around using our data as effectively as possible. We had a plethora of data which could help with our decision making. The technology side, inevitably, was often constrained through a budgeting process. It was noted that we were coming to the end of the process of agreeing budgets. • Jim Austin hoped that the above explanation gave a flavour of the risk of the two elements; his recommendation for discussion by Committee was around the diversification and splitting this Risk into two. • The Chair thanked Jim Austin for the above and explained that SR8 was put together because it was felt that it would be difficult to manage them separately because of the interlinks between them. She felt it was good to hear Jim Austin's views and what had been happening at Executive level, that they were better managed separately. It was the Chair's view that if we were managing them separately, then we ought to be treating them separately in terms of risk, as it sounded like those interlinks were not as inseparable as was at first thought. • Ged Connolly-Thompson agreed with the separation of this risk. He informed members that the risk around the population health management was something that we were working on with other ICBs. • Ged Connolly-Thompson felt that digital needed to be agnostic. He reported on a national programme where we were working with the National Data Guardian, NHSE and other ICBs to address that. From there would come technological enablers; he reported that initial work would be to look at the requirements to make sure we had a legal basis of continuing to do risk stratification with primary care data (specifically for direct care). • Richard Wright also agreed with splitting this risk. • Jim Austin reported that there was still a natural linkage between the two. He reported that there was a requirement to surface the data through a technical platform, that was a digital accountability responsibility. The use of that data and how we then applied that to strategic commissioning and population health interventions was a different skill set. • Richard Wright commented that one was about how we spend our money and the other was about how we could use technology to save some. • Jim Austin reported that if we did split them, as suggested, then maybe one of them would not necessarily score as high. • The Chair asked whether this would then be a risk? • Jim Austin reported that he needed to consider this rather than quickly commit himself at this point. He assumed that Chris Weiner would pick up the data side of things and he would pick up the technology and digital side. He would then assess what that meant and take it through the Finance and Estates Committee to get endorsement through there. • The Chair reported that it may be helpful that if the outcome was to split the risk into two, given the discussions at the Strategic Commissioning Committee this morning, the question might also be worth exploring as to whether the data risk sits better	

	with that Committee or whether the linkage between the two was still of sufficient value that it would make sense for them to be under the same Committee. • Dr Clayton reported that he would endorse this work; he felt this conversation was worthy of merit. He agreed that we had not got the reporting arrangements around this risk correct yet, and time was needed to set out proposals for the Board, particularly about where it wishes to see the energy around those different things being set out. • The Chair felt this conversation had been helpful, and asked Jim Austin through his horizon scanning, whether there was anything that we were not covering that was not perhaps covered by either of these two elements? • Jim Austin reported that from a technology side, the area he was concerned about was artificial intelligence. He reported that we were quite embedded with a big AI Programme of work in breast screening currently. However, there was still a long way to go around MHRA regulation around adoption of AI; it was noted that it could be a game changer for us regarding waiting list management and diagnosis assistance. • It was noted that Jim Austin was doing a digital deep dive at the ICB Public Board next week. He intended to refer to 10-12 significant programmes of work that he would like to deliver this year within Derbyshire. It was noted that we would need to select a few of these programmes, as we did not have the capacity, or finance to do all of them. This would be a challenge and a risk to ensure that we picked the ones that were going to give us the best long term and short-term benefits. • The Chair asked whether we felt we had the processes to prioritise those programmes and the right people involved? • Jim Austin felt we had. It was noted that we had good digital governance oversight through the Derbyshire Digital and Data Board that effectively pushes assurance information up to our Finance and Estates Committee and into the Provider Collaborative. It was noted we also had good clinical representation in that space through the Clinical Professional Leadership Group together with the primary care teams. **Audit and Governance Committee thanked Jim Austin for the Risk Management Deep Dive on Data and Digital Development.**	
AG/2324/199	**Standard Operating Framework and Hosting Agreement** Chrissy Tucker reported that she had hoped to bring the Standard Operating Framework and Hosting Agreement in relation to the delegation of pharmacy, optometry, and dental commissioning from NHSE to the ICB; unfortunately, we had not received it yet. It was noted that it was hoped that it would be received in the next few working days. Chrissy Tucker reported that the Framework would detail the hosting arrangements and the East Midlands ICBs would work together with Notts and Nottinghamshire ICB in the delivery of the POD services.	

	It was noted that the Governance and Finance teams would review the framework thoroughly before submitting it to Dr Clayton for approval and would be brought to the next meeting of this Committee for information. **Audit and Governance Committee thanked Chrissy Tucker for this verbal update and looked forward to receiving the Standard Operating Framework and hosting agreement at its next meeting.**	
CORPORATE ASSURANCE		
GOVERNANCE		

AG/2324/200	**Digital and Cyber Assurance Report**
	
	Ged Connolly-Thompson presented the Digital and Cyber Assurance Report and highlighted the following:
	
	• It was noted that the ICB were pleased with the IT service we received from NECs.
	• We had taken the decision when Glossop joined the ICB not to disrupt their digital service more than we had to; they currently obtained their digital service from T&GIFT. It was noted that we would continue in that vein for the time being. There may be benefits of bringing us together under a single GPIT provider in the future.
	• It was noted that there was a CSU national review taking place and some of the GPIT roles that NECs holds were embargoed, and we were unable to move those at this point in time.
	• There was a consultation period whereby we could put in a business case to NHSE identifying areas that we wanted to insource or otherwise reprocure. This was an active conversation being held internally from a cost saving/service improvement perspective on digital resources across the ICS and within the ICB.
	• It was noted that there was a working group comprised of GP Provider Boards, PCN representation and LMC that was helping to set some of the priorities locally within primary care.
	• Previously it had been more of an informal discussion and reacting to national and regional responses and requirements to put systems in place, including advanced telephony for access to patient records, and things that come down nationally.
	• This was a very different way of working with primary care, and they were very much engaged with the process.
	• Copies of the following documents were attached to this report:
	  • The most recent NECS KPI report
	  • The most recent NECS cyber security report
	  • The most recent T&GIFT KPI report
	• The Digital Development team, supported by colleagues from The Inform Team, recently delivered a presentation to the Primary Care Operational Group to inform the group of the	

	results of the Microsoft 365 training needs analysis and how the ICB proposed to deliver the requirements of the GPIT Operating Model to make ensure maximum benefits were achieved from the investment in the Microsoft 365 NHS Shared Tenancy. • Through the training needs analysis, the Digital Development team were able to identify key training requirements for GP Practices, Primary Care Networks and ICB colleagues as three distinct groups. An overall training programme had been proposed by the Inform Team for meeting all the outstanding training. • The Digital Development team was currently on-track to ensure that all corporate users of NHS Mail would have implemented multi-factor authentication on their NHS Mail accounts by the end of June 2023; the original deadline by which NHSE required all users to be compliant with their policy. The team continued to work with NECS and colleagues within Primary Care to ensure that all their NHS Mail accounts were compliant by the revised deadline of April 2024. **Audit and Governance Committee NOTED the Digital and Cyber Assurance report.**	
AG/2324/201	**Information Governance Report** Ged Connolly-Thompson presented the Information Governance Report covering February- May 2023 and highlighted the following: **DSPT Update:** • It was noted that we on course to submit the DSPT status by the end of the month. **IG Training:** • On 14th March, non-compliance reports for Data Security Awareness Level One were shared with Functional Directors to push for the non-compliant individuals in their team to complete their training. A report for non-compliant Board members was also shared with the Deputy SIRO for escalation. • Emails containing links to specialist SIRO and Caldicott Guardian training have been sent to the ICB's SIRO/Deputy SIRO and Caldicott Guardian/Deputy Caldicott Guardian for completion prior to DSPT submission on 30th June 2023. **IAO/IAA Update:** • The nominated IAOs and IAAs had received an email informing them of their role, responsibilities, and the support they would receive from the IG Team. They had received a web link to access the IAO online training course as an introduction to the topic. • The IG Team would be working with the IAOs & IAAs to identify what information assets their directorate own and to understand and document the flow of data and information into and out of the organisation.	

	Data Flow Mapping Process: • As highlighted at previous IGAF meetings, work was to be undertaken to re-introduce Information Asset Owners to their full role within the organisation. • The scope of the data flow mapping exercise was therefore being undertaken at a higher level initially with a more in-depth programme being delivered by the end of the calendar year. • The Information Governance team would also support the creation of the information asset register based upon the purpose-specific privacy notices and the DPIAs for ICB projects which have been received by the team. This is a pragmatic starting point, pending a more in-depth process once training courses had been completed and roles within the team recruited to. • The Forum approved the Data Flow Mapping process for the ICB. The Chair felt this was a very comprehensive report and requested that mandatory training was pursued and encouraged. **The Audit and Governance Committee NOTED the Information Governance update for February 2023 to May 2023.**	
AG/2324/202	**Procurement Highlight Report** Craig Stephens explained that this report illustrated the ICB's status of projects in terms of services being in progress, future projects or completed. The status of the project was indicated via a RAG rating identifying the level of risk exposure based on the ICB decisions in terms of Process (timeline), Contracting and Compliance with the regulations. Projects with Medium/High risk at present for the ICB were as follows: **In-progress** **Triage Service (Clinical):** Compliance risk was currently red. The Commissioner had confirmed that the budget for the next 12 months was £736k and therefore exceeded PCR threshold. However, it was anticipated that the full budget would not be needed, and Procurement awaited confirmation of anticipated spend from the Commissioner. If spend exceeds the PCR threshold, Procurement had advised the need to comply with Reg.32. The ICB had confirmed they were unable to comply with Reg 32 but would proceed with the extension at their own risk. If the spend was below the PCR threshold, then this may move to Amber/Green based on compliance with PPCC. Alternatively, it may also move to Amber if a procurement was undertaken as per discussion with the Commissioner (jointly with MECs and other elements of the pathway) – commencing July 2023.	

	<u>Future Projects (Contracts coming up for expiry in the next 18-months) and had not been confirmed as procurements, but were coming up to their expiry date</u>: **Impact+ Respiratory Services (Clinical):** the contract had been extended for 12 months and now expired on 31 March 2024. This extension was not compliant with the regulations. An options papers was produced by the Procurement team, which laid out multiple options and sent to the Executive Team in April 2023 for consideration: • Option 1 was to vary the acute contract to include the service. • Option 2 had multiple sub options: a) Sub option to look at a procurement, but with varying extension periods to cover that procurement. b) Sub option to extend for 12/24 months to get the data needed and refine the model to be able to go to procure effectively. c) Sub option to go out to procurement straight away; this was a very risky option. d) Final option was a direct award, which was like Option 1 above, with the same provider continuing, however, it would be based on regulation 32 rather than 72. Legal advice was currently being sought regarding these options. It was noted that as part of the outcome from the Executive Team meeting, Executives had asked for greater scrutiny of performance data to allow them to make a more informed decisions, and the Commissioners had been given until 30 June to go back to the Executive Team with that information. It was hoped that after the Executive Team had met again in July, we would have a definitive way forward of varying the existing contract to encompass that service, or an instruction to go out to procurement. The Chair reported that the Committee had flagged this issue at its meeting in March and this item was currently on the action log as the contract was expiring at the end of March. The Committee had queried why we had a substantial contract that was running out of time, and it had not looked like the procurement routes were being fully explored. It now appeared that the Executive Team had done a temporary extension, the Chair asked Keith Griffiths how that had progressed and what the exact reasoning was behind that decision. Audit Committee had felt this was a risk and it had now moved on a year; the Audit Chair reported that this did not feel right. Keith Griffiths reported that he could not comment on the specifics around this and if Committee wanted to get into this report in some depth, we would need to invite Zara Jones to a future meeting, who was closer to commissioning arrangements that we were putting in place.	

	The Chair reported that the concern was that this issue was flagged as a risk on our action log, and she did not feel as though Committee had had a full update on what was happening with this contract and yet it had appeared to have moved on. The Chair then shared her discomfort regarding the governance around this contract and requested an urgent response; she did not want to wait until the next meeting for an update. Chrissy Tucker agreed to pick this action up with Craig Stephens and link in with commissioning colleagues outside of this meeting.	CT
	The Chair went on to add that given the value of the contract (£1.4m year), she was unclear where this would fit in with delegations – she asked whether the Executive Team could sign this off without reporting back to any Committee? Chrissy Tucker agreed to check on this and provide an update to Committee via email.	CT
	Community Action Derby (Clinical): The intention was to direct award; the contract did not expire until March 2024. Craig Stephens reported that 12-month spend was below LTR threshold. Compliance with PPCC was required specifically (1) Acting in the best interest of providers (2) Encouraging integration of services (3) Achieving best value (4) Awarding to the most capable provider (5) Acting proportionately. This needed to comply with internal ICB governance. Ideally if spend was ongoing and not just for 12-months then compliance with Regulation 32 of PCR should be evidenced. Advice was to be sought from procurement.	
	MSK & Triage Service (Clinical), Community Physio for Non-Complex Service (Clinical) and Occupational Therapies (Clinical): the contracts had been extended beyond their original term and were therefore non-compliant. The Commissioners had been advised of the risk which had been accepted. The contracts were in place until the 31st of March 2024 and no challenge had been received to date. It was noted that multiple extensions had happened which were non-compliant but had not been challenged by the market. However, this could change at any moment in time. Craig Stephens reported that various options were being considered including procurement, and we were feeding into those options and options papers. The options included procurement and the other being delegation of services to the System. It was noted that he was currently awaiting the outcome of those papers and the proposed way forward. Craig Stephens reported that once we had the way forward, he would be able to adjust the rag ratings accordingly to reflect that. Richard Wright asked whether there was potential for contracts being handed back due to the cost-of-living increases/inflation by any of our contractors? He went on to add that he felt this should be included on the risk register if we had not already done so. Keith Griffiths agreed to pick this up outside of the meeting with Richard Wright.	KG/RW

	The Audit and Governance Committee: • **REVIEWED the highlight report for Derby and Derbyshire ICB.** • **NOTED the status of projects – Future project, in-progress and completed.** • **REVIEWED key issues and activities over the current period.**	
AG/2324/203	**Complaints Report Quarter 4 2022/23** Suzanne Pickering presented the Complaints Reports for Q4, 2022-23. The following was noted: • 35 formal complaints had been received during this quarter, 10 of which related to statutory functions. • The themes for the complaints were in relation to commissioning, nursing and quality, and medical issues. • 11 complaints had been closed during quarter 4, 5 of which had not been upheld. **Audit and Governance Committee NOTED the Complaints Report for Q4, 2022-23.**	
AG/2324/204	**Freedom of Information Report Quarter 4 2022/23** Suzanne Pickering presented the Freedom of Information Report Quarter 4, 2022-23. During January – March 2023: • FOI numbers had increased, with 79 FOI requests received compared to 53 in Quarter 3 of 2022/23. • No requests were responded to during this quarter outside the statutory timescale of within 20 working days of receipt. • 60 responses were sent. • 6 responses included exemptions under the Freedom of Information Act. • Suzanne Pickering reported that there was an identified risk with one FOI response which breached in May 2023, and although out of scope for this report, it was felt important to bring it to the attention of Committee at the earliest opportunity. • There were several elements which contributed to this breach, but key factors included a complex, multiple part request which was ambiguous and subsequently re-framed by the requestor, delays as colleagues across different teams sought information that we did not actually hold from other partner organisations and escalation points which were missed. • This breach also coincided with a change of FOI staff in conjunction with a record month of incoming FOI requests at 42 against an average of 20 per month.	

	• It was noted that there had been a robust internal review of process and assurance for the Committee. Steps taken to mitigate against a recurrence, include closer line management involvement and support to further embed critical policy areas such as clarification and extension criteria, reminders for all teams regarding information we do not hold as an ICB, critical escalation points and roles and weekly performance updates. • This breach would be formally reported in the quarter two performance report alongside any further actions taken to prevent a repeat of these issues. • Richard Wright felt that 79 complaints received seemed relatively high for just one quarter. He asked whether this number was just for the ICB or across the NHS family? Suzanne Pickering reported that it was just within the ICB and agreed that it was an unusually high number for just one quarter. • Richard Wright asked whether there were any underlying issues starting to rise; this volume of FOIs requests caused him some concern. • Suzanne Pickering agreed to keep the situation under review and triangulate themes where possible. • It was noted that from 1 July we would also start to receive complaints from pharmacy, optometry, and dental commissioning which would add to the numbers. • The Chair asked whether this was an area that we could address through Comms and public participation to see whether we were missing something? Suzanne Pickering agreed to investigate. **The Audit and Governance Committee RECEIVED the quarterly report on the ICB's performance in meeting our statutory duties in responding to requests made under the Freedom of Information Act.**	SP
AG/2324/205	**Conflicts of Interest Report** Chrissy Tucker presented the Conflicts of Interest Report and highlighted the following: • This report was presented to provide committee with an update and assurance on our Conflicts of Interest activities since last reported in March 2023. • Most recently, the team had been collating the updated declarations of interest for this year from across the organisation and ensuring that our registers for committees were then updated accordingly. • Attached to the report was Appendix 1 forward planner showed the programme of work we were anticipating undertaking. Appendix 2 Confidential Staff Register, and Appendix 3 a note of any interests declared so far, where they had been recorded and how they had been managed. • Staff were regularly reminded about reporting any breaches; the last time this was done was in February this year through the Staff Bulletin.	

	The Audit and Governance Committee NOTED and RECEIVED ASSURANCE from the Conflicts of Interest Report.	
	FINANCE	
AG/2324/206	**Month 1 ICB Financial Position Review** Keith Griffiths presented M1 ICB Financial Position Review and highlighted the following: • DDICB signed off a financial plan for 2023/24 which demonstrated breakeven. • This report highlighted the ICB financial performance, the risks and challenges faced in delivering this year end position, and the actions the organisation had taken. • As of 30th April 2023, the ICB was reporting a small deficit position. The M1 year to date and forecast outturn figures were in line with the recently submitted plan as expected. • Key to achieving the financial plan for 2023/24 would be the delivery of £44.2m of efficiencies, £33.2m of which were planned to be recurrent. • Regarding the System, there was an adverse variance of £3.4m in M1 that was almost 100% identifiably linked to the industrial action; there were cost pressures emerging across all our Providers because of this. • Challenges as a System would impact on the ICB, the details of which would be addressed in the System Finance and Estates Committee. **The Audit and Governance Committee NOTED the M1 ICB Financial Position.**	
	FOR INFORMATION	
AG/2324/207	**Non-Clinical Adverse Incidents** Chrissy Tucker reported that there had been no non-clinical adverse incidents. Chrissy Tucker reported that preparations were underway for the mitigations required for the Junior Doctors industrial action scheduled between 14th-17th of June. It was noted that there had been a System escalation meeting called today to review all the plans and mitigations around that. **Audit and Governance Committee thanked Chrissy Tucker for this update.**	
AG/2324/208	**NHS Oversight Framework 2022-23 - Q4 and Year End Outcome letter** Chrissy Tucker reported that a copy of the Q4 outcome letter had been attached to the agenda papers for information.	

	This letter was confirmation of the segmentation levels, that the ICB had recommended for our Providers, and talked about the next steps. Chrissy Tucker reported that we would be commencing Q1 for 2023/24 shortly, and we had oversight meetings planned with Providers. The Q4 year-end segmentation was subject to a National Review and hopefully this would not change after the National Moderation Panel. It was noted that we were working on those figures currently and had written out to Providers to that effect. **Audit and Governance Committee thanked Chrissy Tucker for this update.**	
	MINUTES AND MATTERS ARISING	
AG/2324/209	**Minutes from the Audit and Governance Committee Meeting held on 4 May 2023** The minutes from the meeting held on 4 May 2023 were agreed as a true and accurate record.	
AG/2324/210	**Action Log from the Audit Committee meeting held on 4 May 2023** The action log was reviewed and updated during the meeting.	
	CLOSING ITEMS	
AG/2324/211	**Forward Planner** Glynis Onley reported that the forward planner against Internal Audit, stated we had an Internal Audit Plan going for approval in August; this would normally be March. The forward planner also stated that Progress Reports were not required for June or December meetings; progress reports were normally brought to every meeting that Internal Audit attended apart from when the annual accounts were reviewed. It was noted that the Forward Planner would be updated to reflect this. **The Audit and Governance Committee ACCEPTED the Forward Planner with the above amendments.**	SP
AG/2324/212	**Assurance Questions:** Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? **YES** Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? **YES** Has the committee discussed everything identified under the BAF and/or Risk Register, and are there any changes to be made to these documents as a result of these discussions? **YES** Were papers that have already been reported on at another committee presented to you in a summary form? **NO**	

	Was the content of the papers suitable and appropriate for the public domain? **YES**	
	Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? **NO, but this was acknowledged beforehand.**	
	Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? **NO**	
	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? **NONE**	
AG/2324/213	**Any Other Business** Richard Wright confirmed that he was taking on the Interim Chair role for the ICB, as a result this would be his last Audit and Governance Committee for the time being. It was noted that Margaret Gildea (NEM) would be joining this Committee, and a temporary NEM would also be joining as Chair of System Finance and Estates Committee. The Chair thanked Richard Wright for his input into the Audit and Governance Committee and confirmed that Richard would revert to this Committee once a new ICB Chair had been substantially appointed. There was no further business. **Post Meeting Note: Jill Dentith had been appointed as temporary Chair of System Finance and Estates Committee.**	

DATE AND TIME OF NEXT MEETING
Date: Thursday 10 August 2023
Time: 2.00PM
Venue: MS Teams

Signed: …… Dated: ……..
(Chair)

NHS
Derby and Derbyshire
Integrated Care Board

MINUTES OF THE ICB PEOPLE & CULTURE COMMITTEE (ICB PCC)

HELD ON WEDNESDAY 07 JUNE 2023, VIA MICROSOFT TEAMS, 0900-1100

Present:		
Gildea, Margaret	MG	ICB Non-Executive Member and Chair of ICB PCC
Clayton, Chris	CC	Chief Executive
Dawson, Janet	JD	DCHS NED and Chair of PCC
Garnett, Linda	LG	JUCD Programme Director, People Services Collaborative
Moore, Liz	LM	Derby City Council, Head of HR
Rawlings, Amanda	AR	ICB and UHDB Chief People Officer
Skila, Jen	JS	Assistant Director HR, Derbyshire County Council
Tidmarsh, Darren	DT	DCHS Chief People Officer / Deputy Chief Executive
Wade, Caroline	CW	CRH Director of HR & OD
Wight, Jeremy	JW	CRH Non-Executive Director and Chair of PCC
In Attendance:		
Mahil, Sukhi	SM	JUCD Assistant Director Workforce Strategy, Planning and Transformation
Sunderland, Sue	SS	ICB Non-Executive Member
Ginniver, Jane	JG	Operational Lead
Bayley, Susie	SB	General Practice Taskforce Derbyshire – Medical Director
Watkins, Kevin	KW	
Oakley, Rebecca	RO	DHFT Deputy Director of People & Inclusion
Smith, Beverley	BS	NHS Derby and Derbyshire CCG, Director of People Transformation, People Services Collaborative
Jandu , Chlinder (Minutes)	CJ	Corporate Administration Manager
Apologies:		
Knibbs, Ralph	RK	DHFT Non-Executive Director and Chair of PCC
Gulliver, Kerry	KG	EMAS, Director of Human Resources & Organisational Development
Thompson, Helen	HT	Executive Assistant to Amanda Rawlings
Blackwell, Penelope	PB	Place Board Chair and NHS Derby and Derbyshire CCG Governing Body GP
Lowe, Jaki	JL	DHFT Director of People & Inclusion
Street, Joy	JS	UHDB Non-Executive Director and Chair of PCC

Item No.	Item	Action
PCC/2223/50	**Welcome, introductions and apologies** Attendees were welcomed, introductions were made, and apologies were noted as above. MG announced that AR at the last meeting was Chief People office for the system but due to demands of her role at UHDB will be relinquishing that role. MG thanked Amanda for everything she has done in getting the people elements of the system up and running.	

	MG introduced Linda Garnett as the Interim ICB Chief People Officer for 6- 12 months. KW introduced himself. KW works for the internal auditors of the ICB and for most of the organisations at the meeting today. KW is doing a piece of work on committee effectiveness for the 5 sub-committees that have a system focus for the ICB, which has meant he has been observing each meeting and feeding that into the piece of work he is doing for the ICB. CC introduced himself and shared that he would like to attend this committee as he does the finance and estates committee to try to ensure that there is the same focus on our people approach and hopes to provide some support but not to interfere with the business of the committee in the way it is going. MG shared that Sue Sunderland, one of the ICB NEM's will be joining the meeting as Richard Wright, Acting Chair, has made a number of proposals for how the committees are somewhat differently organised and has asked SS if she would attend.	
PCC/2223/51	**Confirmation of quoracy** The meeting was confirmed as quorate.	
PCC/2223/52	**Declarations of Interest** MG reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the ICB. No declarations were made at this meeting.	
	ITEMS FOR DECISION	
PCC/2223/53	**BAF risks review** LG spoke about the two risks relating to people and culture that are on the overall Board BAF framework. BAF Risk 5 – System not able to recruit and retain the patient workforce to meet the strategic objectives and deliver the operational plans. Three specific strategic threats were identified: • lack of system alignment between activity people and financial plans. • Concerns about staff resilience and wellbeing, being negatively impacted by environmental factors such as the industrial relations climates and the financial challenges in the system • employees in the care sector not being able to attract and retain sufficient numbers of staff to enable the flow of service users through our pathways and also the scale of	

	vacancies across health and care and some specific professions. Each of the above areas were looked at to see where the gaps were, what the controls are, where assurance can be taken and tried to strengthen some of the system controls as well as trying to get an aligned position across the operational plan between workforce and finance activity. **Comments/Questions** CW raised the point that Risk 5, not being able to recruit and retain sufficient workforce should be associated with Risk 6, integrated workforce. If we are able to create a one workforce and a fully integrated health and social care system then that would have more impact than the recruiting and retaining staff. When you look at the risk scores alongside each other, not sure whether they add up and that a more disaggregation of the scores would be helpful. CC shared some thoughts around risking in its entirety. He recognised where the risks have been set at board level and the clarity of the papers presented today and the thought that has gone into them has made it easy for him to stand back and look at it. CW asked do we have an NHS one workforce plan agreed across all of the key partners in the NHS family which feels like a significant risk for us and the report hints that we have not quite got there and then a separate question, is this something we want to have and how would we want to govern such a thing across the health and care partnership and the link to the Integrated Care Partnership Board. CW felt we need to start to put into risks this conversation about what is the NHS family one workforce plan and what is the joined up between that and an integrated plan across health and care because to solve the big thing on our own without the constituency will lead to problems. if we have not agreed the NHS one workforce plan, how can we recruit and retain against it. LG and SM to have a look at the one workforce plan and look at the difficulties of recruiting and retaining against it, which it was felt might be a more logical order. JW shared that in addition to the disaggregation of the scores it would be helpful to make clear that when a target is set how do we think the target is going to be reached, whether this is by reducing the likelihood or reducing the consequence. JW also noted that there is no mention of pay in the paper and said this may be being ignored because it is out of our control but that it does seem to be a major threat to recruitment as staff are unhappy about the level of pay awards and it gets a lot of publicity and JW wondered why that is not reflected in the paper. DT commented with regard to recruitment and retention we have a broader workforce than the NHS group as we seem to be building in the health and social care workforce which is probably	

	the biggest challenge in terms of capacity. Most of the delayed discharges either from the acutes or from community beds is pathway one whereas in the NHS group our recent trend is an improving level of attrition and the gap on recruitment to this year's workforce plan is minimal and people are putting plans that they are confident that they will be able to deliver. In terms of the likelihood for NHS, the score feels high and if it is the combined health and social care, then it is probably right because of social care risk. one of the actions that we have been considering over the last six months is around scaling international recruitment for domiciliary care and felt since Helen left her role as the kind of assets in the county, we seem to have lost traction and there is good evidence from other systems that it is beneficial and we know that a number of private providers both in the city and the county of carried on independently, but they are in small numbers, but the feedback is really good retention, good engagement and enjoying the type of work that is provided. DT felt there is probably an action for the Board to say how do we ensure that we scale that in preparation for winter 2023 because there is still huge opportunity on the basis of the evidence. AR shared that we know the risks about the alignment of finance activity and people, but it is lacking strategy and without a strategy what are we planning for, we can plan to activity but that leaves us in the here and now and when we get into one workforce, that is about what we utilize all our people for. The 'what' is missing here around where we are going as a system with our overall pathways service models, the patient itself, what is that all going to look like to then line the workforce activity and finance. It has to be noted a risk where we are held to account to a very tight financial plan this year, which means workforce supply, retention, all of that is really critical, but it is all within a very tight context. This is a very big strategic risk and without a strategy, the two things are really quite important in terms of what drives planning. We are looking at these two risks and how to align them, but they are quite different because one is the here and now and the other one is more long term and the here and now need to be informed by the long term. AR felt we have to get into what does Derbyshire need, the long-term vision for services, what the population and patients need, what the activities are going to look, what the money will look like, and we have not got into strategic workforce planning yet as a system. SM stated that we are in the very early stages regarding the strategic approach and the wrap around, we have a framework that we need to work through, and we also need to get to understanding our workforce as a starting point. MG summarised as follows: - we need the strategy of where we are heading, what we are trying to do.	

	- We need the absolute understanding of where we are now and that needs to be absolutely clear. - We need to have that financial alignment, recognise the constraints that may lead to in developing the workforce plan - We need to have a plan that we can risk assess and deliver against. CC made the following points: - the theme around limited by finance, it is of fundamental importance to us now and we need to get out of the mindset of thinking we are now constrained by finance. We have the financial resource that we have, and the vast majority of that financial resource is spent on people and we need to be getting into a mindset around productivity, effectiveness and value and this is now interlinked with our people plan and ensuring that we deliver the activity that we are committed to deliver for the people of Derbyshire. - We need to be careful with the boundary of the NHS workforce plan is and a careful conversation with the Integrated Care Partnership and this is because we have to get the consistency. LG and CC will pick this up colleagues. JD made the following points: - On the information we have we are being asked to take assurances, a lot of the mitigations are about observing and monitoring as opposed to doing. It is helpful to understand the progress that is being made but it is not enough to just look at it, we have got to do something about it. A lot of these are iterative, the mitigations appear in multiple places, and we need to be careful we are not filling the sheet up with words and they are not necessarily going to get us any traction. - It would be helpful to understand the role of the People Services Collaboration Delivery Board and the Workforce Advisory Group and what they do, how are they going to help and how they are going to feed into this committee so that we can see that we are actually making some progress around what we are trying to achieve. MG asked LG to add an item on the agenda for the next meeting: 'Deep dive into how the governance works and comes together' and suggested the Board view the other agenda items at today's meeting in the light of are they mitigating the risks/are they making things better. ACTION: Agenda item to take forward to next meeting: 'Deep dive into how the governance works and comes together'	LG

ITEMS FOR DISCUSSION		
PCC/2223/54	**People Services Collaborative Priorities for 23/23** LG shared that while establishing the People Services Collaborative last year a big part of that was about engagement and trying to bring people together and took a wide lens to include everybody who works in one of the people services functions and teams to feel like they had a stake in this and that they were involved and felt they would create that collaborative approach and that is where the seven by five came from. There are seven work programmes covering the full range of work that happens in people services. A conference was held about six weeks ago where people were brought together who have been working and leading on those work streams to celebrate the work that they have done and shared good practice, talk about some of the barriers that they faced in trying to work collaboratively. The conference provided a good insight and a bit of a challenge back to HR directors about the need to prioritise on some key themes. This was taken on board and conversations were had within the HRD group and at People Services Delivery Board and arrived at two really overarching big priorities for next year: • Improving workforce supply. That brings in all the work around reducing absence, improving retention, reducing vacancies and improving optimization and productivity. • Managing our pay costs to plan and that brings in reducing the cost of temporary staffing, especially agency costs and improving the acuity of the accuracy of workforce data, because that is the thing that will help us understand where we are now, what/where are we spending the 75% of the money. Also identified some enablers, currently there is a big programme of work nationally around scaling in people services and the chairs and the chief executives of the providers have given a clear steer that they want to concentrate our scaling efforts on recruitment, which has been really helpful. This fits in exactly with what we would have chosen, and we are also engaged in a piece of work under AR's leadership around improving the digital approach in people services and so we will be continuing with that. As a secondary enabler we are wanting to look at simplifying and standardising our payroll and that fits really well within the overall programme of scaling work and that is a key enabler for helping us with managing our pay costs. **Comments/Questions** AR shared that she attended a Chairs and Chief Executives session and the general view the s as a provider leadership collaborative we need to bring ourselves down to a very focused set of objectives and to them well. If we take the NHS England model around scaling it is all around simplify, standardise and the think about automisation and consolidation. AR asked how do we simply and standardise something without getting drawn into who is the host, should we have a shared service, should we have a	

	people services collaborative and said too much time has been spent trying to think about the kind of architectural design rather than making progress. If we all did recruitment the same way and we learn what is the best way to do it, bring down that time to hire, that releases time back to line managers brings people on board which has a lot of clinical benefit in doing so. That is what the Chairs and Chief Executives have asked People services team to do is work out best practice to how we could recruit and become a market leader Derbyshire in recruiting. EMAS have said they would like to be part of that as well because they have got a lot of recruitment. AR has been doing some work with NHS England around how do we prepare for replacement of ESR, which is a new workforce solution, what could we look to automate and map out the people services costs, we carry a lot of our workforce and people in the transactional side. We need to simplify and standardise before we think about the automation so that digital work will run parallel, NHS England is supporting us with that. AR said it was important to say on payroll that there is a lesson to learn. Chesterfield Royal still keep their payroll in their subsidiary company, the rest of us all moved their SBS contract into UHDB, which is the host, which means rather than having an ICB, a UHDB, a Derbyshire Healthcare and a DCHS payroll and you would think that is four or five there are 100 different processes going on in a very small team. If we all went to the same payroll date, if we all went to the same processes, that is only going to help the one workforce when you are in an integrated team out there trying to manage workforce for different teams when you are running on different processors. AR has somebody now doing all this work, looking at and saying what could be simplified and standardised and payroll which we presented back to my peers to go here are some options we could look at to do together so. AR reported that the Chairs and Executives were really helpful and thought they will do that with all the other corporate areas as well, and they all absolutely want us to collaborate on everything, bringing bank and agency down, improving attendance and scaling, but not to scale everything as we do not have capacity.to do so. We need to keep running as usual, take one proof of concept and do it really well together, release back to the front line, learn from it and then share the experience with all other areas. DT stated that the provider collaborative needs to focus on where things can be improved together so that there is no duplication ie performance management and assurance of provider actions. Although this is not disputed, DT felt it important that it was recorded. SM asked how the priorities will enable us to move forward towards that one workforce approach which is more holistic including primary care for example. AR responded that the work we do on pay role will be about the NHS family. The work we do on recruitment, if we can get a best practice recruitment process with automation helping speed up time to hire, does not matter what industry you are in because we are going to take the best	

	from industry as part of our benchmarking and everybody will gain from that. If we can do that faster that is only going to be a huge benefit to us. LG pointed out that it gives a steer to colleagues to say think about what you are doing through the lens of how that improves the workforce supply how does that help us managing our pay costs and giving a bit more nuance and it will support the one workforce strategy. LG also mentioned that when we get opportunities to do work, we are kind of using three lenses to think about it, is it something that can only be done collaboratively, in which case it sits in the People's Services Collaborative. Is there an area of good practice in one of the organisations that should be rolled out and extended into other areas or is it something which actually the organisation should just get on with and do themselves. MG agreed with SB's comments to be mindful of smaller organisations because when standardising, simplifying, automating you do have to be mindful of how that plays out in productivity improvement terms, MG thanked SB for speaking up as it is incredibly important that we get primary care and other sectors right. MG agreed that SM's question is it contributing to the one workforce, both strategy and plan is a question that people services collaborative priorities need to always have in mind as things are being done and MG agreed with AR that in any areas if you do best practice and do it once and do it well then one will automatically speed up the journey to becoming one effective workforce. JD challenged the benefits of having one partner in this group leading on a particular function and delivering that function to everybody else, but also being a customer of others because it is quite a powerful mechanism in ensuring that you have got delivery in both ways in that you are both a supplier and a customer of each other. JD also raised her concern about standardisation by itself is the attraction in terms of getting the thing going is we will not make any real organisational savings because you will replicate the senior team specialisms over and over again and that in itself is a bit of a cost leakage. We should not be running non-standard systems and the power in transforming HR delivery is about standardisation. How can we standardise what we do but also streamline it so that we are doing it once for everybody as opposed to doing it multiple times in different places, even if it's in the same way. JD agreed with MG that there are parts of the system that we can deliver services to them if it is helpful, but there be some things that they will need to do themselves because it's not always going to be the way that the NHS would do it, but as anchors within the system, it does give us the leverage to explore and develop and create those single systems and delivery points that people can either buy into or not if they do not want to.	

CC supported the wish to consolidate and agreed with SB that we need to connect the conversation to the BAF and if we do not then we are doing the wrong thing. CC highlighted two priorities out of the BAF:

- the need to create the one workforce strategy and that has two elements really consolidate our NHS family workforce strategy and working in partnership across the ICB on the health and care workforce plan. This is a priority but have also recognized you cannot do that sequentially.
- Improving the effectiveness, productivity and value from our current workforce.

The enablers are:

- how we do the latter as opposed to what we are doing. We need to be very clear what the ask from this committee to the system is and it will be really helpful that we could divide out the work here so that there is something very much for our provider collaboratives, which includes general practice. On the productivity, effectiveness, value question, we have got a massive job to do this year on that.
- we could really ask ICB colleagues who are working on strategy to lead on the other, and this committee could be very clear about the asks on that too. It is not as binary as that and it is interlinked, but there's something about, enabling both contributions to take this forward.

MG summarised the conversations:

- broad agreement to the approach of having three areas to focus on. We are not losing the seven by five, that is the day job, but what we are going to focus on here and now.
- some very helpful thoughts and advice about how best to do this coming from a variety of people and then making sure we have that link to the one workforce.
- Everything we do links back to the BAF and how some of this is about what and some of this is about how so that work will continue and there will be feedback.
- We are not assured on the outcomes yet because it is early days, and this has been described as a bit of a reset.

System WRES report

LG shared that Jaki Lowe, Lead on EDI for the system could not be with us today but thanked JG, Operational Lead who has been leading a lot of work across the system with the ICB for presenting the WRES today.

	JG took the papers as read and aware that colleagues are aware of the WRES and the requirements that NHS providers have in terms of submitting for the WRES. JG stated that this paper is a second iteration of the system consolidation of the organisational WRES reports and the caveat within that is that all of the organisations do have quite localised nuances within that, so we need to make sure that we do not just look at the system report and put in a standard system response to that. We also need to look locally and work locally in terms of the different responses as well, because some of the real issues can get hidden within that consolidated view and so there are some where we have some providers that are performing particularly well on some of the indicators and others that are not performing particularly well and it comes out as an average and we would lose where actually some providers really need to focus on some of those indicators if we did not look at all of the separate reports as well. The areas where we do all need to focus on what we have been doing before we started to get these consolidated system reports, we are sharing information and looking at what we can best do collectively to be more efficient about the work that we are doing and the following are some of those areas: • The one thing that is not in the paper is the work that we have been doing for a number of years on recruitment because going back a few years and still in some of our providers indicater 2 continues to be an issue and it is an improving picture in all of the areas, but it is still an issue. Indicator 2 is the measure that looks at the numbers of people who are appointed from short listing. It looks at the likelihood of black, Asian minority ethnic colleagues being appointed compared with white colleagues and across the board. Going back a couple of years, that was a real sticky indicator across Derby and Derbyshire. It is an improving picture but in some areas still needs to improve a lot more, but it is improving in all areas. • Talent development - participating and engaging with regional initiatives, developing aspirant leaders programme, for example, which is aimed at Black, Asian, minority ethnic nurses and midwives, is something which we have engaged with and are one of the leading systems in the region in terms of engagement with that program. Also showcasing some of the senior leaders that we've got from Black, Asian minority backgrounds looking focusing on clinical roles, nursing, midwifery, AHP roles and getting them to talk about their career progression to provide role models and been looking at recruiting managers to change the view of recruiting managers about what talent looks like, some of these are available on YouTube, links to be circulated. The Talent Development Group has started to look at what do we specifically need to do, what are the views of our black, Asian, Minority ethnic colleagues around what	

	additional support would benefit them, and how can we do that. • Over the next 12 months work to be done looking specifically around bullying, harassment and abuse and at the moment the majority of that work is being done within local organisations as we do need to get in as close to the ground as possible as local as possible and in order to make those messages really heard by the people who need to be hearing them and acting upon them and some work is being done that cuts across the system on training. • Following on from work around recruitment ten people have been recruited across the system and cultural intelligence training and the plan now is they will start to roll out that cultural intelligence awareness across the system and start to raise people's understanding of different cultures as well as and the other training program that is being looked at to implement across the system is an active bystander program which is being led by colleagues in Leicestershire and Rutland and we have got some dates for training facilitators for October for Derby and Derbyshire. We will be the first system that they pair up with in terms of getting that training spread out, the aim of which is to create the confidence and the capability of all of our staff to stand up against discrimination against bullying, harassment and abuse if they see it so that they know what to do and have the confidence to be able to do that. • All the providers have got anti racism programs of work in place and at a system level looking at having an anti-racism statement that brings all of the together for the ICS. **Comments/Questions** DT commented indicators 6, 7 and 8, indicate we are very much in the pack amongst NHS and that we all still have a lot to do as an NHS. CW commented that it would be nice to the ICB included as well. Not sure whether ICB is included in one of the providers figures or whether they should be included as an extra line, but there are relevant indicators in there as well, particularly planning things like Board disparity compared to the rest of the workforce. CC welcomed the paper and agreed with CW about including the ICB. The ICB has two roles, as an organization in its own right and it is a convener supporter of the of the NHS family. From this vantage point as the NHS family's committee looking at this and giving assurance on everybody's behalf and having input from the non-executive community from all our Trusts we need to be able to see ICB level performance and organisational. CC made a point about something that is coming out of local conversations linking to our anchor work on population health is	

	a lens around social mobility inter-roles and this would be an excellent piece of work that could be done collectively across the ICB and with local authority partners. This is going to be looked at in the anchor field about how we do a social mobility view of this because there are significant areas of deprivation and what we are wanting to see and support in social mobility within those areas and then NHS as a huge role to play. To being back to Board at a later date. MG stated that we have partial assurance as we were only in the pack of a pack that is not really leading the way.	
CORPORATE ASSURANCE		
PCC/2223/55	**23/24 Workforce Plan Final Submission and M1 update** SM reported that the final plan was resubmitted on the 4th of May and have had a review undertaken by NHSE Health Education England and feedback has confirmed that there are no issues identified and they were happy with our workforce plan. The plan has since been reviewed against the month 12 outturn and doing a sense check of where the position landed compared to our plans of staff in post baseline position and there is a slight difference. The total workforce movement by the end of March 2024 increase of 615 wte (2.2%) but when it is looked at against month 12 outturn it actually equates to 1.5% growth and the misalignment is being looked at and what it means for NHS providers. There was a total workforce growth in the plan of 615. At the moment there is a misalignment with our workforce plan and the financial efficiency side of the plan. Work is being done on where the gaps are and where there is that misalignment. Alignment with finance was undertaken to ensure that if there was any growth, there were four categories that have been identified where growth would be justifiable and it would align to finance but had to revise the plan so are going round the loop again and working closely with finance colleagues to understand where it is income backed and for what other reasons. Month one position – providers are not required to submit their monthly provider workforce returns in month one, so information has been extracted from the finance ledger and that information is in Appendix B in the paper which shows that there does appear to be point 2.6% a million overspend on the pay costs in month one. When looking at bank and agency usage, it has increased, and the assumption is this is due to the junior doctor strike. The gap at the moment is around the alignment with activity. There is more work to be done around have we delivered the right amount of activity, was our workforce going up or down, did it support that position.	

	Comments/Questions CC asked that recognising that alignment challenge can he be assured that we do have the right forum in place between our senior people colleagues, our senior operations colleagues, COO's and our senior finance colleagues, that we have that in place now not just from an efficiency perspective but from this alignment of plans. SM confirmed that various colleagues are coming together but COO's are not currently involved. MG and CC are in agreement that we can take CC's comments as a potential action rather than take assurance from it and to give that through via Linda into the NHS executive. DT felt there were 3 things that are important: • The EMAS position is clouding the overall ICS position and for clarity it is making it look better • We need variants of actuals to funded establishments which will give clarity on where we are departing from the finance plan • on the basis of the provider, reporting if we take EMAS out of the equation, what month 1 suggests to us is that we continue to have a system over reliance on Temporary staffing and that presents quite a considerable risk for us going forward. Recognising it is month one and all the providers will have been fairly rushed in pulling things together there is further analysis on month one position but take EMAS out and look at it to funded establishment and look at the numbers that have reported for temporary staffing. JD asked the Committee's role in the ICB to think about the strategic direction forwards, as opposed to the tactical stuff that is going on now, should not our response to various providers that you are behind the plan there is a gap, we are not interested to know what it is because that is for you to sort out, but we are noting that we are not going to be in the right place at the right time if operational organisations do not get their act together rather than us worrying about where the little gaps. Colleagues absolutely know where they are in their own organisation. We should not be worried about the detail of this, but we should see the direction of travel. One of the dilemmas that is going to happen in these committees is that the danger is we consolidate the work that is being done at provider level and we try and redo it and I don't think that is our job and that is not where we should be adding value. The power of the data for people who are looking at it is to say where do our priorities need to be, reset ourselves and priorities, but it looks like the issue, which is around agency costs. This year to help us to deliver both the ICB overall plan and our workforce plan, we need to put our emphasis on managing that.	

	CC agreed that we have got to have this connect between strategy plan and reality and there is a real necessity for us to actively get into the space of managing our plan and he will be working with the with colleagues behind the scenes about how we do that and how we show that and how we do this connection between not getting in the weeds of what is happening in an organisation, but seeking assurance from the Boards that they are on this and what the Boards are doing about it individually, where there is a challenge and where Boards are excelling in this, where are we sharing the learning between boards as well. MG summarised as follows: We are not taking assurance and there are actions LG and SM to pull together what we need to do, recognising that we do not want to get into the weeds of too much detail, but we want to be assured that we do know how many people we have got, we know what their costings are and we know the trend we are heading into. **ICB PCC NOTED the report and actions for LG and SM**	
ITEMS FOR INFORMATION		
The following items are for information and will not be individually presented		
MINUTES and MATTERS ARISING		
PCC/2223/56	**Minutes from the meeting held on Wednesday 8th March 2023.** The minutes of the meeting held on 8th March 2023 were accepted as a true record. **ICB PCC ACCEPTED the minutes as a true record.**	
PCC/2223/57	**Action Log** The action log was noted. **ICB PCC NOTED the action log.**	
CLOSING ITEMS		
PCC/2223/58	**Forward Planner** • Clarity on how structures below this committee are working and how they are feeding up and are we assured that all are working effectively. • Six month update on how we are doing with the system consolidation which would be helpful to give focus for people and keep the impetus going for everybody to support the team on it.	

PCC/2323/59	1.	Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? • Apart from EMAS Committee attended by relevant people. (EMAS figures are counted in Derbyshire, therefore EMAS to be represented here)

	2.	Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? YES
	3.	Has the committee discussed everything identified under the BAF and/or Risk Register, and are there any changes to be made to these documents as a result of these discussions? YES
	4.	Were papers that have already been reported on at another committee presented to you in a summary form? YES
	5.	Was the content of the papers suitable and appropriate for the public domain? YES
	6.	Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? • One apology for one paper that had been missed.
	7.	Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? • Deep dive in the next meeting around governance.
	8.	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? • No recommendations made.
PCC/2223/60	**Any Other Business** No Items	
DATE AND TIME OF NEXT MEETING		
PCC/2223/61	**Wednesday 6th September 2023** **0900 - 1100** **via Microsoft Teams**	

NHS
Derby and Derbyshire
Integrated Care Board

MINUTES OF THE PUBLIC PARTNERSHIPS COMMITTEE

DEVELOPMENT SESSION

HELD ON 27 JUNE 2023, 10:00 – 12:00

VIA MS TEAMS

Present:		
Julian Corner	JC	Non-Executive Member DDICB **(Chair)**
Steven Bramley	SB	Lay Representative
Helen Dillistone	HD	Executive Director of Corporate Affairs, DDICB
Karen Lloyd	KL	Head of Engagement, DDICB
Hazel Parkyn	HP	Governor, Derbyshire Healthcare NHS Foundation Trust
Tim Peacock	TP	Lay Representative
Amy Salt	AS	Engagement and Involvement Manager, Healthwatch Derbyshire
Sue Sunderland	SS	Non-Executive Member, DDICB
Sean Thornton	ST	Deputy Director Communications and Engagement, DDICB
Lynn Walshaw	LW	Deputy Lead Governor, Derbyshire Community Health Services NHS Foundation Trust
Carol Warren	CW	Lead Governor, Chesterfield Royal Hospital
In Attendance:		
Lucinda Frearson	LF	Executive Assistant, DDICB (Admin)
Sally Longley	SL	Engagement Specialist, DDICB
Apologies:		
Jocelyn Street	JS	Lay Representative

Item No.	Item	Action
PPC/2324/023	**Welcome, Introductions and Apologies** Julian Corner (JC) as Chair welcomed all to the meeting with introductions being made around the virtual room. Apologies were noted as above.	
PPC/2324/024	**Confirmation of Quoracy** The Chair confirmed the meeting as quorate.	
PPC/2324/025	**Declarations of Interest** JC reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the Integrated Care Board (ICB).	

	Declarations declared by members of the Public Partnerships Committee (PPC) are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link: www.derbyandderbyshire.icb.nhs.uk Declarations of interest from today's meeting: No declarations of interest were made during today's meeting.	
MINUTES AND MATTERS ARISING		
PPC/2324/026	**Minutes from the meeting held on: 30 May 2023** The Public Partnerships Committee **ACCEPTED** the Minutes as a true and accurate record of the meeting following an amendment to Tim Peacock's name on page 2.	
PPC/2324/027	**Action Log from the meeting held on: 30 May 2023** The action log was reviewed and updated during the meeting.	
ITEMS FOR DISCUSSION		
PPC/2324/028	**BAF Strategic Risk 3 – Action Plan** The ICB Public Partnership Committee are recommended to: - • **DISCUSS** and **TAKE ASSURANCE** from the proposed action plan aimed at mitigating BAF Strategic Risk 3. *SR3: The population is not sufficiently engaged in designing and developing services leading to inequitable access to care and outcomes.* Sean Thornton (ST) presented stating the purpose of the paper was to set out the detailed actions supporting mitigation of ICB Board Assurance Framework (BAF) Strategic Risk 3. The strategic risks are the risks that face the system, not just the ICB. The ICB will take a system coordination role to develop the framework that underpins the delivery and will require system partners input to mitigate complex risks. Within the paper ST had provided details of deadlines, mitigating actions being taken and outlined 4 threats: - 1) The public are not being engaged and included in the strategy development and early planning stage of service development therefore the system will not be able to suitably reflect the public's view and benefit from their experience in its planning and prioritisation. 2) Due to the pace of change, building and sustaining communication and engagement momentum and pace with stakeholders during a significant change programme may be compromised.	

	3) The complexity of change required, and the speed of transformation required leads to patients and public being engaged too late in the planning stage, or not at all leading to legal challenge where due process is not being appropriately followed. 4) The communications and engagement team are not sufficiently resourced to be able to engage with the public and local communities in a meaningful way. **Discussions**: **Threat 1**: • Helen Dillistone (HD) suggested capturing and linking into work set out around the Trusts and their responsibilities around engagement, with maybe a conversation around Lead Governors and holding Non-Executive Directors (NEDs) to account raising the importance of comms and engagement. • Tim Peacock (TP) asked about the scope of the PPC and its responsibilities. **Action: Karen Lloyd (KL) to map and visually show responsibilities of the Committee.** • TP enquired on the logging of the measurement of Derbyshire's engagement, how do we measure and benchmark against other strategies nationally. ST felt there was a need to evaluate on a scheme-by-scheme basis and be careful not to take a population view. • KL outlined the evaluation framework which looked at how we evaluate and how well we are doing, this is being co-designed as well as working with an independent consultant and looking at other ICB frameworks. It was felt Derby and Derbyshire were ahead of the majority of frameworks in the work being done. TP believed it would be helpful to be informed when the ICB were doing well. • Steven Bramley (SB) saw the risk as infinite although managed and something that would evolve overtime, but measurement would help with the evaluation. • Sue Sunderland (SS) asked whether members felt the actions were going to mitigate the risks and if they felt the timelines appropriate. **Threat 2**: The second threat being around building and sustaining engagement and communication with stakeholders. Connection with ePMO colleagues was relevant as all schemes need to go through this process with checks and balances in place to ensure requirements prior to progressing.	**KL**

	• SS enquired whether comms received sight of early enough to ensure involvement at an early enough stage, was more knowledge required in early development which may have significant comms input. ST felt this requirement to be on a scheme-by-scheme basis and the team did have links which gave knowledge of proposed schemes. **Threat 3**: The Patient and Public Involvement (PPI) guide had been rolled out to system partners and expectations highlighted to GPs. It was about widening awareness, and this was given a September milestone. **Threat 4**: There was a need to manage the resource capacity taking a look at what others were doing via a workshop. The communications strategy would assist with capacity. Risks also come from national requests received unexpectedly, governance and progress developments and cost reduction work. The Public Partnerships Committee **DISCUSSED** and was **ASSURED** from the proposed action plan.	
	COMFORT BREAK	
PPC/2324/029	**Update: Membership, Terms of Reference (TORs) and steps to implement actions made** The ICB Public Partnership Committee are recommended to: - • **DISCUSS** and **AGREE** the highlighted next steps to implement the phase 2 elements of the committee. ST presented this paper which set out the implementation of agreements made in supporting phase 2 of the Public Partnership Committee. Phase 1 saw the transition from the former CCG Engagement Committee approach into the ICB's Patient and Public Partnership Committee. Phase 2 discussions had focussed on future sub-structures of the committee and membership requirements. JC noted a slight conflict potential for some members and advised they could leave the meeting if they wished. **Discussions:** **Sub-Groups**: The PPC had previously agreed to the adoption of 4 subgroups to support the work of the committee and progress was being made in all areas: - • Co-Production Group • Insight Group • Lay Reference Group • Confirm & Challenge Sessions	

	• SB asked about the Insight Group meetings which took place on a monthly basis and queried the lack of feedback from the meeting if they were a subgroup to the committee. **Action: Insight Group Highlight Report/Minutes to be brought to future PPC meetings add to forward planner.**	**LF**
	• SS asked regarding the setting up of the Lay Reference Group and whether the group was as diverse as possible as diversity was a concern. Was there a need to reach out into other areas as this was a good opportunity to diversify and look to see whether we have the right level of diversity. **Action: Specific issue for committee – Diversity of Membership/Engagement Discussion (July or Sept meeting)**	**KL**
	• KL stated that increasing diversity was something that was being done every day. Due to other commitments renumeration had been considered if they were to give up valuable time as some people need an incentive. **Action: KL to circulate attendees of the evaluation workshop to show diversity.**	**KL**
	• HD informed members that she had attended a Voluntary and Community Social Enterprise (VCSE) Event which had insight and engagement as one of the workshops. There were over 200 representatives from across Derby and Derbyshire.	
	Action: **Paper detailing subgroups brought to the February meeting to be circulated to new members for information.**	**KL**
	Membership: The membership of the PPC had been agreed in the amendments to the TORs and now included the ICB Executive Director of Strategy and Planning to incorporate commissioning. The process of appointments will be led by JC with lay member appointments being for 2-3 years. There was still a need to confirm with the voluntary sector around their representatives, along with encouraging appointments from the Local Authorities although it was NHS business only that the committee would be discussing.	
	• SB supported the idea of changing lay representatives so not to lose out on other ideas and experiences but when it comes to the point of election of lay representatives who does the election. ST suggested it would go out to other groups with particular interest such as Place Alliance and Primary Care Networks (PCNs). Appointing to Committee there would be an interview process if several applications were received.	
	• TP felt the auto selection for 2-3 years a bit uncomfortable but felt it needed to involve such as the Patient Participation Groups (PPG) within the process as much as possible.	

	• SS was concerned representatives could come from the same group if the lay rep group was going to be more diverse then it was necessary to outline that only one from each of the groups would be accepted as it would be a mistake if some groups were not represented and there were several from the same group. The Public Partnerships Committee **DISCUSSED** and **AGREED** the highlighted next steps to implement the phase 2 elements of the committee. The Public Partnerships Committee **AGREED** the appointment process could commence.	
CLOSING ITEMS		
PPC/2324/030	**Any Other Business** No further business was raised.	
DATE AND TIME OF NEXT MEETING		
Date: Tuesday 25 July 2023		
Time: 10:00 – 12:00		
Venue: MS Teams		
NB: Committee on Tuesday 29 August has been stood down		

MINUTES OF THE ICB QUALITY & PERFORMANCE COMMITTEE HELD ON 29th June 2023, 09:00 – 10:30 FLORENCE NIGHTINGALE BOARDROOM, CARDINAL SQUARE & MS TEAMS

Present:		
Adedeji Okubadejo (Chair)	AO	Non-Exec Director, DDICB
Lynn Andrews	LA	Non-Exec Director, DHCFT
Kay Fawcett	KF	Non-Exec Director, DCHS
Brigid Stacey	BS	CNO & Deputy Chief Exec, DDICB
Chris Weiner	CW	Medical Director, DDICB
Zara Jones	ZJ	Executive Director of Strategy and Planning, DDICB
In Attendance:		
Joanne Pearce (Minutes)	JP	Executive Assistant to Brigid Stacey - DDICB
Tracy Burton	TB	Deputy Chief Nurse – DDICB
Jo Hunter	JH	Director of Quality, DDICB
Samuel Kabiswa	SK	Assistant Director Planning and Performance
Dan Merrison	DM	Senior Performance & Assurance Manager, DDICB
Richard Doane – until 9:33am	RD	Planned Care Programme Director
Monica McAlindon- until 9:33am	MM	Head of Cancer Commissioning and Derbyshire ICS Cancer Programme Lead
Lisa Coppinger	LC	Local Area Contact (LAC) for Derbyshire LeDeR Programme and Workstream Lead for Neurodevelopmental Health Inequalities
Apologies:		
Jayne Stringfellow	JS	Non-Exec Director – CRHFT
Robyn Dewis	RD	Director of Public Health – Derby City Council

Ref:	Item	Action
Q&P/2324 /026	**Welcome, introductions and apologies** AO welcomed all to the meeting, introductions were made, and apologies noted as above.	
Q&P/2324 /027	**Confirmation of Quoracy** The meeting was confirmed as **not being quorate** as it did not meet the quoracy requirements of two Non-Executive Members, one ICB Executive or Deputy, one Provider Representative and one Local Authority Representative. There was no representative from the Local Authority.	
Q&P/2324 /028	**Declarations of Interest** AO reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the ICB. Declarations declared by members of the ICB Quality and Performance Committee are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the	

	Executive Assistant to the Board or the ICB website at the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/?cn-reloaded=1 Declarations of interest from sub-committees No declarations of interest were made. Declarations of interest from today's meeting No declarations of interest were made. There were no declarations of interest noted.	
Q&P/2324 /029	**Integrated Performance Report (IPR)** **Quality** JH noted the key highlights in terms of quality of the IPR. • The maternity team are currently developing the LMNS plan. • The IPC trajectory for 2023/24 has been received from NHS England. The trajectory will be challenging to meet considering the performance for last year and the data for quarter 2. • There has been a reported never event around wrong site surgery. This is being investigated appropriately. **Performance** DM noted the key highlight in terms of performance of the IPR. **Urgent Care** During May, the urgent care service experienced pressures which affected ED performance and handovers. There were also bank holidays and industrial action which had an additional impact; however, mitigations were put in place. Delayed discharges also peaked at the beginning of June. Since then, there has been an improvement in performance and the system has recently been one of the best in the region in terms of ambulance handovers. **Planned Care** This was also affected by the bank holidays and industrial action. 52 and 65 day waits are starting to increase, and these numbers are being monitored. **Diagnostics** The diagnostic's waiting list has seen a reduction; however, the six-week performance continues to fluctuate. **Cancer** Referrals continue and these are higher than pre pandemic levels. This is affecting pathways especially at the 62-day stage. **Mental Health** IAPT access and early intervention for psychosis is performing better than expected. Access to perinatal service and Children And Young People's Eating Disorders it is improving. Inappropriate out of area placements and the number of LDA patients in impatient care are below local trajectories.	

	ZJ referred to the improvement in ambulance handover times and noted there is no evidence of improvement in the Cat 2 response time. The unvalidated position does not triangulate. Teams are trying to understand the figures and more work is being carried out to understand the reasons looking at activity, performance and workforce. The workforce plan for EMAS looks to be significantly under planned and this may be a contributing factor. ZJ referred to urgent care and A&E activity data, conversations are taking place around what is included in these figures which may contribute to the reasons why the system is benchmarked low in comparison to other areas in the region whilst at the same time performance seems to be improving. ZJ referred to LD and noted the work being carried out by the ICB around Transforming Care. The system has negotiated a lower trajectory which is currently on plan. KF referred to the 12-hour decision to admit where figures are not decreasing and asked if this was due to the inability to discharge patients. BS gave assurance that following visits from the ICB to both acute trusts, evidence showed patients receiving appropriate nursing care whilst in A&E. TB confirmed that it had been acknowledged at the A&E Delivery Board, length of stay and decision to admit figures are high at UHDBFT. There is strong governance process in place to look at harm and to ensure patients are safe and well whilst waiting in A&E. Early conversations are taking place to identify what the trusts are looking at in terms of harm. LA asked for further assurance around CDiff and asked when the planned improvements which are in progress are due to be delivered. BS noted the challenges around 2022/23 delivery and the current targets which have been nationally recognised. Both trusts are on heightened escalation with the regional team and are part of the regional collaborative for CDiff. Both trusts have received visits from the regional IPC lead. Deep dives have been carried out at both organisations; action plans are in place. There is an issue around compliance for medical staff at CRHFT and robust measures are in place to resolve this issue. There is a system IPC summit planned for September. BS suggested a deep dive is brought to this meeting in October. TB Added that although there are high numbers in relation to CDiff the RCA's have highlighted that there were no lapses in care. KF referred to the continued increase in stillbirths at UHDBFT and asked if there were any contributory factors and asked what the trust are doing to identify the reasons for the increase. CW responded to say there is no single action the trust can take to resolve the issues around the increase in stillbirths. UHDBFT are carrying out a review of stillbirths and it is hoped the detail of this review will be available later this year. Pace is needed in the delivery of the transformation work that has been identified through the Ockendon report and saving babies lives. UHDBFT order into significant scrutiny and the oversight around the delivery of their plan will be subject to a Tier 3 review meeting on July 5th, 2023.	

	NOF Q1 Submissions JH presented on behalf of the Corporate Delivery Directorate. The Committee are asked to note the segmentations within the report. Previous recommendations where that the segmentations should remain as they are. The Committee approved the NOF Q1 segmentations.	
	Deep Dive – LeDeR Review Process PS gave an overview of the LeDeR Review process and LC shared the attached presentation. Link is listed below. LA referred to health inequalities and the LDA reviews and asked if there is an inequality in access that increases mortality in Derbyshire and if work is being done around this. LC responded to say that one of the issues is around the notifications that have been received however this has improved in the last year. There is also a BAME lead who is part of the wider LeDeR team who will look to identify if there are inequalities in these areas. CW noted that there is no one coordinating the epilepsy response at a local level, CW ask that LC formally write to him highlighting the concerns so that he can take this matter further. BS noted the significant reduction in deaths which related to constipation, and they hope that the new work being undertaken around epilepsy will have similar outcomes. AO asked if aspiration pneumonia is at the expected level and if acute kidney injury was due to dehydration or other causes. LC confirmed that aspiration pneumonia figures are high in other areas and have been one of the top reasons for death. AO noted two areas of concern, the first was around sharing of information across providers and the second is around DNA CPR and the high percentage of this process not being followed correctly. JH explained that the figures for DNA CPR are high across the country and there are links to other sections of the population, in particular people with dementia. System work is being undertaken to identify the similarities and put improvements in place. JH highlighted that this had been identified by the LeDeR team prior to it being published as being a national issue. 031a - LeDeR Presentation - 22-5-2	
	Deep Dive – Role of the LMNS	

	CW explained that maternity services is an area of work that is facing intense scrutiny at a national level. At a local level, the areas of concern are related to UHDBFT. In terms of work that is being undertaken at UHDBFT there is the HSIB report thematic review which identified a number of key learning points. UHDBFT also invited the national support team for maternity services list to undertake a review of UHDBFT services. A report is being written highlighting recommendations of work that needs to be undertaken to improve services and outcomes. It is clear that the improvement programme needs to be accelerated and UHDBFT are collecting a prioritised improvement plan. CW assured the committee that the ICB have oversight of the current situation at UHDBFT but noted the concerns locally around the amount of work required to deliver the quality of services for the Derby and Derbyshire community. TB acknowledged the current issues around third-degree tears, moderate harm and stillbirths and that the trust is working hard to deliver improvements in these areas. KF raised concerns around training, workforce and foetal monitoring within Ockendon and the lack of compliance with MSDS data for MIS. CW confirmed that the trust does acknowledge and understand the concerns. There is clear leadership from the Chief Executive and Director Of Nursing. The trust is in the process of recruiting to a new Head Of Midwifery and there is a new Obstetric lead in place. There is still work to do around changing the culture in the organisation. TB added that over the last nine months UHDBFT were working with 50% of establishment for midwives. In terms of PROMPT the trust is testing new ways of working to bring together Anaesthetists , Obstetricians and Midwives. 13 new Midwives are expected in September which will pose a risk as well as a gain. AO summarised noting the amount of work that is being undertaken. Confirmation that the organisation understands and acknowledges the concerns and issues raised. There is engagement from leadership. Significant concerns remain; however, the committee appreciate that a quality improvement plan is being developed by UHDBFT which will be reviewed and managed through the LMNS process to ensure there is appropriate support and challenge. AO requested an update be brought back to Quality and Performance Committee in November which will link the work with the thematic review on perinatal mortality.  032a - QP 230629 Maternity and the rc	
	Board Assurance Framework (BAF) JH presented the paper and noted there are two strategic risks which are managed through the Quality And Performance Committee. A BAF	

	Working Group has been established and met for the first time on 5th June 23. The updates from that meeting are highlighted within the report. There was a detailed discussion around strategic risk SR10, and it was felt this was a duplication of risk SR02. The description of risk SR02 will be amended to reflect these discussions. All members of Quality And Performance Committee are invited to be part of the BAF Working Group, and the invites will be circulated to Quality And Performance Committee members. There were no comments or questions raised by committee members.	
	Risk Stratification And Harm LH took the paper as read. LH noted the progress in areas for all providers. Most areas within the report have an amber rating and it is anticipated these will progress to green by the end of Q4. It is assuring to see processes are being strengthened and developed in terms of communication with GP practices. Going forward the aim is to improve communication with Primary Care as a whole. Processes are in place at all providers around harm reviews and any elements of harm which are moderate or severe are being reviewed through the Patient Safety Incident Response Framework (PSIRF). Next steps are to reassess the template which provides complete as well as closer working with GP partners and practises to identify how patient experience can be captured. AO noted the harm reviews do not include psychological impact on people waiting. LH will explore to see if that is an element within the questioning.	
	System Quality Group Assurance Report JH presented the paper noting there were no areas of concern to escalate following the System Quality Group meeting on 5th June 23. The committee noted the contents of the report.	
Q&P/2324 /023	**Any Other Business** No other matters of business were raised by committee members.	
	Minutes and Matters Arising	
Q&P/2324 /024	**Minutes From The Meeting Held On 25th May 2023.** The minutes from the meetings on 25th May 2023 were approved as a true and accurate record pending the amendment for the job title of Kay Fawcett.	

Q&P/2324 /025	**Action Log and Future Papers - From The Meeting Held On 25th May 2023** The action log was reviewed, and confirmation given that there were no outstanding actions.	
Closing Items		
	Forward Planner	
DATE AND TIME OF NEXT MEETING		
Date: Thursday 27th July 2023		
Time: 9.30am to 11.00am		
Venue: Florence Nightingale Room, Cardinal Square, DE1 3QT		

MINUTES OF THE ICB QUALITY & PERFORMANCE COMMITTEE HELD ON 27th July 2023, 09:00 – 10:30 FLORENCE NIGHTINGALE BOARDROOM, CARDINAL SQUARE & MS TEAMS

Present:		
Adedeji Okubadejo (Chair)	AO	Non-Exec Director, DDICB
Paul Lumsdon	PL	Interim Chief Nurse, DDICB
Jill Dentith	JD	Non Exec Director, DDICB
Jayne Stringfellow	JS	Non-Exec Director , CRHFT
Lynn Andrews	LA	Non-Exec Director, DHCFT
In Attendance		
Joanne Pearce (Minutes)	JP	Executive Assistant to Paul Lumsdon - DDICB
Jo Hunter	JH	Director of Quality, DDICB
Dan Merrison	DM	Senior Performance & Assurance Manager, DDICB
Samuel Kabiswa	SK	Assistant Director Planning and Performance
Letitia Harris	LH	Assistant Director Of Quality
Anne Pridgeon	AP	Head of Maternity Transformation Programme
Richard Doane	RD	Planned Care Programme Director
Monica Mcalindon	MM	Senior Commissioning Manager Operations
Apologies:		
Gemma Poulter	GP	Assistant Director, Safeguarding, Performance and Quality- Derbyshire County Council
Zara Jones	ZJ	Executive Director of Strategy and Planning, DDICB
Craig Cook	CC	Chief Data Analyst, DDICB
Kay Fawcett	KF	Non-Exec Director, DCHS

Ref:	Item	Action
Q&P/2324/039	**Welcome, introductions and apologies.** AO welcomed all to the meeting, introductions were made, and apologies noted as above.	
Q&P/2324/040	**Confirmation of Quoracy** The meeting was confirmed as **not being quorate** as it did not meet the quoracy requirements of two Non-Executive Members, one ICB Executive or Deputy, one Provider Representative and one Local Authority Representative. There was no representative from the Local Authority.	
Q&P/2324/041	**Declarations of Interest** AO reminded Committee members of their obligation to declare any interest they may have on any issues arising at Committee meetings which might conflict with the business of the ICB. Declarations declared by members of the ICB Quality and Performance Committee are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Board or the ICB website at the following link:	

	https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/?cn-reloaded=1 Declarations of interest from sub-Committees No declarations of interest were made. Declarations of interest from today's meeting No declarations of interest were made. There were no declarations of interest noted.	
Q&P/2324 /042	**Integrated performance report** JH presented the quality aspect of the report and noted the high level of focus on maternity services. UHDBFT have received the Royal College of Physicians feedback report following a review of the stroke services, there is an improvement plan being developed. A deep dive on stroke services will be brought back to a future Q and P Committee meeting. In terms of the Transforming Care Programme, there is currently a recovery action plan in place. A series of desktop reviews are being carried out, to provide assurance around the data and the estimated discharge dates. Updates will be brought back to this meeting as the work continues. DM presented the performance element of the report and noted the positive picture for May and June despite the recent industrial action and bank holidays. **Urgent Care** Preventative schemes such as the community response and home visiting service are doing better than expected. Unfortunately, there has been longer response times, especially for category 2 incidents. Hand over times have improved in relation to ambulance handovers and there has been a steady improvement in the four-hour standard. Bed occupancy remains high with more inpatients than expected with the with the criteria to reside meaning long stay patients remain an issue. **Planned Care** Provisional data received yesterday showed there were zero 104 or 78 week waits. There has been a rise in 65-week waiters. **Diagnostics** There has been an improvement in performance. In diagnostic **Cancer** An improved 62-day position. **Mental Health**. IAPT access is better than expected. The dementia diagnosis rates are approaching targets. Early intervention for psychosis continues to do well against target. Out of area placements remain high but are below the target.	

	The Committee were asked for any questions. JD noted the virtual ward remains underutilised and asked how the ICB will put more focus on virtual wards. SK responded to say there are several elements that have been a factor in the underutilisation. there has been an issue with the deployment of the digital tool used by clinicians to monitor vital statistics. The tool has recently been launched and therefore utilisation should increase over the next couple of months. The rate of recruitment varies on each ward and there is also hesitancy around using capacity on the virtual wards directly before winter hits. JD noted a third of the delays that relate to people seven days or longer are associated with hospital process issues and asked why the system cannot enforce some changes. DM explained the rate has been consistent since May, the information is received by the SORG meetings which are attended by the operational leads from the acute trusts and DM confirmed that he would be happy to feedback this comment. PL referred to the virtual wards and added that he would welcome seeing a breakdown of the improvement trajectory into October. PL referred to the mental health data and noted there are some omissions and asked when the missing data would be available. SK explained that the missing data is due to timings. Published data from NHSE is approximately three months old. SK is meeting with colleagues from the mental health trust to explore ways of accessing data which has not been published but would be more reliable. JS referred to stroke services and reporting back to this Committee. JS suggested a report to look back and identify from the reports received, any similarities between the issues experienced within stroke services at UHDBFT and CRHFT. SK agreed to progress this piece of work and feedback to the Committee. AO asked if the 65-week wait is being impacted by the improvement in performance against the 78 weeks wait. RD explained how the waits are being measured and assured the Committee as a whole cohort of 78- and 65-week waiters the figures are actually decreasing in line with trajectory. RD noted the pressure points in specialities that are not performing well, and this is the reason the 65 weeks wait trajectory is increasing. LA made a comment around how this Committee can add value around the improvements for the patients of Derby and Derbyshire as opposed to focusing on how targets are being met. JH conformed that discussions have taken place around how the Quality and performance Committee can be sighted on the quality improvement work that is taking place across the system and how this can be fed into the deep dives.	

	AO noted the comments and questions received from Committee members. AO highlighted the importance around focusing on quality across the system without ignoring the fact the ICB has to report on targets but reiterated the importance of achieving a balance. AO acknowledge the ongoing concerns around maternity and the work that is taking place to make improvements, there will be a detailed report presented to the Committee in autumn. An update around virtual wards will be received within the integrated performance report at the meeting in August or September. There are concerns around delayed discharges and a deep dive on this topic will come to the Committee in December. **Action** – JP to add to the forward planner	**JP**
Q&P/2324 /043	**Deep Dive – Cancer 62 day waits.** RD shared the presentation for the deep dive around 62-day cancer waits. A copy of the presentation can be obtained on request. 043 - QP Cancer JUL23 FINAL.pptx Key highlights to note are: • Focus is on the 28-day faster diagnosis and the number of patients waiting over62 days from referral to treatment. • CRHFT have 44 patients waiting over 62 days against the trajectory of 29. • UHDBFT have 377 against a target of 376. For context, this time last year there was over 850 patients waiting. • Cancer performance pathways continue to struggle. • Referrals are the main factor that drives the position and work has been done to understand what is driving the increased activity. • Derbyshire is an outlier in terms of the increase of referrals since 2019 with a 15-17% increase in 2 week wait referrals. • The deep dive carried out into the referral order showed that while Derbyshire referrals have increased by 20%, in line with the national picture, the referrals into UHDB from the Staffordshire system were at almost 50%. • That activity has been very much driven by lower GI and skin referrals. Staffordshire, they have implemented some referral pathways around lower GI and Skin and it is clear that changes taking place in Staffordshire are driving patients to come to Derbyshire. • There is pressure across the cancer program currently to focus on early diagnosis. The long-term plan talks about 75% of cancers being diagnosed at stage one and two by 2028. • The system is currently at 40%. There is hesitancy around doing big early diagnosis and prevention programs of work because of the impact on the acutes capacity. • Pathfinder is available to support clinical decision making in primary care. the Derbyshire system Cancer alliance have	

invested in this however we still really struggle to get people to use it.

- Histology presents issues in terms of turnaround times at UHDBFT. There is cancer recovery plan in place. Outsourcing as suggested could destabilise the current workforce.
- There are oncology and challenges at UHDBFT. Derbyshire is one of the worst regions in terms of the ratio of oncologist staff and patients.
- There is a piece of work being led regionally to support the system to develop different ways of working.
- CW supported a piece of work regionally over the past couple of months to benchmark where we were regionally and to look at how mutual aid could work. Unfortunately, it has not been supported regionally, so we need to find ways to work differently across Derbyshire.
- from a lower GI point of view, we are rule out cancer as quickly as possible.
- The PTL and the MDT management processes are being followed through to try to make it as slick as possible.
- best practice time pathways are about delivering care as effectively as possible and making sure that there is the right capacity at the right sequence in the pathway to optimize the outcome for patients.
- Developed a system steering group around referrals which is made up of PCN cancer leads and GP provider Board.
- Working with the Cancer Alliance to look at how we can deliver training to support the completion of referral forms.

The following questions were submitted by Committee members.

Is there any learning from the acute trusts that can be shared?
MM replied to say that there is a wealth of organisations that Derbyshire is connected with due to its locality.

Is the Cancer team liaising with the Digital team to ensure collaborative working?
MM confirmed that the cancer team are linked to the Digital team however this could be improved.

Is there a reason for the rise in Staffordshire and Stoke referrals?
RD replied to say that it has been suggested that the increase could be due to challenges in other providers in terms of capacity, however this needs to be explored in more detail.

Is the system planning for an increase in referrals which is an effect of patients increased awareness and sensitivity to ensure there are no future backlogs?
RD agreed that work needs to be done around demand and capacity modelling. The system needs to carry this process out on a more regular basis so that fluctuations in capacity can be understood and plans can be adjusted accordingly.

	How much is the availability of workforce impacting the waiting lists in terms of cross working? RD confirmed there are areas where there are challenges with workforce one of the most acute is oncology not only in Derbyshire but nationally. RD agreed that there needs to be a more networked approach to ensure patients are not disadvantaged. AO thanked RD and MM for the deep dive on cancer waits noting the challenges around digital enablers and how AI can be used safely and effectively in the system. The Committee received the presentation and were assured by its contents.	
Q&P/2324 /044	**Board Assurance Framework (BAF)** JH presented the paper on behalf of the corporate directorate. JH noted risks one and two for which the quality and performance Committee are responsible. extensive work has been carried out in relation to the strategic risks following an internal audit feedback. the risks are in continual development. JH referred to the updates for this Q1 and informed Committee members of the task and finish group which meets on a monthly basis to review undiscussed the risks in more detail. There were no questions or comments raised by the Committee. The Committee received the Board Assurance Framework and were assured by its contents.	
Q&P/2324 /045	**System Quality Group Assurance Report** JH presented the paper to the Committee noting there were no areas of concern to highlight or escalate following the system quality group meeting on 4th July 2023. JH noted a piece of work taking place within the system around the response to chronic lymphoedema where there is a recognised gap in provision. the system quality group have supported the work taking place and have asked for a business case to be developed and brought back to the group at a future date. relevant staff from relevant organisations are engaged in the work. JH also noted that any deep dive presented to the quality and performance Committee will have been presented to the previous system quality group to ensure system partners are aware of what is being submitted and are given the opportunity to challenge the content. AO Asked Committee members for questions and comments. The following questions were submitted.	

	What is the focus on IPC due to the current position and monitoring? JH confirmed that a deep dive on IPC is due to be brought to the next Quality and Performance Committee in August 23. PL added there will be a focused piece of work on both acute trusts around their action plans and improvements. Cdiff rates are concerning. PL will be gathering information on what is happening at a local level. The Committee received the System Quality Group Assurance Report and were assured by its contents.	
Q&P/2324 /046	**Q4 Risk Stratification** LH presented the paper to the Committee noting that since circulation of the papers additional data has been received from DCHS and CRH. The report has been updated and will be circulated after this meeting. There is slow but significant progress taking place with regards to the strengthening of and priorities in the risk stratification processes. LH gave assurance that no harms have been identified as a result of the risk stratification and clinical review processes. Organisations have been asked to look at how they can put systems and processes in place to capture psychological harm monitoring, this was a request from the quality and performance Committee meeting in July 2023. With regards to patient feedback, the system is looking at strengthening the conversations and communication between teams and how we feed it into improvement methodology and improving patient outcomes. AO Asked Committee members for questions and comments. The following questions were submitted. Is the system assured around equity of access? LH confirmed that processes are in place however they do need to be strengthened and therefore would suggest partial assurance. The Committee received the paper and acknowledged that further assurance will be gained at future meetings.	
Q&P/2324 /047	**Quality Accounts** The papers were taken as read and JH noted the Quality Accounts have been published on the respective organisation's websites.	

Minutes and Matters Arising		
Q&P/2324 /048	**Minutes From the Meeting Held On 29th June 2023.** The minutes from the meetings on 29th June 2023 were approved as a true and accurate record.	
Q&P/2324 /049	**Action Log and Future Papers - From the Meeting Held On 29th June 2023.** The action log was reviewed and updated.	
Closing Items		
Q&P/2324 /050	**Forward Planner** It was agreed that the following papers will be added to the forward planner. Delayed Discharges – November 23 Maternity – November 23	
Q&P/2324 /051	**AOB** **There were no matters raised under AOB**	

Assurance Questions		
1	Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes?	Yes
2	Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations?	Yes
3	Has the Committee discussed everything identified under the BAF and/or Risk Register, and are there any changes to be made to these documents as a result of these discussions?	Yes
4	Were papers that have already been reported on at another Committee presented to you in a summary form?	Yes
5	Was the content of the papers suitable and appropriate for the public domain?	Yes
6	Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes?	Yes
7	Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting?	Plan to be received at next meeting
8	What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting?	AO will discuss further with PL and JH
DATE AND TIME OF NEXT MEETING		
Date: Thursday 31st August 2023		
Time: 9.30am to 11.00am		
Venue: Florence Nightingale Room, Cardinal Square, DE1 3QT		

NHS
Derby and Derbyshire
Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board

Meeting in Public

Forward Planner 2023/24

Please Note: All reporting timeframes are currently indicative and subject to review and confirmation.

ICB Key Areas	20 Apr	15 Jun	20 Jul	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
Welcome / Apologies and Quoracy	X	X	X	X		X		X		X
Declarations of Interests • Register of Interest • Summary register of interest declared during the meeting • Glossary	X	X	X	X		X		X		X
Minutes and Matters Arising										
Minutes of the previous meeting	X	X	X	X		X		X		X
Action Log	X	X	X	X		X		X		X
Strategy and Leadership										
Chair's Report	X	X	X	X		X		X		X
Chief Executive Officer's Report	X	X	X	X		X		X		X
Annual Report and Accounts				X						
Risk Management										
Risk Register	X		X	X		X		X		X

ICB Key Areas	20 Apr	15 Jun	20 Jul	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
Board Assurance Framework		X				X		X		X
Strategic Planning & Commissioning										
NHS Joint Forward Plan	X	X	X					X		
NHS Long Term Workforce Plan			X			X				
Operational Plan 2023/24		X						X		
Organisational Development and People – ICB staff survey		X						X		
Organisation Development and People - ICB Strategic Framework		X								
Medium Term Financial Planning								X		
Financial Plan	X	X								X
Winter Plan						X				
Primary Care Strategy						X				
Innovation & Information • Digital Development Update • Research	X									X
Green NHS Progress						X				
One Public Estate Strategy										X
Memorandum of Understanding - Voluntary, Community and Social Enterprise Sector and the ICB		X								

ICB Key Areas	20 Apr	15 Jun	20 Jul	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
Partnership Consultation for DCHSFT Organisational Strategy 2023-2028			X							
System Focus										
Integrated Care Strategy								X		
Population Health & Inequalities						X				X
Place Alliance and Provider Collaborative update						X				
Integrated Assurance & Performance										
Integrated Assurance and Performance Report • Quality • Performance • Workforce • Finance	X		X	X		X		X		X
Corporate Assurance										
Constitution				X						
Audit and Governance Committee Assurance Report	X		X	X		X		X		X
Finance and Estates Committee Assurance Report – verbal	X	X	X	X		X		X		X
People and Culture Committee Assurance Committee			X	X		X		X		X
Population Health and Strategic Commissioning Committee Assurance Report			X	X		X		X		X
Public Partnership Committee Assurance Committee	X		X	X		X		X		X

ICB Key Areas	20 Apr	15 Jun	20 Jul	21 Sep	19 Oct	16 Nov	14 Dec	18 Jan	15 Feb	21 Mar
Quality and Performance Committee Assurance Report	X		X	X		X		X		X
Corporate Committees' Annual Reports						X				
Update and review of Committee TORs				X						
Delegation of Pharmacy, Optometry and Dental Services Update	X									
Hewitt Review – Government response			X							
For Information										
Domestic abuse, sexual violence and serious violence duty briefing	X									
Delegation of Pharmacy, Optometry and Dental Services Update				X						
Ratified Minutes of ICB Corporate Committees	X		X	X		X		X		X
Ratified Minutes of Health & Wellbeing Boards		X		X		X		X		X
Closing Items										
Forward Planner	X	X	X	X		X		X		X
Risk Assurance Questions			X	X		X		X		X
Any Other Business	X	X	X	X		X		X		X
Questions received from members of the public	X	X	X	X		X		X		X